Eastern Oregon CCO

2022 CCO 2.0 Value-Based Payment & Health Information Technology Pre-Interview Questionnaire

Introduction

Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, will be scheduled for June 2022. Please schedule here.

Staff from the OHSU Center for Health Systems Effectiveness (CHSE) will be conducting the CCO VBP interviews again this year. Similarly, they will be using information collected as part of the larger evaluation effort of the CCO 2.0 VBP Roadmap.

Please complete **Section I** of this document and return it as a Microsoft Word document to OHA.VBP@dhsoha.state.or.us by **Saturday, May 7, 2022**.

All the information provided in Section I is subject to the redaction process prior to public posting. OHA will communicate the deadline for submitting redactions after the VPB interviews have been completed.

Section II of this document describes the oral interview topic areas and suggestions for CCO preparation. CCO responses to oral interview questions will be de-identified in publicly reported evaluation results.

If you have questions or need additional information, please contact:

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Section I. Written VBP Interview Questions

Your responses will help the Oregon Health Authority (OHA) better understand your CCO Value-based payment (VBP) activities this year, including detailed information about VBP arrangements and HCP-LAN categories.

A prior version of this questionnaire was collected from your CCO in May 2021. Unless a question specifically instructs otherwise, please focus your responses on new information not previously reported.

1) **In May 2021, you reported the following information about how your CCO engages partners (including providers) in developing, monitoring or evaluating VBP models.**

   EOCCO has an internal VBP workgroup that creates VBPs and engages the quality measure subcommittee of its board to develop, monitor and evaluate VBP models. The subcommittee is made up of hospital, primary care, behavioral health, and public health representatives across EOCCO's geography. EOCCO also discusses VBP models with its Clinical Advisory Panel (CAP) and its contracted providers taking their input and suggestions into consideration when developing new or modifying existing VBP models.

   Any changes or modifications to VBP models or implementation of new VBP models are taken to the EOCCO Board of Directors for approval.

   Please note any changes to this information, including any new or modified activities or formal organizational structures such as committees or advisory groups.

   Due to the strain of the pandemic on the delivery system, EOCCO did not engage the subcommittee made up of hospital, primary care, behavioral health, and public health representatives across EOCCO's geography. EOCCO will continue to evaluate and may engage the quality measure subcommittee in the future.

2) **Has your CCO taken any new or additional steps since May 2021 to modify existing VBP contracts in response to the COVID-19 public health emergency (PHE)? *[Select one]***

   ☐ CCO modified VBP contracts after May 2021 due to the COVID-19 PHE. *[Proceed to question 3]*

☒ CCO did not modify VBP contracts after May 2021 due to the COVID-19 PHE. *[Skip to question 4].*

3) If you indicated in Question 2 that you modified VBP contracts after May 2021 in response to the COVID-19 PHE, please respond to a–f:

a) If the CCO modified *primary care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing PMPM)

b) If the CCO modified *behavioral health care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

c) If the CCO modified *hospital* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)

☐ Modified the payment level or amount (e.g. increasing a PMPM)

d) If the CCO modified ***maternity care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)**

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

e) If the CCO modified ***oral health* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)**

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

The following questions are to better understand your CCO's plan for mitigating adverse effects of VBPs and any modifications to your previously reported strategies. We are interested in plans developed or steps taken since CCOs last reported this information.

4) In May 2021 your CCO reported the following information about processes for mitigating adverse effects VBPs may have on health inequities or any adverse health-related outcomes for any specific population (including racial, ethnic, and culturally based communities; LGBTQ people; people with disabilities; people with limited English proficiency; immigrants or refugees; members with complex health care needs; and populations at the intersections of these groups).

EOCCO has strategies in place for addressing health equity, which help ensure that VBPs do not have adverse effects on any underserved population.

These include strategies targeting both processes and outcomes.

Examples of process strategies include the following:

1. EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data.
2. EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis.

To measure outcomes, EOCCO uses a 'health equity index' to quantify disparities in utilization. This index is based on comparing the age-adjusted utilization levels of certain indicator services (such as PCP office visits) by population. Due to the low number of members in certain groups and the low utilization counts for certain services (e.g. back surgeries for non-English-speaking Asian members), the index is based on a basket of higher-volume services for which a sufficient volume of data exists to achieve credibility. Initial findings of the health equity index suggest that primary care VBPs might be correlated with a reduction in health inequity, perhaps due to the significant focus on member outreach across the entire EOCCO population to achieve quality measures.

EOCCO provides clinics with monthly quality reports and member rosters that include demographic and language data. EOCCO is currently working on collecting more comprehensive REALD data through Arcadia Analytics, our population health management tool, as well as the Accountable Health Communities (AHC) grant project.

The EOCCO Quality Improvement Team stratifies incentive measures by race, ethnicity, language, disability, and other demographic data to identify disparities in care or health outcomes. The team will then implement targeted interventions to address the identified disparities.

Please note any changes to this information since May 2021, including any new or modified activities.

EOCCO collected updated REALD data through the Accountable Health Communities (AHC) Grant project. A team of students at OHSU conducted SDoH screening calls with EOCCO members and collected updated REALD data. Updated REALD data is vital for EOCCO to mitigate adverse effects VBPs may have on health inequities. EOCCO was able to integrate this data into its Data Warehouse to

include in its provider reporting package that is described in the response above and in more detail in question 11.b.

Additionally, EOCCO is in the process of implementing the Unite Us platform across our 12-county service-area which will help all health care and community-based organization send and receive referrals for social needs. In addition to this, EOCCO will receive SDoH data on its population which will further assist us in addressing the complex needs of our member populations. EOCCO is considering how best to integrate this data into its reporting package as well.

