2020 CCO 2.0 VBP Interview Questionnaire and Guide

August 24, 2020

Introduction

As noted in the July 7 CCO Weekly Update, the contractually required Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, were rescheduled for the week of September 14. Please see Appendix A for the interview schedule. Staff from the OHSU Center for Health Systems Effectiveness (CHSE) will be conducting the interviews and using information collected as part of a 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 **Friday, September 4, 2020**. Submissions should be approximately 10–15 pages and should not exceed 15 pages.

All the information provided in Section I will be shared publicly.

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.

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

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Section I. Written Interview Questions

Your responses will help OHA better understand your VBP activities this year, including detailed information about VBP arrangements, HCP-LAN categories and how these compare to what had been planned.

1) Describe how your CCO engages stakeholders, including providers, in developing, monitoring or evaluating VBP models. If your approach has involved formal organizational structures such as committees or advisory groups, please describe them here.

   IHN has active partnerships with our Providers on VBPs. We meet quarterly in most cases to evaluate VBP cost and metric performance as well as discuss the effectiveness of the VBP operations. Internally, Finance, Provider Contracting, Population Health, and Medical Management all contribute in developing and improving our VBP arrangements. IHN also works very closely with Samaritan Health Services (SHS), our largest provider of both PCP services and Hospital Services, to continue to develop risk sharing models that achieve desired outcomes for both parties. IHN is fortunate to have a network of Providers that feel as strongly as we do about the importance of servicing the community.

   Quality Metrics play a critical role in IHN's VBPs. The IHN Quality Improvement Committee(QIC) meets monthly to review performance of metrics, strategies to improve metrics across the network, and technical system requirements to ensure accurate and timely data sharing. The QIC chartered a Value Metrics taskforce to evaluate metric and measure status and to prioritize and implement plans focused on improving performance. Also chartered, is a Provider Network taskforce. This taskforce is focused on driving change in the provider network, alleviating the burden of administrative tasks placed on providers, understanding provider needs and sharing best practices advance the quadruple aim. Together these two QIC taskforces develop strategies to improve VBP performance through education, evidence-based practice, process improvement activities and the alignment of goals and incentives.

   Additionally, the Quality department works closely with the VBP contract development process to identify and prioritize actionable and meaningful metrics to include in contracts. Baseline targets are set that will incentivize performance improvement while still being achievable.

   Once VBP rates, models, and metrics are established, IHN meets with the Provider to discuss the VBP contract. All parties need to develop a contract that both meets the requirements of containing cost growth, improving access and quality, while still providing adequate funds to the network to provide needed care.

   At the beginning of VBPs IHN formed a VBP taskforce to develop payment models. The taskforce was comprised of a group of PCPs, Dental organizations, county health and mental health services, and community partners. This group set the

foundation of VBPs. The group has since disbanded with VBPs getting off the ground and becoming operational in nature. It may be prudent to reform a similar group to evolve VBPs to the next iteration to incorporate social factors, risk factors, cost sustainability, and community engagement.

The Quality metric component of VBPs is overseen by the Regional Planning Council. The RPC approves each year's disbursement methodology of Quality Pool funds to providers. These disbursements are primarily incorporated into VBPs.

2) Has your CCO taken steps in 2020 to modify existing VBP contracts in response to the COVID-19 outbreak? *[Select one]*

☐ CCO did not modify any existing VBP contracts in response to the COVID-19 outbreak. *[Skip to question 5].*

☐ CCO modified all existing VBP contracts due to the COVID-19 outbreak, and we used the same rationale and process for all modifications. *[Proceed to question 3]*

☐ CCO modified all existing VBP contracts due to the COVID-19 outbreak, but we used different rationales and processes for some modifications. *[Skip to question 4]*

☒ CCO modified some, but not all, existing VBP contracts due to the COVID-19 outbreak. *[Skip to question 4]*

3) If you indicated in Question 2 that you modified all existing VBP contracts under a single rationale and process, please respond to a–c:
   a) Describe the rationale for modifying existing VBP contracts in 2020.
   b) Describe the process you used for modifying VBP contracts, including your key activities, stakeholder engagement and timeline.
   c) Describe the payment model/s you have revised (or are revising) this year, including LAN category, payment model characteristics, and implementation date/s.

4) If you indicated in Question 2 that you made modifications to some (but not all) existing VBP contracts, or that your rationale and process varied by VBP model, please respond to d–g:
   d) Among the existing VBP contracts that have been modified due to COVID-19, which payment models included the largest number of members?
   e) Describe your rationale for modifying this existing VBP model in 2020.
   f) Describe the process you used for modifying this VBP model, including your key activities, timeline/s and stakeholder engagement.
   g) Describe how you modified this VBP model, including changes in LAN category, payment model characteristics, or implementation dates.

