Yamhill Community Care

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.**

   YCCO primarily utilizes several methods and forums of developing and engaging stakeholders in the development of VBPs:

   Alternative Payment Model (APM) Sub-Committee of the Board of Directors -YCCO has had a long-standing APM Sub-Committee which meets on a recurring basis to discuss and provide input on the development of new VBPs, review quality metrics programs/performance, and update/adjust current VBPs when necessary.

   Quality and Clinical Advisory Panel (QCAP) – YCCO also formally engages with contracted network providers during monthly QCAP meetings to review VBP model metrics and performance as well as to gain strategic clinical insight into model VBP model development.

   Regular Contracted Clinical Network Site Visits - YCCO directly engages with providers on a clinic level in the development of new VBPs, discussing concerns, goals, and implications of both parties during the process. Dedicated YCCO provider relations staff with operational and clinical expertise lead these discussions. Doing so allows for YCCO to better understand provider perspectives on what VBPs have or have not worked for the provider previously, as well as ensuring that YCCO and the provider are working towards common goals as part of a strategic partnership.

   Technical Assistance (TA) Forums – YCCO hosts TA forums for contracted providers to provide education and ensure understanding of VBP models in place. General model and specific clinic level questions are addressed during these events covering topics such as the member assignment process for VBP arrangements.

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

Primary changes include pre-scheduled and recurring work sessions with key provider hospitals, to develop and implement higher level LAN VBPs. Additional changes include quarterly check-ins with clinical quality and data reporting representatives from a key provider system, inclusive of primary care, specialty care, and hospital services. (have Jim review for provider engagement)

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).**

YCCO continues to monitor VBPs for any unintended consequences that adversely impact any specific population's access to care. YCCO is exploring and leveraging risk adjustment models that also evaluates utilization by demographics to identify if specific populations have different access to care. Through the use of a population health platform, Metrics Manager, YCCO routinely looks at quality measure performance across the system, disaggregated by provider. Performance can be measured through a variety of filters including age, gender, diagnosis, geographic distribution, race, ethnicity, and language. On an annual basis, YCCO evaluates year-end performance as it applies to the CCO's unique improvement targets and through an equity lens determines where disparities exist. In partnership with providers, YCCO then develops actions to address gaps in care. By doing this detailed disaggregation, the CCO is able to identify vulnerable populations and identify and avoid any adverse or unintended outcomes related to VBP agreements. YCCO provides incentives for Member engagement and outcomes for assigned Members.

YCCO will continue to provide Continuing Education for providers to better manage and interact with diverse Members within YCCO. YCCO has a policy that providers must follow in order to reassign or "fire" a Member. In the event that this occurs, a YCCO Community Health Worker (CHW) will reach out to the Member.

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

Integration and tracking of language access measure into multiple VPBs.

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.]**

Such integration is not currently formally planned at this time due to the lack of a proven risk model, but is considered for future integration into capitation agreements where risk scores are already applied.

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?**

    YCCO has continued to restructure VBP arrangements with our primary oral health provider, with greater shifts of funding from capitation to quality performance incentives.

    YCCO is also evaluating options for oral health integration into our PCP cap pilot program, as well as potential for co-located oral health care in hospital settings.

    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).**

    Primary providers for oral health VBP integration includes PCPs (LAN 4A), hospitals (LAN TBD), and oral health providers (LAN 4A).

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

    Currently in place and by 2024.

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?**

    YCCO's current PCP Cap pilot includes a children's health component, with specific payment rates, risk adjustment factors, TCOC evaluation, and quality metrics.

    YCCO's current dental health capitation agreement includes a children's health component, with specific payment rates, TCOC evaluation, and quality metrics.

YCCO is actively collaborating with pediatric specific clinics, with efforts focused on achieving such milestones as certified PCPCH status and APM program participation.

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).

As described above, plans include efforts with primary care clinics, pediatric specific primary care providers, clinical quality metrics, and VBPS in LAN categories 4A and 2Aii.

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

Some arrangements are already in place for 2022, with targeted expansion in 2023.

