Columbia Pacific 2020 CCO 2.0 VBP Interview Questionnaire Responses

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.**

   Columbia Pacific CCO (CPCCO) actively collaborates with stakeholders and providers in the development, monitoring and evaluation of VBP models across our physical health, behavioral health and oral health networks. Providers are engaged at the beginning of the process to help identify quality measures through a shared, iterative process. Multiple data points are reviewed jointly, and key performance indicators are chosen. Once those areas are identified, targets for improvement are jointly agreed upon. A regular review process is then set up for the providers and CPCCO staff to review how the provider is performing. During these meetings, performance is reviewed, areas of improvement are discussed, and technical assistance offered if needed to support the provider. Regular reports are provided on the VBP performance; however, 2020 reporting has been placed on hold due to the impact of COVID-19. The CPCCO Board was kept abreast of adaptations to the VBP made in response to COVID

   The CPCCO Board of Directors has knowledge of the VBP models and monitors CPCCO's Risk Shares via their Finance Committee and quality metric attainment via their Network & Quality Committee. Each County Collaborative Risk Share also has a committee comprised of participating provider groups that meets regularly to monitor their performance throughout the year. In addition, CPCCO's Clinical Advisory Panel is comprised of a cross section of providers within the CPCCO network, and reviews performance indicators at both a clinic and CCO level. Committee recommendations based upon their expertise guide CPCCO improvement activities. CPCCO also plans to work with a third-party evaluator on formal evaluation of the Primary Care VBP programs (Primary Care Payment Model [PCPM]). Results will be shared with network partners and used as a basis for program refinement.

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

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

3) **<u>If you indicated in Question 2</u> that you modified all existing VBP contracts under a single rationale and process, please respond to a–c:**

4) **<u>If you indicated in Question 2</u> 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?**

1. Primary Care Payment Model (PCPM) program: as detailed in the RFA, an alternate payment program that aims to support PCPCHs in building capacity for population health management and reward clinics that achieve high quality performance across multiple care areas.
2. Integrated Behavioral Health (IBH) program: as detailed in the RFA, an alternate payment program that is linked to PCPM and supports practices ability to integrate behavioral health services to provide same-day access to integrated population-based preventive behavioral health services.
3. Shared Risk Models – as detailed in the RFA, a model that facilitates upside payments/downside risk based either on the total cost of care, or a Medical Loss Ratio (MLR) model with upside payments influenced by established quality metric gates. The Impact to cost targets and metrics are being evaluated and needed adjustment will be made in collaboration with provider partners.
4. Behavioral Health Outcomes Based Performance Model: Forgiveness on BH metric performance in BH VBP contract for 2020.

e) Describe your rationale for modifying this existing VBP model in 2020.
   1. PCPM & IBH
      i. Continued pursuit by PCP's to work on some of the quality measures and Targets contained in the model were counterintuitive to behaviors and practices desired by the population to counter the spread of COVID-19. This was especially prevalent with those in the preventive care and patient outreach areas.
      ii. PCP resources were strained and it was felt that requiring reporting of data was an unnecessary administrative burden particularly since the expected data results would be unfavorable as a result of the stay at home practices put in place during the middle of the reporting period.
      iii. The visit modality needs changed through a shift from in office to telehealth, so resources needed to quickly refocus on meeting that challenge, both for payors and PCP clinics as providers. This wasn't a key element of the program at the time.
   2. Shared Risk Models - As service volume dropped and elective services postponed, we saw changes in the total cost of care for our members. We are monitoring how service levels recover and will make any necessary target or metric adjustments in collaboration with our partners.
   3. Behavioral Health Outcomes Based Performance Model - BH provider resources were strained and it was felt that requiring reporting of data was an unnecessary administrative burden particularly since the expected data results would be unfavorable as a result of the stay at home practices put in place during the middle of the reporting period.