The primary modification to contracts was to the NEMT capitated contract. The contract was modified to expand services. This allowed the existing payment to be redeployed towards other services not covered in the contract to keep members safe during the stay at home period, such are meal delivery, grocery shopping, and banking needs.

The following questions are to better understand your CCO's plan for mitigating adverse effects of VBPs and any modifications to your original plans.

5) Describe in detail any planned 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; lesbian, gay, bisexual, transgender and queer [LGBTQ] people; persons with disabilities; people with limited English proficiency; immigrants or refugees; members with complex health care needs; and populations at the intersections of these groups).

IHN is in the infancy stage of developing a mechanism to capture provider REAL-D data in an effort to align member needs more efficiently. IHN's current VBP's ensure positive quality of care outcomes are consistent across our entire population in addition to adequate access to care. We will be researching the inclusion of additional metrics and care management activities that are targeted to ensure all of IHN's membership are served equally and without cultural biased.

6) Have your CCO's processes changed from what you previously planned? If so, how?

IHN's processes have not changed materially in 2020. In 2020 we moved away from a Professional capitation to SHS due to financial transaction complexities stemming from being a related entity. Going forward we are modeling a more simplified VBP that will still achieve the required 20% VBP requirement without the additional accounting reserve complexity required on both sides of the agreement. The agreement will target rate of growth objectives.

7) What approaches are you taking to incorporate risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?

    IHN is in active development with Arcadia to create both CDPS and ACG risk scores at the member level. IHN also uses the UC San Diego SAS model to validate OHA's CDPS risk scores. These scores can then be used to inform prioritization of member as well as adjust payment models. We understand the difficulty of PCPs to fully understand their panel's risk. We hear that they have the most-high risk members. To use the Lake Wobegon effect, all our members have above average risk scores. Published risk score would allow PCPs to understand how they sit in the IHN network and better manage their member requirements.

Currently some PCPCH capitation payments use OHA rate categories as the basis for risk payments. Each rate category is assigned a risk based rate. The members assigned to the PCP are bucketed in the rate categories to determine a total monthly payment. Once CDPS or ACG risk scores are in place, we will utilize those risk stratifications to bucket members into rate groups.

The next phase of VBP PMPMs will use risk data to tailor payments and PCP assignments to better manage health conditions and costs of members. In theory lower risk PCP panels could see a lower rate than higher risk PCP panels. Alternatively risk corridor incentives could be adjusted based on risk trends.

8) Have you considered social factors in addition to medical complexity in your risk adjustment methodology?

   If yes, please describe in detail your use of social risk adjustment strategies in your VBP models, including the following:

   a) Whether social risk adjustment is applied to quality metrics, overall payment (for example, capitation), or both;
   b) Specific social factors used in risk adjustment methodology (for example, homelessness); and
   c) Data sources for social factors, including whether data is at the individual/patient or community/neighborhood level.

   At this point IHN is not at a point to incorporate social factors or medical complexity into VBPs. However we have restructured our organization and infrastructure to fully manage our IHN populations' health. With the systems and staff being put into place we will have the ability to better understand each member's health risk factors and communicate that to the Member's care network. Once the data, analysis, care management, and communication processes are in place, IHN can then incorporate this into a VBP model.

The following questions are to better understand your CCO's plan to achieve the CCO 2.0 VBP Patient-Centered Primary Care Home (PCPCH) requirements.

9) Describe the process your CCO has used in 2020 to address the requirement to implement per member per month (PMPM) payments to practices recognized as PCPCHs (for example, region or risk scores), including any key activities, timelines and stakeholder engagement.

IHN identified all PCPCHs and their existing tiers. Prior to 2020 some PCPHs were already receiving a form of care management payments. In those situations, IHN

continued with the existing payment with the intent to move to the tiered payment during a contract renewal cycle that would not negatively impact IHN's total rate of cost growth. For those PCPCHs not receiving a payment, contracts were sent to the entire network with those electing to participate receiving a tier based PCPCH payment.

The standard PCPH contract is based on tier level.

Tier	PMPM
1	$0.50
2	$1.00
3	$2.00
4	$3.00
5	$4.00

IHN set aside funding for PCPCH educational activities. Coordination to improve activity development of PCPCHs is centralized in the Quality department. IHN coordinates closely with SHS's PCPCH program which has been very successful in moving up the PCPCH tier level and offers great best practices that are shared with the entire IHN network.