5) **Is your CCO planning to incorporate risk adjustment for social factors in the design of new VBP models, or in the refinement of existing VBP models? [Note: OHA does not require CCOs to do so.]**

EOCCO is not planning to incorporate risk adjustment for social factors in the 2022 VBP model. It is yet to be determined for 2023.

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements that will take effect in 2023 or later. This includes oral health and children's health care areas. CCOs are required to implement a new or enhanced VBP in <u>one</u> of these areas by 2023. CCOs must implement a new or enhanced VBP model in the remaining area by 2024.

6) **Describe your CCO's plans for developing VBP arrangements specifically for <u>oral health care</u> payments.**
   a. **What steps have you taken to develop VBP models for this care delivery area?**

      EOCCO is in the initial phase of development. The internal VBP workgroup will be used to develop and implement this CDA. EOCCO has engaged DCO partners to better understand the current VBP arrangement with their provider network, to help inform current activities.

b. **What attributes do you intend to incorporate into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier).**

EOCCO will focus on implementing a quality measure. The quality measure will meet the requirements outlined in Exhibit H of the CCO contract.

c. **When do you intend to implement this VBP model?**

Implementation is scheduled for a 1/1/2023 effective date.

7) **Describe your CCO's plans for developing VBP arrangements specifically for <u>children's health care</u> payments.**
   a. **What steps have you taken to develop VBP models for this care delivery area?**

   EOCCO is in the initial phase of development, as many of quality measures are already included within the current quality bonus formula within the shared saving model.

   b. **What attributes do you intend to incorporate into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier).**

   Due to EOCCO's expansive rural and frontier geography, many of our children are seen at family practice clinics versus pediatric clinics. Due to this, we will focus on quality measures.

   c. **When do you intend to implement this VBP model?**

   Implementation is scheduled for a 1/1/2024 effective date.

8) **CCOs will be required in 2023 to make 20% of payments to providers in arrangements classified as HCP-LAN category <u>3B or higher</u> (i.e. downside risk arrangements). Describe the steps your CCO is taking in 2022 to prepare to meet this requirement.**

EOCCO is currently meeting the requirement of having 20% of payments at 3B or higher. However, to ensure suitability throughout 2024 and beyond, EOCCO is continuing to utilize the internal VBP workgroup to monitor and evaluate VBP

models. One area being evaluated is the use of downside risk for behavioral health providers.

EOCCO also continues to engage the Clinical Advisory Panel (CAP) and its contracted providers to obtain their input and suggestions when developing new or modifying existing VBP models.

The following questions are to better understand your CCO's technical assistance (TA) needs and requests related to VBPs.

9) **What TA can OHA provide that would support your CCO's achievement of CCO 2.0 VBP requirements?**

No support identified.

10) **Aside from TA, what else could support your achievement of CCO 2.0 VBP requirements?**

No support identified.

Health Information Technology (HIT) for VBP and Population Health Management

Questions in this section were previously included in the CCO HIT Roadmap questionnaire and relate to your CCO's HIT capabilities for the purposes of supporting VBP and population management. Please focus responses on new information since your last HIT Roadmap submission on March 15, 2021.

Note: Your CCO will not be asked to report this information elsewhere. This section has been removed from the CCO HIT Roadmap questionnaire / requirement.

11) You previously provided the following information about the HIT tools your CCO uses for VBP and population management including:

a. HIT tool(s) to manage data and assess performance

EOCCO utilizes the Arcadia Analytics Population Health Management tool to manage data and assess performance on VBP measures. Arcadia Analytics is a health information exchange (HIE) platform that integrates EHR data with pharmacy, medical, behavioral, and oral health claims as well as EOCCO eligibility files to create a single patient record to be shared across the exchange. The platform provides a quality performance dashboard, care gap lists, condition history, utilization history, upcoming appointments, medications, problem lists, demographics, provider attribution, and risk scores.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

EOCCO has three new healthcare systems live on the Arcadia platform since March 15, 2021, and one that is in the initial phases of onboarding. EOCCO also plans to utilize the Arcadia Analytics platform to measure performance on the Plan All-Cause Readmission measure that's part of one of our new care delivery areas.

Since the previous year's submission, EOCCO has implemented VBP arrangements with its contracted community mental health programs (CMHPs) utilizing a different measure set than what is used under EOCCO's primary care agreements. In addition to Arcadia Analytics, EOCCO is currently utilizing the Collective Medical platform to track performance on multiple behavioral health metrics used in the VBP arrangements with

CMHPs. Care coordinators within the CMHPs, and at the CCO, are using Collective Medical to track ED and acute care utilization for our members with behavioral health diagnoses, coordinate follow-up visits, and review progress on readmission targets under the behavioral health VBP arrangements.

b. Analytics tool(s) and types of reports you generate routinely

EOCCO's Analytics team provides an electronic monthly reporting package through a provider reports portal for all primary care clinics who have assigned members and participate in EOCCO's VBP arrangements. In addition, we provide quarterly reporting to hospitals and specialty care groups who participate in shared savings/shared risk VBP arrangements. The available reports and frequency are outlined below.