f) Describe the process you used for modifying this VBP model, including your key activities, timeline/s and stakeholder engagement.
   1. All programs listed above – In early Spring, leadership collected input from key external stakeholders via existing standing provider meetings, and other ad hoc provider concerns and assimilated comments and concerns at a high level. Our team initially and continues to review key elements of the current programs at risk for negative impact by the COVID event.
   2. PCPM and IBH: The APM Operations team developed a set of recommendations for modifying the program requirements through the end of 2020. Communications were sent to providers advising that the current program would continue unchanged through the end of 2020, with forthcoming communications describing any changes to the program in 2021.
   3. Shared Risk Models: collaboration with community risk model partners occurs monthly in our Joint Operating Committee (JOC) meetings. We review monthly cost and metric progress and continue to discuss the COVID –19 implications and will adjust as necessary and agreed.
   4. Behavioral Health Outcomes Based Performance Model - BH provider resources were strained and it was felt that requiring reporting of data was an unnecessary administrative burden particularly since the

expected data results would be unfavorable as a result of the stay at home practices put in place during the middle of the reporting period.

g) Describe how you modified this VBP model, including changes in LAN category, payment model characteristics, or implementation dates.

1. PCPM & IBH: The LAN category will remain a 2C. Agreements were amended to continue through the end of the year instead of terming in July. The planned renewal APM program containing additional measures, and more aggressive measure targets and different reporting processes was postponed until January 2021. Additionally, the data reporting event for submitting performance on the first 6 months of 2020 was cancelled. Current PMPM rates remained in place through December 2020. PCP's that were able to submit reports and did meet or exceed their targets were granted any earned increases. PCP's unable to report or significantly declined in performance level were not penalized and will have an opportunity to increase their performance and payment levels in the next APM program.
2. Shared Risk Models – The LAN category will remain a 3B. We will review, discuss and agree on any needed adjustment as more data is available over the next few months.
3. Behavioral Health Outcomes Based Performance Model – The LAN category will remain a 2C. Cancelled a specific quality reporting event to ease the administrative burden on providers and avoid COVID-impacted utilization patterns to impact data-validity

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).

Columbia Pacific CCO requires all staff working at our primary care clinics to engage in cultural responsiveness training. Clinics can choose to participate in their own trainings or take advantage of a free, CME accredited online training series the CPCCO provides to our network. This expectation is enforced via our provider network audits. Additionally, we ask each clinic that participates in our Primary Care Payment Model (PCPM) VBP to provide a narrative overview of their equity initiatives via an affidavit in their performance reporting. Our PCPM also includes an access and engagement measure that is intended to balance targeted metric achievement with widespread population outreach and engagement. CPCCO partners with our clinics by regularly discussing this equity work at our Clinical Advisory Panel and at our quarterly meetings between CPCCO leadership and clinic leadership. CPCCO also maintains a dashboard that identifies potential disparities within certain populations in metric achievement and health care engagement.

Columbia Pacific CCO has also invested heavily in bolstering members access to quality interpretation. CPCCO has assisted clinics in having current bi-lingual staff become certified interpreters to bolster options for in-person interpretation. We also will be completing retrospective chart reviews to assess if meaningful language access was provided and will be conducting a baseline assessment process for each clinic where a trained interpreter will assess the process of a limited English proficiency patient acquiring an appointment. We have also placed our two providers of language interpretation at risk for three quality measures;

- 80% of interpretation must be done in person,
- demonstration of less than 1% complaint rate, and
- demonstration of less than 1% rate of interpreter no shows.

Providers report on these measures monthly and failure to meet them results in a payback per person encounter from the previous quarter.

CPCCO's network includes FQHC's and community based physical health and behavioral health providers. We work closely with this group to ensure that they have the resources they need to be there for our members, a disproportionate share of which are high risk, come from culturally based communities or are part of underserved populations. During COVID 19, CPCCO offered stability funding payments to ensure this important part of our network would remain financially stable and available to our vulnerable members.

As demonstrated by the quick action taken to address payment models during the COVID 19 crisis, CPCCO is keenly aware of our vulnerable members and the very important network of providers that support them. We will continue to monitor and support this provider population as we move forward in the VBP journey to ensure our vulnerable members are not adversely impacted by payment models or environmental factors.