10) Has your CCO implemented new, or revised existing, payments to PCPCHs during 2020?

☐ Yes

☒ No

If yes, describe the characteristics of new or revised PMPM payments to PCPCHs.

If no, describe how your CCO intends to address this requirement in the remainder of 2020.

IHN is meeting the PCPCH payment requirement in 2020. As we move into 2021 IHN will increase the rate according to cost trends. In addition, we intend to move those providers that are on similar PCPCH payment agreements to the standard PCPCH payment schedule.

The following questions are to better understand your CCO's VBP planning and implementation efforts. Initial questions focus on the three care delivery areas in which VBPs will be required beginning in 2022 which are behavioral health, maternity and hospital care.

11) Describe your CCO's plans for developing VBP arrangements specifically for behavioral health care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

IHN is in active discussions with our county MH providers to identify target areas for investment. Substance abuse has been an ongoing need for services in our region

and will likely be a focus area. We are also evaluating our capitation payment models to ensure we are paying our MH providers an adequate amount and allowing them to flex services appropriately in response to need in the county.

Other THW services continue to expand in our region to serve Mental Health needs, such as Chance and Pathfinder. We are working to leverage these non-traditional services to augment our network in a cost effective manner through VBPs.

12) Describe your CCO's plans for developing VBP arrangements specifically for maternity care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

IHN is in active discussions with SHS to develop a Maternity case rate payment. SHS owns and operates the 5 hospitals in IHN's region that cover the vast majority of deliveries. The VBP would be a bundled payment for all facility costs related to a delivery. The payment model would be set at a blended rate that factors in a targeted Vaginal/C-Section delivery target to incentive proper medical use of C-sections towards agreed upon and safe delivery standards of care. Medical Management is involved in these discussions to develop these standards, as well as benchmarking C-section rates and sharing data with providers to take corrective action to maintain quality standards. A portion of the payment may be tied to quality related performance, integration with Doulas, and pre/post delivery follow ups.

13) Describe your CCO's plans for developing VBP arrangements specifically for hospital care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Hospital care (inpatient and outpatient) costs have been identified as a key driver in IHN's rate of growth. To date, IHN has held several meeting with SHS to develop a VBP arrangement that will incentive the control of Hospital costs. We are progressing with a PMPM risk corridor VBP for 2020 and 2021 that will incentivize our Hospital system, in coordination with PCPs, to manage the rate of growth in these services. The VBP would set a PMPM target for all SHS costs, Inpatient, Outpatient, and Professional that allows for a 3.4% increase from the prior year. Costs that are above or below this PMPM would have a % of costs at risk (from 20% up to 70%) within a 2% risk corridor.

14) Have you taken steps in 2020 to develop any other new VBP models?

☒ Yes (please respond to a–c)

☐ No (please respond to d–e)

a) Describe the care delivery area(s) or provider type(s) that your new value-based payment models are designed to address.

The models in development bring in all costs tied to a member to provide a comprehensive look into each members costs. Each service area cannot be treated in isolation. Mental Health services affect Medical, which affect Rx, and can be influenced by PCPs and THWs. To tie this network together around a member we need to create incentives to manage the entirety of a member's cost profile. The next models will incentivize providers to manage all members costs and network connections in relation to that member's available funds (premium) and risk.

As these models are developed they will first be tailored to PCPs and our Hospital System. From there Mental Health, Dental, Rx, and THWs should be brought into the holistic cost profile of their members.

b) Describe the LAN category, payment model characteristics and anticipated implementation dates (2021, 2022, etc.) of new payment models you have developed (or are developing) this year. If you have developed multiple new value-based payment models this year, please provide details for each one.

c) Describe whether your approach to developing these payment models is similar to, or different from, what you had originally intended in 2020; if different, please describe how and why your approach has shifted (for example, please note if elements of your approach changed due to COVID-19 and how you have adapted your approach).

The new version of this model that is in development that would incorporate all revenue and costs (including Rx, THWs, and MH) into a comprehensive look into a member level MLR. Each member's premium would be brought in, along with all costs tied to that member. Costs would be a simplified reflection of non capitated, or variable costs, that can be influenced by the PCP network. In this would be inpatient, outpatient, professional, Rx, and any VBP associated with the Provider. In theory, all controllable costs, even if the control isn't direct but an influential relationship.