Report	Description	Use Cases	Frequency
Member Roster	A complete list of all assigned members for which a VBP applies, plus risk stratification, diagnosis history, recent utilization, assigned PCP, and contact information.	Identification of members most likely to benefit from PCP outreach Outreach to high-risk members who utilize the ED and/or are admitted Connect members to primary care	Monthly
Quality and Care Gap Report	Performance statistics on all quality measures that are part of VBPs administered by EOCCO. Also includes list of potential care gaps.	Outreach to members with a care gap Track clinic performance toward quality bonuses	Monthly
Pharmacy Opportunity Report	Specific evidence-based pharmacy management opportunities for all VBP members, such as low medication adherence, low-cost (generic) drug alternatives, polypharmacy, and high-risk opioid prescribing.	Discuss potential opportunities with patients, to: • Lower patient expense • Increase adherence • Reduce opioid risk	Monthly

		Manage pharmacy spend to increase shared risk or total cost of care bonus	
ER-IP Notification Report	Frequent updates on any member admitted for an inpatient stay or to a hospital emergency department.	Follow up with members to ensure continuity of care Manage ED/IP to increase shared risk or total cost of care bonus	Weekly
EOCCO Shared Risk Report	For participating EOCCO providers, shows the amount of shared risk / shared savings bonus accrued under the EOCCO shared risk/shared savings model.	Track performance on cost of care and estimated bonus	Quarterly
Primary Care Scorecard	For participating EOCCO primary care providers, shows a variety of cost and utilization statistics for their assigned population.	Compare clinic performance to peer group and benchmarks; analyze utilization and referral patterns	Quarterly (in beta testing)
Behavioral Health VBP Progress Report	Performance statistics on all behavioral health quality measures that are part of VBPs with contracted CMHPs.	Aid in coordination of care for members eligible for / seeking Medication Assisted Treatment Outreach to members to coordinate outpatient treatment and reduce readmissions to ED and acute care Track clinic performance toward quality bonuses	Quarterly

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

The only changes since March 15, 2021, are: 1) the frequency of the ER-IP notification report has changed to weekly; 2) the Primary Care Scorecard has recently been developed and is in the final stages of review and testing; and 3) The addition of the Behavioral Health VBP Progress Report.

12) You previously provided the following information about your staffing model for VBP and population management analytics, including use of in-house staff, contractors or a combination of these positions who can write and run reports and help others understand the data.

EOCCO has two distinct teams who provide support for VBP and population management analytics. First, EOCCO has an in-house analytics team who produces, maintains, and distributes reports. This team has a deep knowledge and experience in health care data and VBP reporting through the use of analytics tools such as SAS, Tableau, and Power BI. The analytics team uses a robust data warehouse that is built on SQL Server technology, updated daily, which includes all medical, pharmacy, vision, dental, behavioral health, enrollment, and demographic data needed to support VBP administration.

The analytics team produces and maintains the recurring reports described above, often adjusting the content or design based on provider feedback, to make sure the data is as clear and actionable as possible. In addition, the team responds to various provider and internal EOCCO requests for data and analysis. For example, some providers have detailed questions about ow they can succeed under their VBPs, and some additional ad hoc analysis on their specific member panel is often helpful.

Additionally, EOCCO has a quality improvement team who communicates regularly with the provider network regarding VBP arrangements and population health management. This team serves as data translators between the analytics team and the clinic staff in EOCCO's provider network. The quality improvement team reviews the monthly reports with clinic staff, identifies opportunities for improvement, works to integrate workflows that may impact their quality performance, and discusses additional resources available to them. Lastly, EOCCO's quality improvement team works with Arcadia Analytics and providers who are onboarded to ensure that data is being captured accurately and transmitted correctly. This includes validating information, working as a liaison when there are issues, and providing technical assistance when providers need to make workflow updates in their EHR.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

One minor clarification to EOCCO's staffing model for VBP and population management analytics, EOCCO always collects feedback on proposed VBP

changes and enhancements from our Clinical Advisory Panel and our clinical consultant who is an MD.

Questions in this section relate to your CCO's plans for using HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models).

13) You previously provided the following information about your <u>strategies</u> for using HIT to administer VBP arrangements. This question included:

a. how you will ensure you have the necessary HIT to scale your VBP arrangements rapidly over the course of the contract,

b. spread VBP to different care settings, and

c. include plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract.

EOCCO has had advanced VBP arrangements for several years, with most primary care practices already converted to HCP-LAN category 4A reimbursement methodologies. In addition, a shared savings/shared risk (3B) model captures most other spending, including prescription drugs. EOCCO maintains robust HIT infrastructure for administering these arrangements which will prepare us to scale our VBP arrangements over the course of the contract with OHA. This includes, for example:

1. Arcadia HIE platform enabling providers to identify and close care gaps, to improve performance on quality measure VBPs
2. Robust analytics and reporting infrastructure capable of producing customized VBP reports for each participating provider in an automated way
3. Monthly automated VBP and care gap reports accessible to all providers, even those not connected to Arcadia
4. Provider reports platform through which participating providers can browse and access information on their own VBP performance, in a secure manner
5. Member assignment processes to accurately connect members to PCPs, which is the foundation of most VBPs
6. Dedicated VBP analytics team, which can track and report on all aspects of EOCCO's VBPs – for example calculating the percent of

payments that are in the form of a VBP as required throughout the contract.

EOCCO is committed to investing in additional HIT solutions across care delivery areas as needed.

Please note any changes or updates for each section since your HIT Roadmap was previously submitted March 15, 2021.

a. how you will ensure you have the necessary HIT to scale your VBP arrangements rapidly over the course of the contract,

EOCCO has an HIT Committee with representatives from physical health, behavioral health, and oral health partners. The Committee discusses necessary HIT expansion to meet the needs of our provider networks as well as our contract requirements such as VBP expansion. Additionally, EOCCO established a VBP workgroup in Q3 2021 with a primary focus on VBP expansion where HIT needs are regularly evaluated.

b. spread VBP to different care settings, and

EOCCO is continually working on expanding HIT for VBP to support different care settings and integrate additional data sources. Since March 2021, EOCCO has expanded the Arcadia Analytics platform to its Behavioral Health providers and is currently in the process of onboarding two of EOCCO's largest Community Mental Health Programs (CMHP). Additionally, EOCCO incorporated dental claims data into the Arcadia Analytics platform and is exploring the idea of connecting dental EHR data from one of its integrated primary care practices. This is innovative work that has never been done before at Arcadia.

c. include plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract.