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

YCCO estimates performance that is already above 20% with current VBP arrangements, but is pursuing increased risk and complexity of VBPs with two primary hospitals, as well as expanding PCP Capitation to more providers. Actual performance projections are based upon the current CCO benefit package, and will be adversely impacted by any significant changes/additions to what CCOs are contractually obligated to integrate in 2023 and beyond.

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?

Three areas where TA would be beneficial would include 1) pharmacy cost VBPs that may or may not include PBMs, 2) long term implementation of SDOH risk scores, and 3) oral health VBP development inclusive and exclusive of the traditional DCO model.

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

YCCO would request assistance and review on two items:

1. Evaluation of VBP targets and focus areas balanced with the moving targets/global budgets of CCOs. More specifically, the CCO global budgets continue to experience significant increases/changes for OHP policy changes such as the SUD waiver, integration of the OSH waitlist risk, and the 30% behavioral health fee schedule changes.
2. Evaluation of the adverse impacts of financial reporting and regulatory oversight of sub-capitated value-based payment arrangements. Greater scrutiny and reporting requirements that are pushed down to the provider level will disincentivize the implementation or continuation of higher-level LAN category 4 VBP arrangements. These payment arrangements are necessary for CCOs to meet overall VBP requirements, achieve sustainable rates of growth, and the ability to engage even smaller community-based providers. Mechanisms or drivers that essentially eliminate the use of LAN Category 4 VBPs both inhibit the use of population health management strategies and limit CCOs/providers to a very small subset of LAN Category 3B VBPs in meeting CCO contract requirements.

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

Throughout 2019 and 2020, YCCO has collaborated with its strategic partner, [redacted] to model some existing VBP arrangements and administer related payments in [redacted] while relying upon its use of NetSuite to administer some other VBP arrangements. During 2020, YCCO also collaborated with [redacted] and [redacted] to implement [redacted], a web-based provider performance measurement and population health management tool. Updated weekly based on recently adjudicated claims, this tool supplanted CCO Metrics Manager in July 2020. 100% of the contracted providers with whom VBP arrangements have been established have had access to [redacted] since January 2019 and, all but two, have had access to [redacted] since September 2020. The remaining two contracted providers are expected to have access to [redacted] by March 2021.

YCCO shares information regarding providers' performance across measures pertinent to VBP arrangements in one of two ways:

1. When the measures of relevance are tracked within [redacted], providers for whom these measures pertain are invited and encouraged to monitor their performance through this application.
2. For measures that aren't tracked within [redacted], YCCO uses Jupyter Notebook, SQL queries, Tableau, and Excel to produce and distribute reports on a recurring schedule (e.g. quarterly for most; monthly for some) to pertinent providers.

Over time, the set of measures tracked within [redacted] is expected to align with all measures pertinent to VBP arrangements established with providers thereby eliminating the need for YCCO to produce and distribute separate reports.

Patient attribution is based on PCP assignments administered by YCCO. PCPs to whom YCCO members are assigned, including those with VBP arrangements, learn of assignments by virtue of viewing and, if desired, downloading an up-to-date PCP roster report available within the [redacted] Provider Portal. In addition, an up-to-date provider roster is available to PCPs engaged in [redacted].

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

Since hiring an Information Systems Director in the fall of 2021, IS efforts have been largely focused on building our IS capabilities, including adding IS staff and implementing infrastructure enhancements to better support YCCO in performing on our mission. That said, in reference to the above section of the March 15, 2021 HIT Roadmap, we have:

- Integrated most but not all VPB metrics into [redacted], reducing the need for a separate methodology for communicating status of VBP metrics to providers.
- Successfully established [redacted] access to the two remaining providers, resulting in 100% of contracted VBP providers having access to [redacted] and [redacted] for ongoing monitoring of metrics. YCCO has performed multiple site visits with each VBP provider confirming their ability to access [redacted] and [redacted]

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

Member-specific gaps in care are summarized within [redacted] which providers are encouraged to monitor and address proactively or in the context of scheduled encounters. Contracted providers can view members' demographic data including "flags" indicative of certain known characteristics within [redacted]. For those privileged, additional member-specific information is also visible within [redacted] – e.g. prior authorizations and referrals as well as historical claims and related documentation.

