Health Share Oregon

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.**

Health Share holds subcontracts with four Integrated Delivery Systems (IDS) and an Integrated Community Network (ICN) to deliver the full range of OHP services to Medicaid recipients. These contracts entail full-risk arrangements with sub-contractors and include quality incentives to support continuous quality improvement and on-going focus on the needs of special populations.

Integrated Delivery Systems are integrated delivery and finance systems comprising integrated inpatient, specialist and outpatient networks, while the Integrated Community Network holds contracts for a broad primary care and specialty provider network. The ICN also oversees network processes for dental, behavioral health and NEMT services on behalf of the IDS partners. This arrangement necessitates a significant amount of collaboration, coordination and shared decision making to ensure alignment around common goals.

The primary governance bodies responsible for VBP activities include Health Share's full Board of Directors, and Board Subcommittees including the Board Governance and Operational Excellence Committee, Finance Committee and Quality Health Outcomes Committee. Hitting OHA's VBP thresholds across the CCO's network will depend on operational and policy-level accountability, financial reporting and resource allocation, and intentional monitoring of quality performance. Each of these Board Committees also sponsors a Member Advisory Committee, uniquely charged with engaging Health Share IDS, ICN, County, and Provider partners in joint decision making and collaboration toward Board and OHA priorities, including VBP. Health Share's Clinical Advisory Panel (CAP) is also responsible for recommending and supporting implementation of payment models and new VBP arrangements that reflect integration priorities and to into account the complexity of models of optimized care delivery including care coordination and coordination with community-based services. The CAP also has 2 subgroups – a Behavioral Health Advisory Council and a Children's Health Advisory Council, both of which are chartered to advise on VBP models in their relative areas of expertise.

Health Share's VBP arrangements are embedded in the core subcontracts mentioned above and in downstream subcontractor arrangements, driven by contract requirements that they engage in VBP development and implementation. Direct subcontracts with the IDSs in Health Shares network qualify as LAN 4C as they include full population risk at the delivery system level and are inclusive of quality metrics with incentives based on performance.

In the Integrated Community Network, provider stakeholders are directly engaged in the design, implementation, and evaluation of VBP models through the ICN Advisory Committee, the Clinical Workgroup, and the Behavioral Health Outcomes Based Care Advisory Committee. A focus is placed in development payment models that support shared goals of improving member access, experience, and outcomes with reducing unnecessary administrative burden by providers. Particular attention has been paid to aligning payment models and reporting structures with other external reporting requirements (e.g. PCPCH, FQHC reporting).

The ICN 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.

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

The information above is still accurate. We have done significant work to address the workforce crisis within the Behavioral Health Network, including standing up a Task Force approved by the Health Share Board and chartered by the Quality and Health Outcomes Committee to address payment, process, and community investments needed to mitigate negative impacts on access and looking to maximize the skillsets of the BH workforce. The BH Advisory Council mentioned above is also updated on the task force work.

Additionally, the timeline for the PCPM evaluation was pushed back to the end of 2022 due to the COVID-19 PHE and inability to meaningfully engage participating providers in the qualitative portion of the study.

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

☒ CCO modified VBP contracts <u>after May 2021</u> due to the COVID-19 PHE.
[Proceed to question 3]

☐ CCO did not modify VBP contracts <u>after May 2021</u> 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).

Health Shares Board recently approved our 2021-2024 Strategic Plan, which orients all our work toward an outcome of Health Equity. As part of that work, the collaborative has identified specific impacts in Racial Equity, Early Life Health, and Behavioral Health that we are aiming for in our areas of focus: Social Determinants of Health, Integration, and CCO 2.0 model requirements. Additionally, we have adopted a Racial Equity Tool to support our decision making in key processes and program decisions to help mitigate any adverse equity impacts.

As the CCO incentive metric program returns, we plan to enhance our standardized reporting on metric performance for our subcontracts to include stratification by race/ethnicity and language. Decreases in performance for subpopulations will be called out

during the oversight process with the Quality and Health Outcomes Committee. We are also leveraging the Health Equity Plan requirement in the CCO contract to better assess our measurement processes and are in the process of formally evaluating our policies for opportunities to increase our explicit focus on racial and health inequities. Additionally, our measurement systems analyze provider performance against historical performance and we monitoring grievances and patient re-assignments on a routine basis.

