2021 CCO 2.0 VBP Interview Questionnaire and Guide

Introduction

Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, will be scheduled in June 2021. Please schedule here if your team hasn't already done so.

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 **Friday, May 28, 2021**. 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.

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 and HCP-LAN categories.

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, 2021 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 of our three County Collaborative Risk Share groups also has a committee comprised of participating provider groups that meets regularly to monitor their performance throughout the year. CPCCO's leadership team meets with each of our clinic leadership teams on a quarterly basis to review individual performance on our Primary Care Payment Model and with our Community Mental Health Providers leadership teams to gather feedback on our behavioral health VBPs. 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 is also working with a third-party evaluator on formal evaluation of the Primary Care VBP programs (Primary Care Payment Model [PCPM]). Preliminary results will be available at the end of 2021 and will be shared with network partners and used as a basis for program refinement.

In addition to the forums to engage with our network partners described above, CPCCO is participating with CareOregon and FQHCs across CareOregon's network in the development of a Safety Net - Shared Accountability, Total Cost of Care (TCOC) Model. We are working with the Community Health Center of Oregon (CHCNO)[1]and non-CHCNO clinics to define a VBP model that shares savings/risk across the FQHCs and with CareOregon for the total cost of care (see more detail below in Questions 13-14). We are currently in the process of formalizing a structure to co-

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[1] Community Health Center of Oregon (CHCNO). 15 FQHCs across the state of Oregon founded by Oregon Primary Care Association. 8 of the 15 clinics are in CareOregon's service areas.

design the model, define data / reporting needs, and share learnings to achieve the desired outcomes. The oversight team and work groups will include organizational and clinical leadership from participating FQHCs, (CHNCO and non-CHCNO clinics) CPCCO and CareOregon.

This TCOC model is intended to further the goals of the quadruple aim. Specifically, we hope to:

- Build shared ownership and accountability among partners and CareOregon for patient health at the provider and community level
- Encourage service redesign and practice transformation to meet the needs of the whole population
- Increase the partners clinical, technical, and administrative ability to participate in total cost of care contracting models and meet their needs for more revenue opportunity
- Align partners' financial incentives around cost, access, quality, and member experience
- Incent and support providers and community partners in working together sharing data-driven, experience-based approaches, to improve quality care and reduce avoidable costs and utilization
- Supports CCOs' commitments to implement value-based payment arrangements and further the goals of CCO 2.0

The CPCCO/CareOregon team also remains an active member of the statewide Primary Care Payment Reform Collaborative, CPC+ state payer group and has signed on to the Oregon Value-based Payment Compact sponsored by OHA and OHLC.

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

☒ CCO modified VBP contracts due to the COVID-19 PHE. *[Proceed to question 3]*
☐ CCO did not modify any existing VBP contracts in response to the COVID-19 PHE. *[Skip to question 4].*

3) <u>If you indicated in Question 2</u> that you modified VBP contracts 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 fee-for-service [FFS] to capitation)

☐ Modified the payment level or amount (e.g. increasing per member per month [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 the payment mode (e.g. from FFS to capitation)

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

4) Did your CCO expand the availability or the provision of telehealth to members as a result of COVID-19? If so, describe how telehealth has or has not been incorporated into VBPs in 2021.

CPCCO has always supported and advocated for more telehealth services to ensure that all members have access to care, regardless of their specific life circumstances. During COVID-19 we have strengthened our policies and resources in support of telehealth services. This is an added level of assurance that our high risk and marginalized populations will not be negatively impacted by payment models or metric performance. CPCCO has implemented telehealth payment parity and recognizes telehealth visits similarly to face-to-face encounters for both cost and quality measures. We will continue to explore opportunities for possibly including telehealth more explicitly in future VBP models.

5) Has your CCO's strategy to measure quality changed at all as a result of COVID-19? Please explain.