YCCO's Care Management team utilizes Optum's Impact Pro solution seamlessly integrated with Cognizant's CareAdvance Care Management system to assess member cost, risk and quality; identify, profile and stratify members; and determine which members are in need of specialized intervention programs and which intervention programs are likely to have an impact on the quality of individuals' health. This information informs who the team is to engage in specific care management programs as well as crafting member-specific care plans. As warranted, this information is shared with providers servicing members engaged in care management programs.

As described in the response to 5.i above, YCCO expects to further bolster population health and risk management activities by incorporating a member-specific

REALD and SDH demographic data elements into [redacted], [redacted], and reports that YCCO shares with contracted providers with whom VBP arrangements have been established. YCCO also intends to provide actionable data, including risk-based cohorts, to contracted providers with whom VBP arrangements have been established.

YCCO acknowledges the importance of understanding the diversity and health outcomes of the population we serve. It is of critical importance that YCCO partner with the providers in the community to best serve our patients and share timely and actionable information when warranted. YCCO also acknowledges the necessity to effectively manage financial risk associated with the administration of OHP benefits for its members.
YCCO intends to stratify its membership based on one or more risk scores (e.g. CDPS+, ACG) in order to target appropriate interventions and inform care management and care coordination efforts aimed at improving health outcomes and managing financial risk thereby enabling YCCO to achieve the triple aim objectives.

YCCO receives CDPS+ risk scores calculated for each of its members from OHA and its actuary, Wakely, on an annual basis and YCCO can calculate ACG risk scores for each of its members whenever it desires via the use of DST Health Solutions' ACG System. Although neither type of risk score is currently incorporated into YCCO's data warehouses, based on an assessment of value and relevance, YCCO expects one or both to be incorporated into its data warehouses during the 1st half of 2021 at which point YCCO will be able to identify, analyze and report upon a broader set of member characteristics of interest.

YCCO expects the risk score(s) deemed valuable and relevant to be incorporated and possibly presented within [redacted] and [redacted] in the 2nd half of 2021, thereby enabling an additional means by which YCCO can identify and report upon member characteristics of interest and share risk-based cohorts with pertinent contracted providers.

Lastly, beginning in 2020, YCCO began embracing the Prometheus (MEPP44)-derived data shared by OHA with YCCO to analyze potentially avoidable costs. This analysis has and is expected to continue spawning ideas for new/revised VBP models, particularly related to contracted specialty providers.

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

Since hiring an Information Systems Director in the fall of 2021, IS efforts have been largely focused on building our IS capabilities, including adding IS staff and implementing infrastructure enhancements to better support YCCO in performing on our mission. That said, in reference to the above section of the March 15, 2021 HIT Roadmap, we have:

- Incorporated the CDPS+ risk score into our database providing for enhanced care management, reporting, and analytics.
- Initiated an effort to enhance our Tableau deployment in order to provide more readily available data and analytics.

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.

YCCO and our partners, [redacted], dedicate various resources to VBP initiatives and Population Management Analytics. By monitoring and reporting provider performance across process and quality outcome measures applicable to VBP arrangements established with contracted providers and informing providers of member-specific gaps in care, we aim to ensure that our members receive appropriate whole-person care regardless of the PCP to whom they're assigned while simultaneously reducing health disparities or inequities when observed. We administer assessments that strive to identify health risks and health-related social needs (i.e. social determinants of health). Through our population health and risk management analytics, we continually identify and assess member risks and needs and, when appropriate, engage high-need members in comprehensive care management programs aimed at addressing needs and minimizing risks. These care management programs often require effective care coordination across providers of medical and social services, delivery systems, or settings to effectively manage member safety and outcomes during transitions.

With regards to YCCO's staffing model for VBP and population management analytics, the following staff, board members, and strategic partners play integral roles:

APM Sub-committee (CEO, CFO, CMO, 4 BOD members) – YCCO's board of directors (BOD) has established and designated the APM Sub-Committee as the group to initially review and help develop new APMs/VBPs for the CCO. The APM Sub-Committee recommends new proposals and contract changes to the BOD for ultimate approval when needed.

Executive Team (CEO, CFO, CMO) – YCCO's Executive team acts as advisors to the APM Sub-committee and ensures that the design and development of APMs align with related intentions and expectations.