As described previously, Health Share's CAP is also focused on how best to ensure that our VBP arrangements address the complexity of member needs across multiple service types and community-based services, including through additional risk adjustments.

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

Health Share focused significant effort on the Emergency Outcome Tracking Metric of COVID-19 vaccination and made very deliberate efforts to collaborate across county public health and community based organization efforts to reduce disparities in vaccine administration. As a result, disparities in vaccination administration by race/ethnicity and language closed significantly and Health Share had the highest immunization rate among all CCOs. We are now in discussion about how best to apply the learnings from that process to our policy for quality pool distribution and utilization within our VBP models.

Additionally, since May of 2021, Health Share has partnered with CareOregon to develop and implement staff training on Equity in Data Analysis. This training is intended for all staff members who research and prepare or consumes data and is reviewed by staff who develop information around our Value Based Payment programs.

This course offers concrete suggestions to think differently about how our CCO prepare and view data, specifically as it relates to demographic characteristics like race/ethnicity, sex assigned at birth, language and more. This course is a starting point in learning about the intersection of equity, diversity, & inclusion (EDI) and data.

Training Outcomes:
- Learn the definition of Data Equity and why it is important
- Discover options for changing the way we view or interact with data
- Locate resources for continued learning
- Understand why there is a need for continued learning

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.]

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

Health Share's LAN 4C models with the Integrated Delivery Systems include risk adjustment based on OHA risk adjustment methodology and take Health Share's global budget decisions into account (i.e. a CCO wide priority on BH).

Within the Integrated Community Network, subcontracts incorporate a variety of risk adjustment models including traditional risk adjustment models in shared risk models and risk adjustment that is modified to account for the work that providers with lower acuity members still need to do in order to achieve quality metrics for primary care based contracts.

CareOregon is in development of a Shared Accountability Model VBP contract (LAN 3A for 2022) among 9 FQCHs in Health Share that will eventually incorporate social factors / social determinants of health into our risk adjustment methodology and develop a model that relates social risk factors to the Total Cost of Care by 2024. However, we must address two key areas before this can occur:

- Consistent and accurate data for the population; and
- Sufficient confidence and testing that the Social Risk Adjustment process improves accuracy.

The first step in working toward the above is to identify social needs most affecting health outcomes for the SAM population/subpopulations, which is work that is underway.

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?**

      Health Share, via CareOregon, contracts with Advantage, CareOregon Dental, Kaiser, ODS and Willamette Dental for the provision of dental services. In 2021, these contracts incorporated report-only quality metrics. In 2022, these contracts contain a withhold that can be recovered based on performance on pre-defined dental-related metrics. In 2023, these contracts will expand the VBPs to include additional metrics and risk. In addition, the dental plans continue to develop and enhance their well-established VBP arrangements within their provider networks.

These VBP models hold providers accountable and produce positive oral health outcomes. They include capitation payments, performance withholds, and/or upside risk opportunities. Through these programs, primary dental providers are incentivized to drive utilization and engagement, prioritize prevention and improve patient satisfaction.

Additionally, within the Integrated Community Network, the oral health focus area of the Primary Care Payment Model (PCPM) incentive program has expanded over recent iterations of the program. The Payment Model is a long-standing value-based payment incentive program that the majority of primary care providers are very familiar with.

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).**

In our delegation agreements, we intend to incorporate Access and Engagement measures, Health Equity measures, and CCO dental-related Incentive measures focusing on empaneled Primary Dental Providers. Much of the payment model will be LAN Category 2C, 2B or 4C.

The oral health focus of PCPM is prevention of oral health disease and caries, assessment of oral health needs, and referral to care. It strives to promote collaboration and coordination by aligning priorities and incentives across both physical and oral health sectors.

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

With our delegated partners, as noted above, much of the implementation is underway and will continue to be enhanced each year.

This oral health focus area of our PCPM program is active in the 2022 calendar year. This work continues to expand and evolve.

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?**

Across all Health Share VBPs, we are in discussion about how best to incorporate the Social and Emotional Health metric performance into existing VBP arrangements. Discussions are in progress across the Quality and Health Outcomes Committee and the associated advisory councils.