EOCCO is still committed to investing in additional HIT solutions across care delivery areas as needed or expanding its current HIT tools. Examples of this are listed in section b.

14) You reported the following information about your <u>specific activities and milestones</u> related to using HIT to administer VBP arrangements.

For this question, please modify your previous response, using black font to easily identify updates from your previous HIT Roadmap submission on March 15, 2021. If the field below is blank, please provide specific milestones from your previous HIT Roadmap submission.

HIT to Administer VBP Strategy 1 - Use HIT to inform how EOCCO develops new VBP models: Throughout 2021 EOCCO will be working with our provider partners to implement the three new care delivery areas including hospital care, maternity care, children's health care, behavioral health care, and oral health care over the next four years. This includes the reporting necessary to inform and ultimately administer these new VBP arrangements. EOCCO will select measures from the HPQMC aligned measure set for each category. These measures will be integrated into the current reporting systems including Arcadia Analytics and EOCCO's internal data warehouse to be included in current/future reporting packages. Currently, EOCCO is working on implementing a behavioral health integration VBP arrangement with integrated primary care practices. EOCCO will incorporate quality performance metrics and reporting requirements into this arrangement.

<u>Milestones:</u>

By 12/31/2022, implement behavioral health integration VBP arrangement with 4 integrated primary care practices and collect VBP quality data using Arcadia Analytics and standardized reporting mechanisms.

This milestone is complete, EOCCO executed a behavioral health integration arrangement with 10 integrated primary care practices and developed an attestation process for reporting. EOCCO will also utilize Arcadia Analytics to measure performance on screening based VBP measures such as SBIRT and Depression Screening.

By 12/31/2022, design and implement an Oral health care CDA, effective 01/01/2023 and incorporate into EOCCO's reporting packages.

New milestone added. EOCCO will utilize the established VBP workgroup to design and implement this CDA.

By 12/31/2023, design and implement a Children's health care CDA, effective 01/01/2024 and incorporate into EOCCO's reporting packages.

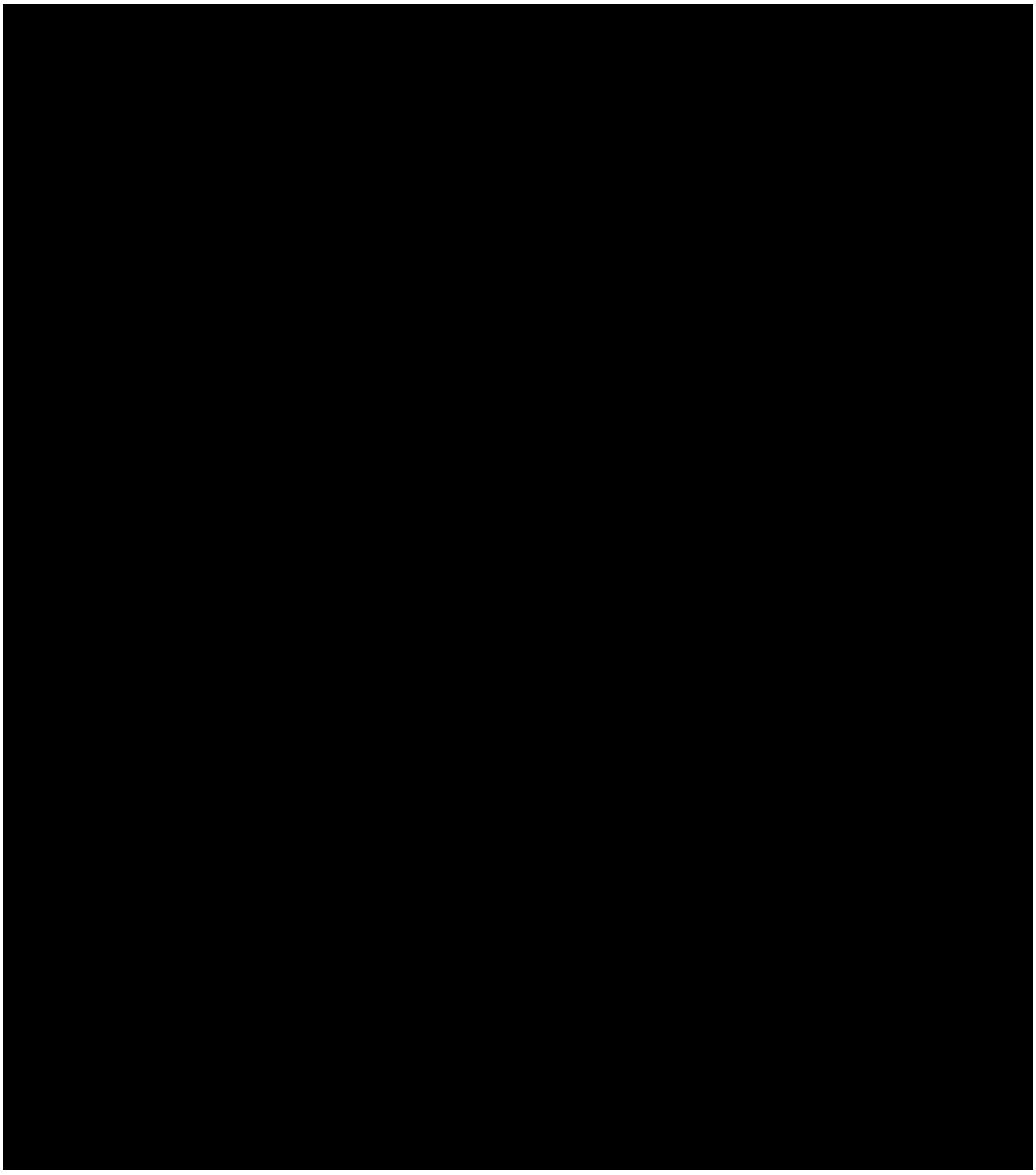
New milestone added. EOCCO will utilize the established VBP workgroup to design and implement this CDA.