[redacted] & Finance Team – YCCO's CFO and Finance team define APMs, collaborate with partners to implement payments based on the APMs, and craft and share reports regarding the APMs with relevant stakeholders.

[redacted] – [redacted] bears responsibility for the successful implementation and use of [redacted] among providers with whom APM-based contracts are established.

[redacted] – YCCO's CMO and colleagues responsible for provider relations communication and collaborate with providers with whom APM-based contracts are established to ensure they understand the APM and related implications and expectations. They also ensure that leverage tools (e.g. [redacted]) and reports appropriately as they service members and manage population health risk.

[redacted] – YCCO's strategic partner, [redacted] ensures that [redacted]-enabled Provider Payments (FFS, Capitated) are made in accordance with APM contracts, produces APM Reports, processes monthly 820 files and conveys related capitated payment information to applicable providers (Virginia Garcia & Physicians Medical Center), and processes daily and monthly 834 files and conveys related membership assignments to capitated partners (Capitol Dental Care, Yamhill HHS).

[redacted] – YCCO's strategic partner, [redacted] implements and maintains [redacted], and administers Utilization Management and Care Management activities in accordance with APM contracts.

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

[redacted] and IS team – YCCO's IS Director and the IS team members are responsible for providing stable, accurate, and readily available data and analytics tools, intended to enhance YCCO internal analysis supporting operational and strategic initiatives.

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.

YCCO's five-year Value-Based Payment (VBP) roadmap includes all the necessary focus areas for CCO 2.0, inclusive of PCPCH foundational payments, hospital, maternity, child, behavioral, and oral health care. During the five-year term of our CCO 2.0 contract, we are committed to transitioning provider payments from 20% VBP-based to 70% in accordance with OHA's COVID-19 revised timeline. By 2024, VBP arrangements will be predicated on Health Care Payment Learning & Action Network (LAN) category 2C or higher as summarized below. The primary partners in focus for upscaling include primary care, hospital, specialty care, and oral health care providers. Within primary care, YCCO's foundational payments for PCPCH tier levels will continue to be leveraged and expanded, with the goal of increasing tier levels and certified providers. The projected roadmap is subject to change as well, pending further development and discussions with providers.

Year one VBP advances focus on primary care, behavioral health, and hospital care. For hospital and maternity care, LAN Category 2C pay-for-performance VBP are to be implemented with one hospital, as well as developed for future expansion to at least one additional hospital in year two. Behavioral health payment models were revamped from a LAN Category 4N to a LAN Category 4A VBP with one provider. Primary care efforts focused on development of a LAN Category 4A VBP pilot with two provider groups, with implementation in 2021.

Year two VBP advances include implementation of the primary care LAN Category 4A pilot VBP, as well as development and adjustments to the pilot model for expansion in year three to include as many as thirteen primary care and children's care providers. The hospital care LAN Category 2C VBP will expand to a second hospital, and development for LAN Category 3B or higher VBPs are targeted. Solely within maternity care, YCCO's Maternal Medical Home model will be adjusted from a LAN Category 3N to a LAN Category 3B VBP, as well as expanded from one to two providers.

Year three VBP advances include implementation of primary care LAN Category 4A VBP for up to thirteen more providers, inclusive of three children's care specific clinics. Additional advances target implementation of up to two more hospitals on LAN 2C VBPs, and implementation of one hospital advancing from LAN Category 2C to LAN Category 3B VBP. Within behavioral health, LAN Category 2C VBPs are targeted for development and possible implementation for possibly five more providers.

Year four and five VBP advances currently target focuses on primary care with behavioral and oral health integration, as well as possible total cost of care risk to up

to twenty-two providers. Additional advances may include maternity care expansion to one or more providers, behavioral health expansion, oral care revamping and risk advancement, and hospital expansion to two or more hospitals.

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,

Increase staffing support/infrastructure for both HIT and VBP analysis.

b. spread VBP to different care settings, and

Ensure systems are scalable to new benefits, metrics, and populations.

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

YCCO has recently implemented technology improvements to initiate a more reliable cloud-based infrastructure, moving our primary business server to Microsoft Azure. This gives us the ability to quickly and reliably add IS resources as they become necessary. That, along with our previous responses to 13.a and 13.b positions us to scale as needed.