Within the ICN, The Primary Care Payment Model has a specific track for pediatric providers with quality measures focused on the pediatric population. Additionally,

Within the Providence Integrated Delivery System, there is a LAN 3B ACO model between Providence Health & Services and the Childrens Health Alliance, a robust IPA serving the metro area.

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).

In addition to the existing models (LAN 4c and 2B/C), we will be working to incentivize providers developing / maintaining the following services to children:

- Behavioral Health/Integrated Behavioral Health Staffing
- Social Emotional Health Assessments and Services Process
- Community partnerships and educational opportunities

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

These models are already implemented and will continue to be expanded and refined in the 2022 calendar year.

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.

Health Share is already meeting this target.

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?

We would like to see OHA provide a review of risk adjustment models that incorporate social health data.
Specific Questions that might be answered:
1. What social health data is being used – i.e., individual level data, population level datasets like neighborhood indices defined at the census block or zip code level? What are the differences in risk adjustment between the different approaches

2. Are organizations weighting specific social domains in the model based on literature that demonstrates the relationship between specific domains and disparities in health outcomes (i.e., housing and health outcomes)
3. Are there organizations who are looking at other social health domains outside of the traditional ones captured in PRAPARE, AHC, etc. – thinking about the social complexity factors in the OPIP peds complexity data. What risk adjustment models/approaches appear effective for adults and child populations

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

Oregon Health Authority's continued focus on Value Based Payments development drives this work forward. The more OHA can facilitate the sharing of information on effective VBP strategies and remove roadblocks and hinderances to implementing new and creative value based payment methods, the faster VBP goals can be achieved.

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

Health Share's HIT Roadmap related to VBP and Population Management is extensive. Health Share's VBP approach includes sub-capitated arrangements with IDS and ICN partners who are at risk for their population with enhanced payments based on quality metric performance. In 2020 many of these requirements were waived both by OHA and by the CCO due to the substantial changes due to COVID. However, this primary arrangement whereby Health Share's VBP goals are largely addressed through a LAN-4C arrangement based on Quality performance measures, means that the CCO's provision of data, specifically as it relates to quality metrics, is crucial. Additionally, as a central aggregator of population level data, Health Share's data sharing supports many population management functions among and across partners, including perspectives on integration across care categories, risk stratification, and tracking patient movement from one CCO or IDS/ICN to another.

The six workstreams mentioned in our attached roadmap are as follows:

1. Risk Stratification Tools: Health Share has started to convene our IDS/ICNs in 2020 to discuss population health and risk stratification needs. This year we are focused on assessing local and national risk stratification methods, create a workgroup to discuss and create use cases, and then get approval from IDS/ICNs as well a provider on risk markers and stratification. Additionally, the CCO has focused substantial risk stratification efforts on emerging COVID vaccine provision efforts and ensuring equitable distribution. This including clinical risk and population risk based on known disparities due to language and race (see additional section of roadmap, 'O.COVID')

2. Improve Bridge (Tableau dashboards): As mentioned in the above HIE Care Coordination section, Health Share Bridge is widely used amongst up IDS/ICNs and partners. The dashboards are slated to be improved over the next year to increase speed, efficiency, look for any opportunities to enhance data sharing for better care of our members. In addition, we are looking at improving the overall usability of the interactive dashboards and filters to make them more seamless.

3. Composite Score in Behavioral Health: Refining the accuracy and availability of our provider data sets to lead to developing a score for SUD detox, residential, outpatient, and MAT programs.

4. Improve operational data collection and quality / Data Source: There are many manual reports that our IDS/ICNs send on a frequent basis, we are currently taking inventory of manual reports to see how we can operationalize them and create process improvements. We started this project in Q4 of 2020 and continue our efforts through our HIT Governance committee. To name a few we are currently operationalizing the DSN quarterly data submissions as well as the monthly PCPCR reports. There are more opportunities we are inventorying and prioritizing for process improvements.

5. Dissemination of Data: Tableau Public: Provide aggregate population data in order to provide transparency and insights into the metro region Medicaid population as it pertains to condition prevalence rates, BIPOC, race, ethnicity and engagement in health activities.

6. Incorporate Geo-mapping: Incorporate geo-mapping into all relevant dashboards to enable more location relevant action and outreach programs.