By 12/31/2024, EOCCO will integrate the metrics outlined in the new VBP arrangements for hospital, maternity, and behavioral health into Arcadia Analytics and EOCCO's internal reporting packages.
EOCCO is working with Arcadia to integrate the new Plan All-Cause Readmission measure into the platform for the new hospital care delivery area.
EOCCO established a separate tracking process for the maternity care delivery area using Smartsheet.
For Behavioral Health metrics, EOCCO is implementing the Behavioral Health VBP Progress reports in 2021.

HIT to Administer VBP Strategy 2 - Onboard additional EOCCO primary care practices to the Arcadia Analytics platform:
EOCCO currently has 12 large clinics systems onboarded with Arcadia Analytics, this makes up approximately 47% of EOCCO's membership. EOCCO plans to onboard additional clinic systems over the course of the next four years as outlined in the table below to get to 80% membership representation by 2024. This will provide opportunities for reporting on quality measures outlined in the primary care VBP arrangements as well as future arrangements including a behavioral health integration model that is under development.

Milestones:
By 12/31/2024, onboard four additional primary care practices to Arcadia Analytics to achieve goal of 80% membership representation in the platform.
This milestone is in progress, EOCCO had one clinic discontinue using Arcadia Analytics after an EHR platform switch. However, EOCCO onboarded three additional clinics systems and is in the process of onboarding one more. The table below is updated to reflect those changes.

Clinic System Name	EOCCO Population *(as of 12/16/21)*	EHR/Version	Arcadia Live Date
[redacted]			



HIT to Administer VBP Strategy 3 - Onboard Community Mental Health practices and utilize the platform to administer VBP arrangements:

[redacted] This will provide further opportunities for care coordination and improve the HIT tool. Additionally, EOCCO will be able to utilize Arcadia Analytics to calculate performance on behavioral health

metrics and initiatives using integrated EHR and claims data to establish VBP arrangements.

Milestones:

[redacted]

By 3/30/2022, onboard all contracted CMHPs to Arcadia Analytics. This milestone is in progress, EOCCO has held meetings with HIT leads at each of the CMHPs to coordinate onboarding to Arcadia. The updated goal date for this milestone is 3/31/2023.

By 12/31/2022, implement VBP arrangements with CMHPs tied to behavioral health metrics tracked through Arcadia Analytics. This milestone is in the initial phase. The updated goal for this milestone is 3/31/2023.

Community Mental Health Practice Name	Tentative Live Date
[redacted]	In progress
[redacted]	12/31/22
[redacted]	In progress
[redacted]	8/31/22
[redacted]	8/31/22
[redacted]	12/31/22
[redacted]	Live

Over the past few years, EOCCO has worked to enhance the Arcadia Analytics tool in order to meet VBP requirements. This includes the addition of dental claims data, behavioral health claims data, new quality metrics, and a data extract to integrate into EOCCO's data warehouse. EOCCO also works with clinics who change EHRs and have to reconnect to the Arcadia Analytics platform. EOCCO is prepared to change its HIT solution if needed to administer VBP arrangements for the remainder of its contract with OHA.

Briefly summarize updates to the section above.

EOCCO successfully onboarded three new Primary Care Practices (PCP) to the Arcadia Analytics platform and one CMHP. EOCCO is currently in the process of onboarding one more PCP and two additional CMHPs.

New milestones have been added to account for EOCCO's work related to the Oral health care and Children's health care CDA's.

EOCCO has worked diligently throughout 2021 to provide technical support to our contracted CMHPs in connecting to the Arcadia Analytics platform, though many have experienced a number of unforeseen business challenges in adopting this HIE technology. EHR transitions, CMHP county contract transitions, and technical workforce shortages / transitions have all been challenges to CMHP adoption of the Arcadia Analytics platform. As such, EOCCO have adjusted targets for implementation with some of these CMHPs to provide additional technical support and give CMHPs the time needed to work through these complexities. Despite these challenges, EOCCO has a number of milestones to celebrate from 2021 including onboarding our first CMHP to the Arcadia Analytics platform [redacted] and implementing CMHP VBP arrangements for the 2022 contract year.

Additional updates to question #14 are noted throughout the response in black font.

15) You provided the following information about <u>successes or accomplishments</u> related to using HIT to administer VBP arrangements.

Due to the pandemic, EOCCO had to adjust its VBP arrangement specifically related to quality. In alignment with OHA, EOCCO released quality pool funds to the delivery system early which meant that we couldn't include quality components for 2020. EOCCO distributed partial payments based on 2019 performance in which EOCCO utilized Arcadia Analytics to calculate EHR based quality measures for the connected clinics.

EOCCO implemented a reporting bonus using quality funds to incentivize clinics to report on the EHR based quality measures for 2020. Many clinics who are connected to Arcadia Analytics plan to report that way. EOCCO will extract numerator, denominator, exclusion, and exception data from the platform on behalf of the clinics for calendar year 2020.

Please note any changes or updates to these successes and accomplishments since your HIT Roadmap was previously submitted March 15, 2021.

EOCCO is holding clinics accountable for quality measure performance through the clinical quality bonus formula in our shared savings model for 2021. Many clinics who are connected to Arcadia Analytics report clinical data using the HIT tool. EOCCO extracted numerator, denominator, exclusion, and exception data from the platform on behalf of the clinics for calendar year 2021.