While some reporting requirements and/or targets have been modified over the past year, CPCCOs overall strategy to measure quality has not changed because of COVID-19. CPCCO is

monitoring COVID vaccination status to inform outreach efforts and has integrated these activities into its quality strategy, similar to other vaccination campaigns. That said, COVID-19 has changed the appetite of some providers within the network to participate in VBP arrangements. Some have indicated an increased interest, while interest from others has declined.

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 September 2020, when CCOs last reported this information.

6) Describe in detail any 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). Please focus on activities that have developed or occurred since September 2020.

   The activities described in the last report are still in place. Since September of 2020, CPCCO has completed our retrospective chart reviews and anonymous baseline assessment of our primary care clinics' ability to provide interpretation services to our members. The results were shared with each clinic individually and improvement initiatives have been discussed in our Quality Improvement Workgroup and clinic individual coaching sessions that are offered as part of our technical assistance offerings. CPCCO also received the first equity narratives as part of our Primary Care Payment Model and incorporated the scores into clinic payment adjustments and quality improvement initiatives.

   CPCCO also launched our Justice, Equity, Diversity, and Inclusion (JEDI) workgroup infrastructure. This effort includes nine workgroups focused on integrating equity into CPCCO's internal and external work. Our VBP contracts falls under the purview of the Resource Allocation and Contracting Practices workgroup that is responsible for auditing and monitoring how our VBPs are being used to further equity within our region.

   CPCCO has also partnered with CareOregon on development of a Data equity guide which will inform analytic activities, including VBP performance measures, moving forward. The guide includes practical recommendations for integrating equity into data analysis and data visualization.

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

   No change from previously reported activities

8) Is your CCO planning to incorporate risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?

We are still approaching risk adjustment as previously reported and described again below:

- 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.

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

9) Describe the process your CCO has used to address the requirement to implement PMPM payments to practices recognized as PCPCHs (for example, region or risk scores), including any key activities, timelines and stakeholder engagement. Please focus on new developments, changes or activities that have occurred since September 2020.

There have not been any changes to our PCPCH payment approach since the last report. We have included a description again below.

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) Please describe your CCO's model for providing tiered infrastructure payments to PCPCHs that reward clinics for higher levels of PCPCH recognition and that increase over time. If your CCO has made changes in your model to address this requirement since September 2020, please describe any changes or new activities.

See response to Question #9

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? 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).

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 in late 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) as FIT administration will become part of the composite score.

CPCCO has also 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? 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).

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 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 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.

CPCCO's existing Freestanding Birth Center Policy was updated Q1 of 2021 with the intention of improving access to birth centers outside of the carve-out benefit. Partnership opportunities are in development for birth centers who meet the policy criteria, including access to direct entry midwives. Partnership agreements are intended to be initiated 2021-2022 with annual review of sustainability and assessment for potential need of VBP development.

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? 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).

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 then ceased engagement for four years before deciding to return to the model in 2021. Columbia Pacific CCO met with each hospital throughout 2020 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 their feedback, Columbia Pacific CCO developed a new version of the Collaborative Risk Share model that has been adopted in all three of our counties including all three of our local hospitals and builds more targeted accountabilities via the incorporation of quality measures. The selected measures focus on Substance Use Disorder to help drive the partners to collaborate across the care continuum to improve the health outcomes for their local Medicaid community. The quality measures impact both upside and downside risk in an attempt to drive collaborative quality improvement regardless of financial performance.

As mentioned above in answer 1, CPCCO and CareOregon are in the process of co-creating a shared accountability, total cost of care (TCOC) model in partnership with our FQHC partners. While the payment itself will go to primary care providers, hospital costs will be addressed given the nature of the model.

14) Have you taken steps since September 2020 to develop any new VBP models in areas other than behavioral health, maternity care or hospital care? If so, please describe.

CPCCO is currently developing a Traditional Health Worker (THW) VBP model proposal which would be gradually implemented over the next three years.