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

Our approach remained largely the same, continuing to focus on data dissemination and improving data collection and automation across most domains. Our efforts to create more public facing data were largely thwarted by our shift to focusing on COVID vaccination response. Vaccination response required a deeper focus on risk stratification methods to support a more targeted outreach and engagement strategy.

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

We use a variety of industry-leading tools to drive analytics. VBP data is ingested into our EDW, whereas Tableau is used for generating and distributing robust, meaningful, and easy-to-understand analysis dashboards and scorecards. Our Tableau infrastructure delivers these dashboards within our CCO and to our system

partners. These dashboards are refreshed between weekly and quarterly depending on business needs.

We use SQL Server Reporting Services to deliver transactional and detailed reports to users on regular basis. Frequency of these reports varies from real-time to quarterly depending on business needs.

Tools such as R, SAS, SPSS, and Python are used across our partnership for statistical and predictive modeling to answer advanced analytics questions such as identifying populations at risk of adverse health related events.

Tools such as the Johns Hopkins ACG are used for risk assessments and stratification of population, and other third-party tools are used to distribute reports. We use our care Coordination platform to provide up-to-date information on care coordination activities.

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

In 2021 the CCO completed its planned migration to a new Enterprise Data Warehouse, and prioritized building the necessary VBP data supports in early stages of new development to maintain high quality and reliable data.

Related specifically to VBP infrastructure, Health Share continues to provide regular quality metrics data to all IDS/ICN partners on a monthly basis. This includes dissemination of OHA's calculated performance of annual metric rates broken out for each partner, as well as dashboards updated monthly for each of the claims-based metrics that reflect projected "Year to Date" performance, which look at month over month trends against a projected annual target.

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.

Going into 2020 Health Share had one IT team that consisted of 2 analysts, 2 business analysts, 1 project manager, and 1 systems administrator. The vision for the department was to substantially increase the analytics half of the department, as well as the technology half to increase responsiveness to requests for information, depth of analytics skills, and a create robust data platform.

Mid-year 2020 Health Share moved away from an IT department and rebranded themselves the IS (Information Services) department. The new department now employs an analytics manager and an IT manager to set strategic roadmaps and direction for analytics and technology, respectively. The analytics team now has 4 dedicated analysts reporting to the analytics manager. The IT team now has 1 DBA, 2 system administrators, 1 help desk person, and 1 project manager reporting to the IT manager. The additional staff and proper team infrastructure have allowed us to initiate building a proprietary enterprise data warehouse (EDW) which will allow for the ingestion of SDOH data along with many other non-health related information. We are currently halfway through this intense project.

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

Health Share underwent another organizational restructure to its staffing model for this work. Technology and Quality Improvement remain under the same leadership structure, with a team now focused specifically on IS functions including database development, ETL, data provision and data validation, while analysts and BI Development have moved with an Analytics Manger to a new Quality and Analytics Insights (QAI) team which provides analytic support to a number of strategic areas, including the quality metrics program that supports our VBP model. Currently, the analytic staffing model supports 2 Systems Administrators, 1 DBA, 2 Database Developers, 2 Sr. Data Analysts, and 4 analysts spanning QI, Business, Operations and Population Health areas. These teams work under an IS Director and a Medical Director, spanning IS and QI functions respectively.

Unfortunately, workforce challenges are quite prevalent in this space, as analytic talent is in high demand. Health Share is currently exploring how to fill all of the above roles and whether external resources will be needed to maintain or expand program offerings.

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.

Between our IDS' and ICN, since the start of 2020, we estimate that at least 68% of Health Share's provider payments qualify as HCP-LAN 2C or above. While these numbers are continuing to be finalized we anticipate that the CCO is on track to hit VBP targets initially established in the RFA.

Although we are starting from a position of strength in this area, we still have a lot of work to do to continue to advance VBP in our region. Health Share will build upon this strong baseline from year one and focus on:

1. Increasing the number and breadth of VBPs
2. Progressing existing VBPs beyond a LAN 2C status
3. Supporting our IDS partners' expansion of VBP within the LAN 4C payment category by expanding service categories covered by the IDSs (e.g., specialty behavioral health and dental)
4. Addressing social determinants of health and health equity through VBP

In years three and four, we will focus on developing HIT support for OHA's VBP payment priorities:
hospital, maternity, children's health, pharmacy, behavioral health, and oral health.