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.

YCCO is in the process of updating their HIT Plan of which the previous response was an excerpt. The follow updates (in black font) will reflect the current status of those activities and milestones along with any cosmetic edits and corrections.

The following goals and related strategies, and tactics summarize our complementary HIT plans to enable and support YCCO's VBP Roadmap.

Goal 11: Ensure that existing and future VBP arrangements can be modeled and related payments can be administered in [redacted]

YCCO desires to model all VBP arrangements and administer related payment exclusively in [redacted] and intends to collaborate with [redacted] to achieve this goal.

Strategy 20: Confirm [redacted] ability to model VBP arrangements

Tactic 20.a.: Before establishing a VBP arrangement with contracted providers, collaborate with [redacted] to ensure that the VBP arrangement can be accurately modeled and related payment can be appropriately administered in [redacted]

Tactic 20.b.: If an enhancement to [redacted] is required before a new VBP arrangement can be accurately modeled and/or a related payment can be appropriately administered in [redacted], ensure that the effective date of any provider contract(s) predicated on the new VBP arrangement follows the date at which [redacted] confirms intent to release the necessary enhancement.

Timeline for Strategy 20

	2020				2021				2022				2023				2024			
Strategy	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tactic 20.a	O			X																
Tactic 20.b	O			X																

O Anticipated Start Date

X Anticipated Completion Date

Ongoing Effort

Evaluation of Strategy 20

YCCO will evaluate the success of this strategy by monitoring the instances in which [redacted] is unable to administer payment related to VBP arrangements established with contracted providers within [redacted] thereby necessitating a less desirable alternative payment mechanism.

Goal 11, Strategy 20 and Tactics 20.a and 20.b are in place and in "Ongoing Effort" status as shown in the Timeline above.

Goal 12: Enable stakeholders to actively monitor provider performance pertaining to VBP Arrangements predicated on provider performance and/or health outcome measures

YCCO staff and contracted providers with whom VBP arrangement exists must be able to actively monitor provider performance and/or health outcome measures upon which VBP arrangements are predicated.

Strategy 21: Ensure that YCCO and contracted providers with whom VBP arrangements are established can measure, report, and actively monitor provider performance across related performance measures

Tactic 21.a.: For performance measures that YCCO is capable of measuring, ensure that requisite data is obtained and stored within appropriate YCCO's data warehouses and that performance is calculated, reported, and monitored in the context of [redacted] or dashboards and reports shared with pertinent YCCO staff and contracted providers with whom related VBP arrangements exist.

Tactic 21.b.: For performance measures that YCCO is incapable of measuring, ensure that contracted providers with whom VBP arrangements are established can calculate and report performance across these measures in a mutually acceptable manner and cadence prior to establishing VBP arrangements predicated on these performance measures.

Timeline for Strategy 21

	2020				2021				2022				2023				2024			
Strategy	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tactic 21.a			X																	
Tactic 21.b			X																	

O Anticipated Start Date

X Anticipated Completion Date

Ongoing Effort

Evaluation of Strategy 21

YCCO will evaluate the successful execution of this strategy by assessing the number of VBP arrangements for which related provider performance measures can't be accurately calculated, reported, and monitored.

Goal 12, Strategy 21 and Tactics 21.a and 21.b are in place and in "Ongoing Effort" status as shown in the Timeline above.

Strategy 22: Ensure that YCCO and contracted providers with whom VBP arrangements are established can measure, report, and monitor related health outcome measures

Tactic 22.a.: For health outcome measures that YCCO is capable of measuring, ensure that requisite data is obtained and stored within appropriate YCCO's data warehouses and that achievement of these measures is calculated, reported, and monitored in the context of [redacted] or dashboards and reports shared with pertinent YCCO staff and contracted providers with whom related VBP arrangements exist.

Tactic 22.b.: For health outcome measures that YCCO is incapable of measuring, ensure that contracted providers with whom VBP arrangements are established can calculate and report achievement of these measures in a mutually acceptable manner

and cadence prior to establishing VBP arrangements predicated on these health outcome measures.