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

While overall our processes have not change, we have had to reconsider our performance targets due to COVID-19 implications. Columbia Pacific CCO remains committed to developing innovative payment models that incent providers to deliver high quality care while also ensuring no adverse behavior by providers towards certain patient populations because those members may require additional or unique support. Our existing analytics platform, experience with risk adjustment, and established processes embedded within VBPs equip us for ongoing system evaluation and management. Specifically, we guard against potential unintended consequences primarily by:

- Measuring provider performance against the clinic's own historical performance
- Exploring VBPs that consider social and medical complexity in the risk-adjustment
- Monitoring grievances and patient re-assignments

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?

We are taking different approaches to incorporate risk adjustment into both new and existing VBP models.

- PCPM & IBH we applied adjustment to each PCP practice to classify them in a risk-tier which affects their overall payments. The intent is to connect the complexity of the population (measured via risk score) to the size of the value-based payment.
- Shared Risk Models we adjusted financial targets and claims experience to reflect changes in the risk of assigned membership that are included in the agreement. For Our Medical Loss Ratio (MLR) Risk agreement we adjusted the revenue allocated for members assigned to the clinic system to reflect their risk relative to the CCO's total membership.

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.

Yes, we have considered adjusting for social factors in our overall risk adjustment methodology. Our current risk adjustment methodology applies to overall payments not to quality measures in most programs. We have chosen to adjust payments, in recognition that it costs more to achieve good outcomes for medically and socially complex patients. However, we do not want to set the expectation that it is ok for more socially complex patients to have

worse outcomes, which is the concern with risk-adjusting quality performance. This would not align with our commitment to equity and to supporting health in our communities. The exception is that, our shared-risk contracts do risk adjust the cost targets.

To date, we have only considered risk adjustment at the individual/patient level not at the community/neighborhood level. The only comprehensive source of social risk data that we have access to for our individual members at this point in time is the pediatric health complexity data provided by the OHA in conjunction with OPIP. We do not have a similar data source right now for adult members. We did explore how we might use the pediatric health complexity data in our risk adjustment methodology for pediatric clinics. However, implementing this would have disadvantaged our family practice clinics who also see a large portion of pediatric patients but who would not receive the same social complexity adjustment. Trying to implement the social complexity adjustment for all pediatric *patients* regardless of whether they seek care at pediatric or family medicine practice also comes with methodological challenges as we would have a different methodology for adults and children assigned to the same practice.

We would be willing to explore using community or neighborhood level data to risk adjust, but this is not an avenue that we have explored yet.

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.**

CPCCO has implemented a tiered primary care VBP (PCPM) as described above. All participating clinics must be PCPCH recognized and payments range from $1 for PCPCH Tier 3 to a maximum of $18 for Tier 5 clinics demonstrating high quality performance and outcomes. The majority of our members are seen in tier 3 and above clinics, justifying the approach to this payment structure. We will continue to evaluate the PCPCH engagement of our network and invest in new or lower tier PCPCH clinics if warranted by changes in our current PCPCH clinics or by new primary care providers entering the market. If impacted membership warrants the added operational and administrative complexity, we will add a separate PMPM payment for tier 1 or 2 clinics of $.50 - $1.00. We currently have no members assigned to tier 1 clinics and four members assigned to tier 2 clinics. CPCCO sought guidance from the OHA during the CCO 2.0 contract development process on this requirement and never received a response. It is our understanding that implementing a PMPM payment for a clinic with extremely low membership would be administratively burdensome for the clinic and CPCCO and would not meet the spirit of this requirement.

All program rates have been developed with the intent of engaging and rewarding clinics that have attained higher PCPCH Tier status (Tier 3 – 5). PCPCHs at the higher tier levels have demonstrated the sophistication and capacity necessary to effectively participate in value-based payment programs and further the goals of the triple aim.