The shift is tied to both Covid-19's impact as well as the requirement to contain cost growth below 3.4%. Current VBP models and thought do not incentivize the Provider network to contain and eventually reduce costs. At best they put the Provider network at risk for cost growth. However the Providers can still negotiate rate increase in capitations to offset that growth. What IHN needs is a payment model that incentivizes the Provider to first stabilize cost growth through innovation and member cost management, but then to be flexible in the face of changing demands.

In order to create and manage this type of full view model, actionable cost and utilization data must be made available to the Providers. Revenue and risk must also be incorporated and transparent. This requires a robust system of reporting and data in order to work. IHN is currently working with Arcadia to develop this system of Quality, Risk, and Cost reporting system.

If no, please respond to d–e:

d) Describe any decisions made to date regarding the eventual design of your payment models, including the care delivery area(s) or provider type(s) that VBPs will cover, LAN category, payment model characteristics, and implementation dates.
e) Describe whether your approach to developing these models will be similar to, or different from, what you had originally intended in 2020, and why.

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

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

As VBPs incorporate more variables, such as quality, rate of growth, SDoH, and risk they will inherently become more complex. Best practices around the evolution of VBPs would be very helpful. In some senses each CCO is tasked with developing VBPs that will re-engineer the entire healthcare payment process, a tall order. Any publications or sharing of success stories with operational details would help.

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

CCOs are able to develop and contract with willing partners in our network and region. However much cost growth occurs in the Pharmacy and at high cost level services, specifically at OHSU. IHN can address Pharmacy to some extent with our PBM, but this is somewhat limited by formulary and macro trends. OHSU has been a big driver of Inpatient claim growth at IHN. Developing a CCO wide VBP with them to contain cost growth would be very beneficial to all CCOs.

Optional

These optional questions will help OHA prioritize our interview time.

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

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

Part II. Oral Interview

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

Purpose

The purposes of the CCO 2.0 VBP interviews are to expand on the quantitative information CCOs report and have provided in the written section; provide CCOs an opportunity to share challenges and successes; and to identify technical assistance needs. OHSU staff will ask these questions of all CCOs, although they will tailor the questions to each CCO after reviewing written interview responses.

Format

Oral interviews will be conducted via a video conference platform such as Zoom. These interviews will be recorded, transcribed and de-identified for further analysis. This analysis may include overarching themes and similarities or differences in how CCOs are engaging in VBP-related work. Results may be publicly reported in a de-identified and aggregated way that will be made available 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 2020, 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:

Accountability and 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 follow-up questions about your written interview responses, including your approach to developing new payment models and any technical assistance you may need. We may ask about how COVID-19 has impacted your CCO's plans.

Design of VBP models and CCO capacity for VBP. These questions will relate to how your CCO is designing new VBP models and payment arrangements. We are interested in better understanding your approach and process as you work toward your CCO's VBP goals. We may ask about the types of information you are drawing on to inform the design of your VBP models. We may ask follow-up questions regarding the characteristics of your new VBP models described in your written interview responses.

Promoting health equity and VBP models. These questions will explore how your CCO's work on health equity is informing your VBP efforts. We may ask about how your VBP models are being designed to promote health equity and to mitigate health inequities. We may also ask about your future plans to promote health equity through VBPs.

Provider engagement and readiness for VBP. These questions will explore how your CCO is supporting providers in VBP arrangements, and how COVID-19 may be affecting these arrangements. We may ask about any data or support tools your CCO is using with providers in VBP arrangements, and any successes or challenges you have had.

Appendix A. CCO VBP Interview Schedule

Date/Time	Time (Pacific Time)	CCO
Mon 9/14/2020	9 AM - 10:30 AM	PacificSource Community Solutions
Mon 9/14/2020	1 PM - 2:30 PM	Yamhill Community Care
Mon 9/14/2020	3 PM - 4:30 PM	Columbia Pacific CCO
Tue 9/15/2020	8:30 AM - 10 AM	Trillium Community Health Plan
Tue 9/15/2020	1 PM - 2:30 PM	Jackson Care Connect
Tue 9/15/2020	3 PM - 4:30 PM	Cascade Health Alliance
Wed 9/16/2020	9 AM - 10:30 AM	Advanced Health
Wed 9/16/2020	3 PM - 4:30 PM	Eastern Oregon CCO
Fri 9/18/2020	9 AM - 10:30 AM	InterCommunity Health Network CCO
Fri 9/18/2020	11 AM - 12:30 PM	AllCare CCO
Fri 9/18/2020	1 PM - 2:30 PM	Health Share of Oregon
Fri 9/18/2020	3 PM - 4:30 PM	Umpqua Health Alliance