EOCCO onboarded its first contracted CMHP, [redacted], to the Arcadia Analytics platform in 2021. While progress in this area has been slow, behavioral health clinical data remains a top priority for the CCO's ongoing HIE development efforts supporting VBPs and developing infrastructure to ensure the safe, secure, sharing of this data is paramount.

16) You also provided the following information about <u>challenges</u> related to using HIT to administer VBP arrangements.

EOCCO has a large provider network with clinics of varying sizes that each utilize different EHR vendors. EOCCO currently has 13 different EHR vendors in our service area. This makes it challenging to onboard every clinic with a Health Information Exchange platform such as Arcadia Analytics.

Please note any changes or updates to these challenges since your HIT Roadmap was previously submitted March 15, 2021.

The above challenges remain the same.

Questions in this section relate to your CCO's plans for using HIT to support providers.

17) You previously reported the following information about your <u>strategies, activities, and milestones</u> for using HIT to effectively support provider participation in VBP arrangements. This included how your CCO ensures:

a. Providers receive timely (e.g., at least quarterly) information on measures used in the VBP arrangements applicable to their contracts.

b. Providers receive accurate and consistent information on patient attribution.

c. If applicable, include specific HIT tools used to deliver information to providers.

EOCCO provides monthly reports to all primary care providers and quarterly reports to all other providers who participate in VBP arrangements. These reports include, for example:

1. Year to date performance data on VBPs, such as current numerators/denominators of quality measures and cost vs. budget for shared savings/shared risk models
2. Care gap data on specific members that providers can use to improve VBP performance
3. Specific action items that providers can use to improve chronic condition management, such as highlighting members with low medication adherence
4. Identification of members most likely to benefit from PCP outreach to improve performance on quality and total cost of care targets – such as high-risk members with a history of ED/Inpatient utilization but no primary care connection
5. Member attribution lists to help providers understand the specific patient population they will be measured on, including warning flags for chronic conditions, care gaps, high utilization, demographic data, etc.

For the IET quality measure, we are in beta testing of a weekly report showing members in urgent need of drug/alcohol treatment, which is intended to help providers improve performance on that measure. The EOCCO quality team will conduct outreach to providers on a weekly basis to encourage utilization of the report.

Support for Providers with VBP Strategy 1: Providers utilize the monthly reports regularly to outreach to members and track clinic performance toward quality bonus payments. EOCCO plans to implement enhancements and improvements to the existing reports as well as integrate additional clinical data into existing HIT tools.

Milestones:

By 8/31/21, roll out a package of enhancements to existing reporting, such as identification of some care gaps on clinical measures that can be determined from claims, even for providers who have not yet been submitting clinical data.

By 12/31/21, integrate EHR data from data sharing agreements and Arcadia extract.
By 12/31/23, integrate ALERT data into the Arcadia Analytics tool to view more comprehensive gap lists for immunization measures included in VBP arrangements.

Additionally, the providers outlined in the table in Question 14 have access to Arcadia Analytics which provides real time data on quality measure performance for all claims, EHR, and hybrid quality measures. Clinic staff can view gap lists, prepare for upcoming visits, and compare performance by provider. The tool also includes a full patient registry with condition history, risk scores, and cost saving data. The pre-visit planning report allows providers to prepare for upcoming appointments by viewing risk and condition gaps, quality gaps, recent utilization, and recent medication fills. The milestones for increased onboarding and support for providers is also outlined in Question 14.

EOCCO provides monthly member rosters to providers that includes a complete list of all assigned members for which a VBP applies, plus risk stratification, diagnosis history, recent utilization, assigned PCP, and contact information. In addition, the reports show a summary of all credentialled PCPs at each clinic, so that clinics can have complete visibility into the results of member attribution processes and notify EOCCO of any problems. EOCCO also sends patient attribution and provider hierarchy data files to Arcadia on a monthly basis.

Support for Providers with VBP Strategy 2:

Milestone:
By 8/31/21, EOCCO will implement a patient attribution audit process that evaluates utilization to ensure that the patient is assigned to the provider that they are seeking care from. This will then get updated in the member roster report that is available on a monthly basis.

Please note any changes or updates to your strategies since your HIT Roadmap was previously submitted March 15, 2021.

In March 2021, the Analytics department began generating weekly reports documenting all EOCCO members that entered the denominator for the Initiation & Engagement in Substance Use Disorder Treatment (IET) incentive measure. The Quality Improvement Specialist uses these reports to update a shared Smartsheet tracking document with the newly diagnosed members each week. The Quality team also created a small IET workgroup with members of the GOBHI Substance Use Disorder (SUD) team. This workgroup uses the Analytics

report and the Smartsheet tracking system to perform outreach to primary care clinics and behavioral health providers whose assigned patients have entered this measure.

Minor formatting and logic updates have been made to the weekly Analytics report over the past year to streamline the data. The Analytics team is currently working to update the weekly reports to align with the 2022 statewide IET measure specifications. These updates include revising the continuous enrollment criteria, expanding the negative diagnosis history period, and adding a negative medication history component.

a. Providers receive timely (e.g., at least quarterly) information on measures used in the VBP arrangements applicable to their contracts.

EOCCO still provides monthly information and performance on measures in our VBP arrangements via its reporting package. Some of the milestones outlined above in the Support for Providers with VBP Strategy 1 section have been accomplished. In the past year, a significant amount of clinical data has been incorporated into the reports, along with claims data. For example, blood pressure and HbA1c test results are now used to calculate providers' performance on quality measures, for providers who submit clinical data directly to EOCCO. For providers who provide their clinical data via the Arcadia platform, the process for integrating that data into the reports is nearing completion and we hope it will be complete by 9/30/22. Additionally, EOCCO clinics who are onboarded to Arcadia have access to performance measure data that is updated daily. EOCCO has engaged in initial conversations with Arcadia about integrating ALERT data into the platform for the immunization measures as well. The timeline for that milestone remains the same.