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,

Health Share is continually monitoring resource needs against demand for information. As noted above, we are exploring options to ensure that all positions are filled and, when possible, external resources or analytic contracts to ensure adequate capacity. These capacity decisions are reviewed by Health Share's Executive team, as well as the CCO's HIT Governance Committee, which meets monthly to support organizational decision-making around IS capacity and focus. This will include exploring the use of HRS/HIT funds to support expanded population health analytics capacity as appropriate.

b. spread VBP to different care settings, and

No significant changes to previous reporting in this area.

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

Health Share remains committed to further enhancing analytics capabilities to better model, negotiate, administer, and monitor value-based payments by stronger integration of data between financial systems, contracting systems, clinical systems, and claims systems. Integration will allow us to better track the percentage of VBP payments in relation to claims payments and ensure provider expectations are being met. While data integration is the overarching strategy, Individual steps include:

1. Ensure payment systems can administer non-FFS based arrangements as needed across the ICN Network. The ICN continues to leverage the Provider Incentive Payment System (PIPS), a tool which streamlines the administration of PMPM payments. The tool facilitates a programmatic structure to manage attributed member-based payments made according to different quality performance levels, and population risk tiers. The system is integrated with our claims system taking advantage of existing provider EFT payment pathways. This infrastructure has added significant efficiency to the process of evaluating and ultimately making PMPM payments to providers. Going forward, we plan to continue to migrate other PMPM based payment programs into PIPS to leverage the workflow and reporting capabilities. This will include all of our current and future Primary Care capitation contracts.

2. Ensure metrics calculation and analytics tools can generate robust reports
The CCO's HIT infrastructure will play a key role in monitoring both CCO performance and accountability of its partners. Our analytics platform is the result of considerable investments to ensure that validated and reliable metrics are available. Data and measures will be regularly shared with partners to identify opportunities and drive performance.

Our platform is capable of attributing members to particular clinics (PCPCH assignment) and can also track members as they move from one delivery network to another. Maintenance of provider attribution information has required considerable effort and will be an area of continuous improvement to ensure that performance is tracked accurately in an increasingly risk-bearing environment for physical, dental, and behavioral health.

Health Share's ICN continues to partner with consulting actuaries, Wakely, to provide monthly reporting packets to Total Cost of Care VBP partners. These reports are reviewed in depth at our monthly provider meetings. We plan to continue this partnership with plans to enhance reporting and bring pieces of the work in house. All of this will enhance flexibility and nimbleness in meeting the needs of provider partners.

3. Explore additional enhancements and technologies

While the PIPS tool remains a key to numerous VBP programs and oversight, we are continuing to evaluate the market for tools to enhance our capabilities

During 2020 we explored integration options, feasibility of integration of these systems, and developed concrete roadmaps based on findings. In the coming years, we expect to implement identified roadmap items and make them fully operational in Years 4 and 5. Additionally, our capability to more nimbly calculate and report on metrics in new care delivery areas will be enhanced as we continue to expand our EDW. Given that we have not yet developed the payment models for future years, we cannot articulate specific data-related milestones as we do not yet know the performance metrics or other parameters associated with those models.

In latter half of 2020 we implemented a business glossary (data dictionary) in order to support continued data fluency across the organization. We are also migrating our EDW from on-premise MSSQL infrastructure to Snowflake (hosted on Microsoft's cloud platform – Azure) in support of the increasingly large datasets which we have cultivated.

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.

In late 2020 and early 2021 we have completed a VBP assessment with each our IDS' in their progress towards VBP arrangements and provider contracts. According to the original HIT Roadmap, the majority of areas for VBP growth for these IDS's occur in future years and as such these goals are largely on track. Health Share feels they have made sufficient progress in year one and will continue to set important dates/milestones for the subsequent years as the strategy in key population areas matures. Unfortunately, the shared focus on COVID response and, now, vaccinations has made alignment more difficult.

As indicated in the original HIT Roadmap, a majority of the VBP work will exist within the ICN where direct payment arrangements between non-integrated PCPCHs, BH and Oral Health providers comprise the VBP arrangements.

Our ICN is uniquely positioned with not only physical health coverage but also manages all dental and behavior health as well as our non-emergency transport (NEMT). The ICN will support integration of behavioral health and oral health benefit administration on behalf of the broader network in partnership with Health Share, through the provision of data to

behavioral health providers to ensure accurate panel management and improvement on key quality measures. We will also continue HIT strategies to hit the 70% VBP target by 2024.