To-date, work has been focused on ensuring a common understanding of the THW requirements, developing program goals and reporting strategy, and how best to engage the network. The team building the model is centering the work around consideration of member needs and application of an equity lens. Several opportunities for optimizing existing VBP arrangements to incorporate support of clinically based THWs have been identified. Additional work is needed to develop sustainable payment models that support the community based THW network.

In addition to the work above, CPCCO partnered with CareOregon Dental to implement a VBP with its main oral health network providers in late 2020.

15) Beyond those that touch on models described in questions 11-13, describe the care delivery area(s) or provider type(s) that your new value-based payment models are designed to address.

a) Describe the LAN category, payment model characteristics and anticipated implementation year of new payment models you have developed (or are developing) this year. <u>If you have developed multiple new value-based payment models this year</u>, please provide details for each one.

- **County Collaborative Risk Shares:** We updated the model to incorporate quality measures that accompany separate measures already employed with these providers in our PCPCH payment program. The model remains as a LAN category of 3B. We also expanded the model to Tillamook county so that all three hospitals, all our FQHCs and major primary care providers, and all our community mental health providers are part of the model.
- **Behavioral Health Composite:** CPCCO is building out a “composite score” for BH providers, which we hope to roll out by late 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 began building out last summer (2019). FIT administration will become part of the composite score. If implemented as intended, it will be a category 2C.
- **Safety Net - Shared Accountability Model (SAM)**: Although our partners in the shared accountability model are primary care providers, we hope the incentives of the model will impact coordination among and utilization of specialty and hospitals services. The model will be based on a global budget for total physical health benefit cost. We

anticipate the model will phase in the amount of downside risk over time based on the clinic's readiness. The entry phase in the model will be upside savings only with no downside risk (3A). The other phases will provide progressively higher levels of shared savings and downside risk (4B).

- Oral Health: The oral health VBP for primary dental providers is a payment for metric-based performance (2C).
- Medical Loss Ratio Risk Agreement: CPCCO has implemented a Medical Loss Ratio (MLR) Risk Agreement with a primary care practice that manages the health of a significant proportion of our membership. This agreement compares actual cost of care to the revenue CPCCO receives for that assigned population. Any surplus earned is gated by performance relative to establish quality metrics and targets. Based on the current structure of this agreement, it falls into the 3B LAN category.

b) If you previously described these plans in September 2020, describe whether your approach to developing these payment models is similar to, or different from, what you reported in September 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).

No change from what was previously reported.

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

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

Overall, our requests for TA have not changed from our last reports and are provided again below. The first bullet point is the only new addition from last year:

a) Best practices on developing VBPs to support social health, public health, and CBO sustainability.
b) 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.
c) Create library of basic VBP models and contract language
d) Host workshops on performance benchmarking
e) 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.

f) Provide TA to hospitals in support of population-based strategic thinking and Medicaid sustainability

17) 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. This is particularly true of non-primary care providers who have not been engage in this work with CCOs for as long. Oregon Health Plan participation requirement possibly?

Continued work to align statewide efforts focused on VBP. CCO requirements, Oregon VBP compact, PCPRC work. All of the initiatives have different targets and slightly different areas of focus, making it challenging to focus efforts and substantially impact any given area.

Optional

These optional questions will help OHA prioritize our interview time.

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

- New Oregon Value Based Payment Compact
- Long Term COVID implications to VBP Roadmap
- Alignment of accountability between CCO's and provider network to participate in VBP migration. Financial incentives and metric performance can only go so far. Consider provider participation requirements.
- Collaboration between CCO's/Payers could support consistency and ease administrative burden for both providers and payers.
- Common reporting platform

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

- Attempt to pull this information from other OHA deliverables where similar content is shared.

Part II. Oral Interview

This information will help your CCO prepare for your VBP interview.
Written responses are not 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, 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:

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, particularly in the areas of behavioral health, maternity and hospital care.

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.