We will continue to review and upskill staff on PCPCH program revisions to standards and measures in order to Identify major shifts and implications for the network. Clinics that may need support to remain recognized based on changes will receive focused outreach and TA support. With the recent decision by the PCPCH Program to make available to payers upon request the PCPCH application summaries for their network clinics, we will have additional information readily accessible to enhance and sequence the support offered across the network.

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

☒ No

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

Per the description above, we are currently meeting all contractual payment requirements and no changes have been made.

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?

CPCCO contracts with regional CMHPs for the majority of routine MH and SUD outpatient, ACT, Wraparound, EASA, Supported Employment, and crisis services. Beginning in October 2020, ACT, Wraparound and EASA will have performance metrics attached to the contract with an upside risk opportunity. By January of 2022, these will become downside risk arrangements through a withhold.

CPCCO is building out a "composite score" for BH providers, which we hope to roll out by 2021. This is a composite score based on a set of outcomes measures, weighted by provider or program type. Initially this will lead to a performance bonus and over time it will become part of a downside risk arrangement. This will also incorporate Feedback Informed Treatment (FIT), which we are beginning to build in fall of 2020. FIT administration will become part of the composite score.

CPCCO also has implemented the IBH component within the broader PCP APM program. The IBH program incentivizes the integration of behavioral health services into the Primary Care space.

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?

CPCCO has drafted an Integrated Perinatal & SUD VBP. Metrics are in development as discussions continue with the provider network. Implementation is currently estimated to occur between Q3 2021 or Q1 2022. Additional payment enhancements have been implemented 8/1/20 to provide improved access and network sustainability for doula services. Enhanced payment applies to bundled doula services (prenatal, birth, postpartum) as well as the itemized service for labor/birth. A Doula VBP has been created with an estimated implementation in Q4 of 2020 or Q1 2021 with a community-based doula organization offering linguistically responsive/specific services.

CPCCO is also collaborating with hospital partners to discuss potential case rate payment approaches, and quality metrics potentially including C-section rates to address the VBP requirement for this care delivery area.

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?

Two out of the three hospitals located within Columbia Pacific CCO's region have participated in our County Collaborative Risk Share payment model since 2015. The third hospital participated during the first years but has since ceased engagement. Columbia Pacific CCO has begun meeting with each hospital this year to explore their interests and priorities as it relates to VBPs and gather feedback on the County Collaborative Risk Share model from those that still participate. Based on initial feedback Columbia Pacific CCO has begun to develop a new version of the Collaborative Risk Share model that builds more targeted accountabilities for each participating provider. CPCCO has continued to schedule meetings throughout 2020 with all three of our hospital partners to

share the proposed changes to the County Collaborative Risk Share model with the intent of having all three participate in the model beginning in 2021.

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

☒ Yes (please respond to a–c)

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

i. **PCPM & IBH:** the CCO developed new components to be included in the Primary Care APM program. We are incorporating health equity, oral health, and Access and Engagement measures into the program.

ii. **Shared Risk Models:** as referenced above, CPCCO has included hospitals in our County Collaborative Risk Share model since 2015. The model also includes Primary Care, and Behavioral Health providers and the costs associated with providing care to the assigned membership within the model and is meant to drive a team approach to improving quality and reducing the total cost of care.

iii. **PCP Capitation:** transitioned from FFS to capitation as the payment methodology for Primary Care Services with one of our key provider partners.

iv. **Maternity VBP Payment Development –** CPCCO has drafted an Integrated Perinatal & SUD VBP. Metrics are in development as discussions continue with the provider network. Implementation is currently estimated to occur between Q3 2021 or Q1 2022. Additional payment enhancements have been implemented 8/1/20 to provide improved access and network sustainability for doula services. Enhanced payment applies to bundled doula services (prenatal, birth, postpartum) as well as the itemized service for labor/birth. A Doula VBP has been created with an estimated implementation in Q4 of 2020 or Q1 2021 with a community-based doula organization offering linguistically responsive/specific services.

v. **Behavioral Health VBP Development**

1. **ACT, Wraparound, and EASA:** Beginning in October 2020, these programs will have performance metrics attached to the contract with an upside risk opportunity. By January of 2022, these will become downside risk arrangements through a withhold.
2. **Composite Score:** CPCCO is building out a "composite score" for BH providers, which we hope to roll out by 2021. This is a composite score based on a set of outcomes measures, weighted by provider or program type. Initially this will lead to a performance bonus and over time it will become part of a downside risk arrangement. This will also incorporate Feedback Informed Treatment (FIT), which we are beginning to build in fall of 2020. FIT administration will become part of the composite score.