Additionally, EOCCO has begun providing quarterly Behavioral Health VBP Progress Reports to its contracted CMHPs to support behavioral health VBP arrangements. These reports include:

1. Year to date performance data on behavioral health VBPs, such as current numerators/denominators of quality measures.
2. Results of timely access reporting requirements.
3. Member attribution and care coordination gaps related to the 5 measures included in the behavioral health VBP arrangements

b. Providers receive accurate and consistent information on patient attribution.

PCPs still receive accurate and consistent information on patient attribution through their monthly member rosters. EOCCO also implemented a PCP assignment reconciliation process that evaluates utilization data on a monthly basis to ensure that the patient is assigned to the provider that they are seeking care from. This then gets updated in the clinic's member roster. Therefore, the milestone outlined above for Support for Providers with VBP Strategy 2 has been completed.

Under EOCCO's behavioral health VBP arrangements with contracted CMHPs, patient attribution is assigned by county of benefit and sourced from CCO enrollment data. As part of quarterly Behavioral Health VBP Progress Reports, providers receive lists detailing member attribution for each of the 5 reporting measures.

c. If applicable, include specific HIT tools used to deliver information to providers.

Our HIT tools haven't changed since our previous submission.

18) You previously reported the following information about how your CCO <u>uses</u> data for population management to identify specific patients requiring intervention, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes.

Support for Providers with VBP Strategy 3: EOCCO utilizes a CCO level quality performance report to monitor performance towards VBP measures. EOCCO's analytics team produces a quarterly cost and utilization report that informs targeted inventions, for example the implementation of a primary care utilization roster. EOCCO also utilizes Arcadia Analytics for population management to view complete gap lists for all EOCCO members represented in the platform (57%) for each quality measure. This data includes demographic information, risk score, risk percentage, and open risk categories as well as provider and appointment information. Additionally, we have access to COVID-19 risk outreach lists to inform targeted interventions in response to the pandemic. EOCCO plans to develop a full member roster and complete gap list within the CCO level quality performance reports that includes all EOCCO members, not just those represented in Arcadia Analytics.

Milestone:
By 12/31/21, integrate a full member roster and full gap list of all EOCCO members for the EOCCO quality team to utilize to identify patients/populations who need interventions.

Support for Providers with VBP Strategy 4: EOCCO's data infrastructure has enabled staff to carry out analytics functions focused on health equity, such as: compiling and analyzing our membership's linguistic preferences and ethnic/racial backgrounds estimating service needs relative to current membership demographic profiles, anticipating preventive, specialty, and critical care needs and developing dashboards with the disaggregation of metrics by key demographic identifiers, such as race and ethnicity. EOCCO's quality team is working on analyzing incentive measure data using REAL D (race/ethnicity, language, and disability) stratifications as well as gender, age, county/zip code, primary care provider, and service utilization patterns to find overarching trends in data. Once trends are identified, EOCCO's quality team will develop novel targeted interventions that address the health disparities.

Milestones:
By 12/31/21, identify a health disparity among one of the incentive measures using internal data infrastructure and Arcadia Analytics.

By 12/31/22, implement a targeted intervention that addresses the disparity and improves health outcomes.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

EOCCO's Analytics team successfully integrated a full member roster and full gap list of all EOCCO members for the EOCCO quality team to utilize to identify patients/populations who need interventions. Therefore, the milestone outlined in Support for Providers with VBP Strategy 3 has been completed.

The milestones outlined in Support for Providers with VBP Strategy 4 have been delayed. In 2021, EOCCO has realigned our focus to collect updated demographic information to fill the gaps in missing or incomplete demographic information prior to stratifying measures. During a yearend review of non-compliant members, EOCCO identified a moderate rate of Hispanic/Spanish speaking members who have not completed their childhood or adolescent immunization series. This has prompted the need to address vaccine hesitancy in a culturally relevant format. EOCCO is also in the process of creating a Spanish Resource Guide, which will provide members with

direct access to services such as interpretation, transportation, and assistance with medical, dental, and behavioral health services. While the initial version of this guide will provide support to operational services, future versions will include member education on topics such as addressing vaccine hesitancy or managing chronic conditions.

19) You previously reported the following information about how your CCO <u>shares</u> data for population management to identify specific patients requiring intervention, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes.

The monthly member rosters that EOCCO's analytics team provides to all clinics who participate in VBP arrangements includes risk stratification data. Providers are able to use this data to outreach to high-risk members. Additionally, the quality and care gap reports provide care gap lists for the majority of the quality measures to assist with population management.

Arcadia Analytics provides data on risk stratification to the onboarded EOCCO clinic systems. The risk scores are calculated using the HCC algorithm. Providers are also able to view a full risk and condition gap list that are weighted based on severity so providers can prioritize and target interventions to improve health outcomes.

Support for Providers with VBP Strategy 5: Some EOCCO clinics have expressed interest in implementing a more interactive risk module where they are able to dismiss certain conditions that may be included in a given risk score. This would help them prioritize which conditions to focus on and which are weighted higher in the risk calculation.

<u>Milestone:</u>
By 12/31/23 EOCCO will explore additional risk module solutions to share interactive risk data on EOCCO members with providers.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

EOCCO has been working with Arcadia to enable a risk module for clinics to be able to view interactive risk data on EOCCO members. We plan to implement this over the next few months.

20) You previously reported the following information about your <u>accomplishments and successes</u> related to using HIT to support providers.