Timeline for Strategy 22

Strategy	2020				2021				2022				2023				2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tactic 22.a	O					X														
Tactic 22.b	O				X															

O Anticipated Start Date
X Anticipated Completion Date
Ongoing Effort

Evaluation of Strategy 22

YCCO will evaluate the successful execution of this strategy by assessing the number of VBP arrangements for which related health outcome measures can't be accurately calculated, reported, and monitored in a timely and effective manner.

Goal 12, Strategy 22 and Tactics 22.a and 22.b are in place and in "Ongoing Effort" status as shown in the Timeline above.

Briefly summarize updates to the section above.

YCCO has initiated processes to work closely with [redacted] to ensure that VBP contract arrangements can be administered effectively from a payment/processing perspective as well as a provider VBP metric reporting and collaboration perspective.

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

See Question 11

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

Since hiring an Information Systems Director in the fall of 2021, IS efforts have been largely focused on building our IS capabilities, including adding IS staff and implementing

infrastructure enhancements to better support YCCO in performing on our mission. That said, in reference to the above section of the March 15, 2021 HIT Roadmap, we have:

- Incorporated the CDPS+ risk score into our database providing for enhanced care management, reporting, and analytics.
- Initiated an effort to enhance our Tableau deployment in order to provide more readily available data and analytics.

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

We've not yet encountered any challenges as the HIT we utilize to administer VBP arrangements has satisfied our needs and expectations to date.

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

No such challenges identified.

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.

As described in the response to 6.a.i. above, YCCO shares information regarding providers' performance across measures pertinent to VBP arrangements in one of two ways:

1. When the measures of relevance are tracked within [redacted], providers for whom these measures pertain are invited and encouraged to monitor their performance through this application.

2. For measures that aren't tracked within [redacted], YCCO uses Jupyter Notebook, SQL queries, Tableau, and Excel to produce and distribute reports on a recurring schedule (e.g. quarterly for most; monthly for some) to pertinent providers.

Over time, the set of measures tracked within [redacted] is expected to align with all measures pertinent to VBP arrangements established with providers thereby eliminating the need for YCCO to produce and distribute separate reports.

As described in the response to Question 11 above, Patient attribution is based on PCP assignments administered by YCCO. PCPs to whom YCCO members are assigned, including those with VBP arrangements, learn of assignments by virtue of viewing and, if desired, downloading an up-to-date PCP roster report available within the [redacted] Provider Portal. In addition, an up-to-date provider roster is available to PCPs engaged in [redacted].

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

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

We are maintaining our strategy in the direction of providing all important metrics to providers via [redacted] and [redacted]. YCCO will continue to initiate site visits with providers and encourage/confirm their ability to access [redacted] and [redacted] [redacted]

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

No change in our previously stated strategy at this time.

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

No changes in tools intended for delivery of metrics analysis to providers. Although we are enhancing our own internal Tableau environment to better serve/inform internal YCCO staff.

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.

See response to Question 11

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

The most impactful change has been our incorporation of the CDPS+ risk score providing for enhanced care management, reporting, and analytics.

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.

As noted in the response to Question 11 above, member specific data intended to inform and enable population health management activities is shared with providers within whom VBP contracts have been established in the context of [redacted]. In addition, YCCO's Care Management team pro-actively communicates with and shared information about members engaged in care / case management via phone, fax, and the [redacted] provider portal.

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

No changes to this information at this time.

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

See Question 11

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

No major changes or updates. Although, we continue to work closely with [redacted], [redacted], and internal YCCO experts to enhance reporting and analytics; and make them available to our providers.

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

We've not yet encountered any challenges as the HIT we utilize to administer VBP arrangements has satisfied our needs and expectations to date.

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

It probably does not need to be said, but as is true for numerous of our strategies, the COVID-19 pandemic led us to slow some strategies and efforts across our contracted network. We have also been in the process of building our IS capabilities, including adding IS staff and implementing infrastructure enhancements to better support YCCO in performing on our mission. To some degree, the focus and timing on these initiatives have impacted progress as well.

<u>Optional</u>
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?

Please see question #10 above in regards to TA and related concerns.

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

Click or tap here to enter text.

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.