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.

i. **PCPM & IBH**: this program will continue to be categorized as a 2C in the LAN framework with the proposed changes and will continue to function as a risk-adjusted PMPM payment program based on assigned membership with quality metric performance influencing payments received.

ii. **Hospital VBP / Community Risk Share**: the model falls into the 3B LAN category. The model benchmarks risk and membership adjusted costs from the previous year to establish a total cost of care target, with performance driving potential upside/downside payments.

iii. **PCP Capitation**: The capitation model would fall into the 4A LAN category

iv. **Maternity VBP Payment Development**: The anticipated LAN category would be 2C for both the integrated Perinatal and SUD VBP and the Doula VBP
v. **Behavioral Health VBP Development:** The anticipated LAN category would be 2C for both the ACT, Wrap, and EASA, and Composite Score VBPs under development.

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).

i. **PCPM & IBH:** The components were set for July 2020 implementation, but this was delayed until January 2021 allowing all parties to focus elsewhere while adjusting to the COVID-impacted operational environment.
ii. **Hospital VBP / Community Risk Share:** while the model currently under construction has changes from the current version, those changes were not driven by COVID-specific impacts.
vi. **PCP Capitation:** the implementation of this model was not influenced by COVID-19 and was part of our strategy to transition from FFS reimbursement structures to VBPs
vii. **Maternity VBP Payment Development**: The approach didn't change due to COVID
viii. **Behavioral Health VBP Development:** The approach didn't change due to COVID

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?

CPCCO has a robust team of innovation specialist who support both our physical health and behavioral health network providers. One of the key strategic focuses of this team this year and next is supporting our providers in developing their VBP muscle. We are developing tools, attending trainings and connecting with our providers to fully understand the needs. We believe that to ensure success in the VBP space we need to work collectively, will continue to share what we learn with OHA and our CCO peers as we move forward.

While not intended to be an exhaustive list, below are some areas we believe assistance from OHA would be beneficial:

a) Purchase and make available to CCOs access to online academic databases and articles. Access to new research and best practices in the space of implementation science, community and cross-sector models for collaboration and engagement.
b) Create library of basic VBP models and contract language
c) Host workshops on performance benchmarking
d) Hold Providers accountable to billing requirements as a core element of participating in the Oregon Health Plan. Claims data is only as good as the claim it came in on. If providers are not appropriately and consistently using the claim forms, data is not accurate nor comparable. Example here is the very inconsistent use of box 32 for site of service, NPI utilization here varies within and across providers.

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

CPCCO currently participates with and/or provides financial support to statewide provider organizations and third parties that are working to support providers in the VBP space. OHA's participation and financial support of these efforts would make a significant impact on participation, engagement and results.

Create regulatory or systematic support to align accountabilities between the CCO's and the provider community. The current one-sided model places full accountability on the CCO, but we need to the providers with us to succeed. Oregon Health Plan participation requirement possibly?

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?
    a. Alignment of accountability between CCO's and provider network to participate in VBP migration. Financial incentives and metric performance can only go so far.
    b. Collaboration between CCO's/Payers could support consistency and ease administrative burden for both providers and payers.
    c. Common reporting platform

18) Do you have any suggestions for improving the collection of this information in subsequent years? If so, what changes would you recommend?
    a. Be clear on timing and expectations with advance notice. This detailed questionnaire came with a short turnaround time. Many OHA/CCO deliverables are due
    b. Share questions well in advance.