EOCCO has provided monthly quality and care gap reports for years however, they were recently redesigned to include more pertinent information and data points centered around VBP models. This milestone was completed in Q3 2020, and the access was streamlined to a centralized portal.

EOCCO has worked with four clinics systems to improve workflow mapping for two specific VBP quality measures in the Arcadia Analytics portal over the course of 2020. This included many meetings with the clinics, Arcadia Analytics, EOCCO staff, and the EHR vendors. EOCCO has also worked to optimize data resources within the Arcadia Analytics tool to assist with VBP arrangements such as dental claims data, behavioral health claims data, and improved backend EHR data collection.

Most clinic systems who participate in the VBP arrangements are engaged and actively use the HIT and population health resources that EOCCO provides however, there are a handful of clinics who are less engaged due to leadership decisions. One clinic system in particular has declined to participate in our VBP arrangement in the past but in 2020 we were able to get them involved, this was a huge success as they hold a large portion of our membership.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

EOCCO was able to onboard three additional primary care practices to Arcadia and is beginning implementation with one additional practice. This is a huge accomplishment for EOCCO after not onboarding any new practices over the past two years. Overall, clinics seem to be more engaged with Arcadia and EOCCO was able to host a joint training with all onboarded practices to increase engagement overall.

21) You previously reported the following information about your <u>challenges</u> related to using HIT to support providers.

Integrating all of the data sources into one platform has always been a challenge. We are very fortunate to have a robust analytics team and data warehouse to create our own in-house reporting packages. However, we don't have access to every

clinic's EHR data therefore there are gaps in reporting capabilities. When it comes to implementing HIT tools such as Arcadia Analytics, the platform isn't particularly useful to clinics who don't have a large portion of our membership or who have less advanced EHRs that are unable to integrate with the tool. We also run into barriers with clinic or hospital systems that have parent companies out of state. There is often pushback to utilize the HIT tools that EOCCO provides. We have worked really hard to address these barriers and will continue to do so throughout the next four years.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

The sharing of mental health and substance use disorder clinical data across our provider network has proved to be a particularly challenging effort to work through, especially in the rural and frontier communities of Eastern Oregon. EOCCO has concentrated efforts in 2021 and 2022 on expanding the use of Arcadia Analytics to contracted CMHPs across the region, which all face a different set of challenges to supporting HIE technologies comparative to larger hospital and primary care settings. Ensuring compliance to 42 CFR Part 2 and HIPAA data sharing requirements, working with smaller behavioral health EHR vendors, and providing HIE technical assistance to CMHPs have all required more care and FTE than originally assumed in the 2020 HIT Roadmap. EOCCO continues to make significant progress in this area but acknowledges that the unique resources challenges facing the state's behavioral health network can decelerate adoption and use of HIE platforms.

Optional
These optional questions will help OHA prioritize our interview time.

22) Are there specific topics related to your CCO's VBP efforts that you would like to cover during the interview? If so, what topics?

No topics identified.

23) Do you have any suggestions for improving the collection of this information in subsequent years? If so, what changes would you recommend?

No topics identified.

Part II. Oral Interview

This information will help your CCO prepare for your VBP interview.
Written responses are <u>not</u> required.

Purpose

The purpose of the CCO 2.0 VBP interviews is to expand on the information CCOs report and have provided in the written questionnaire; provide CCOs an opportunity to share challenges and successes; and discuss technical assistance needs. OHSU staff will ask these questions of all CCOs, tailoring the questions to each CCO based on written interview responses.

Format

Oral interviews will be conducted via a video conference platform (such as Zoom) and will be recorded, transcribed and de-identified for further analysis. Analysis may include overarching themes and similarities or differences in how CCOs are engaging in VBP-related work. OHA may publicly report de-identified and aggregated results next year. Before we begin, participants will have an opportunity to ask about the interview format. CCOs are encouraged to send questions to OHA *prior to* the interview, as discussion time will be limited.

Interview topics

Questions topics will include your CCO's VBP activities and milestones in 2021, any early successes or challenges encountered in this work so far, and how your CCO's plans for future years are taking shape. Questions will cover four primary areas:

1) Provider engagement and CCO progress toward VBP targets. These questions will explore what has been easy and difficult about your CCO's VBP efforts so far, recognizing that each CCO operates within a unique context that must be considered when designing new payment arrangements. We may ask questions about your perception of provider readiness for or receptivity to VBP arrangements, factors affecting your progress toward VBP targets for future years (including overall VBP participation as well as downside risk arrangements), and how to make OHA technical assistance most relevant to your needs.

2) Implementation of VBP models required in 2022. These questions will address how your CCO is making decisions about and designing required VBP models. We may ask about factors influencing the design and scale of your PCPCH infrastructure payment model and models to meet the Care Delivery Area requirements. These questions may address your experience designing quality strategies in hospital, maternity, and behavioral health VBP arrangements; and your progress developing HIT capabilities with providers to implement these VBP arrangements. We are particularly interested in understanding CCOs' experiences promoting VBP arrangements with a) various hospital reporting groups (DRG, A/B, etc.), b) behavioral health providers operating independently

as well as in integrated primary care settings, and c) maternity care providers reimbursed in standalone as well as bundled payment arrangements.

3) Planning and design of VBP models required in 2023 or later. These questions will follow-up on information you provide about your progress developing VBP arrangements in children's health and oral health. We may ask about factors influencing your planning in these areas, perceived provider readiness, and assistance needed from OHA.

4) Promoting health equity through VBP models. These questions will explore how your CCO's work on health equity relates to your VBP efforts. We may ask about your CCO's progress with collecting social needs data; how health equity informs your VBP planning in specific areas such as maternity care; and whether you have identified opportunities to use VBPs to address other CCO 2.0 priorities or requirements.