In year five and beyond, we will pursue further integration of NEMT and SDOH event capture and benefit administration for non-health care provider entities. Developing and improving the HIT capacity to ensure accountability and measurement of these systems will be critical to monitoring the health and functioning of these efforts as they relate to VBP models.

We wanted to showcase the VBP work that CareOregon (ICN and largest partner) has put forth:
CareOregon's 2020 Payment Arrangement File submission, based on 2019 payment data, showed that over 72% of payments had a link to a qualifying VBP contract utilizing LAN categories and the OHA methodology defining that link. CareOregon anticipates this proportion will increase over time.

CareOregon's VBP arrangements incentivize and hold partners accountable for performance on Oregon's CCO incentive metrics as well as other measures of clinical quality. While the measures for these arrangements are currently aligned with OHA priorities, future governance decisions and VBP needs could expand these measures of accountability to include engagement with high-priority populations, elimination of health disparities, and other measures.

To that end, CareOregon is well poised to operationalize these evolving arrangements through their software platform that supports PMPM VBP administration. This VBP tool, a leading third-party application, currently allows us to administer payments, adjust performance-based payments, and integrate VBP and claims data. This functionality is critical for their ability to report on payment arrangements by LAN category, as required.

CareOregon will use this software to manage payments for our PCPM, CPC+ and IBH programs. The evolution of work in this area may seem intuitive, however, administration of non-claims-based payments in a health system that was built on a fee-for-service system has required a significant amount of operational overhaul. Moving from manually processing checks to integrating this work into our claims processing system, including records of performance has greatly improved efficiency and allows us to administer and record performance and associated payment in one location. In 2020, they expanded use of this tool to include capitation payments and other PMPM contract models.

Another critical tool supporting VBP expansion is the financial model developed by Wakely, an actuarial consulting service, which provides the architecture that supports our primary care Total Cost of Care (TCOC), and Medical Loss Ratio (MLR) risk agreements. This financial model calculates the total cost of care for a primary care partner's assigned membership, along with detailed cost data analytics allowing the provider to identify trends, and areas of opportunity to better manage resources. In 2019 and 2020, Wakely further

developed modules within this model that aid in the process of risk recapture and managing the health of a population. The risk recapture/population health module allows the provider to search for members previously diagnosed with high-risk conditions, without a recent claim showing that diagnosis. This tool can be used to proactively outreach to members with chronic conditions to ensure they are receiving preventive care.

Activities	Milestones and/or Contract Year
Hospital VBPs – establish standard report sets for VBPs implemented with hospital partners	2021
Develop and implement a Behavioral Health VBP model, including development of performance management infrastructure	2021
Develop and implement a Maternity VBP model, including development of performance management infrastructure	2021
Develop and implement a Children's Health VBP model, including development of performance management infrastructure	2022
Develop and implement an Oral Health VBP model, including development of performance management infrastructure	2023
Conduct semi-annual reviews of existing reporting and performance management infrastructure. Identify opportunities to further develop and update HIT to streamline program administration	2021 - 2024

Briefly summarize updates to the section above.

The above narrative remains largely accurate and was not edited. In summary, the CCO's efforts and focus areas have remained largely the same from the original HIT Roadmap submission, including working through delegated arrangements to IDS/ICN partners, and ICN efforts to support VBP arrangements in the BH and Oral Health spaces (detailed in previous sections). The above table has one edit, which is moving the 2022 goal for development of an Oral Health VBP model to a 2023 goal. Please see Oral health answer in question 6 above.

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

Because Health Share's VBP arrangements include significant risk sharing among Integrated Delivery Systems who are held to Quality Incentive Measures, the arrangements largely classify as LAN-4C. Health Share provided key data related to both population health and quality measures to each of these systems as it has in the past, including both aggregate, year-to-date, and annualized performance reports on all key measures, data sets identifying gaps in care (ALERT and DHS Metrics) and other key clinical quality measures

data. Unfortunately, due to COVID, OHA's Metrics Program—the backbone of Health Share's VBP arrangements with these IDSs—was suspended and so development of the nuances of this data sharing was suspended so the system could collectively focus on COVID response.

Similarly, within Health Share's ICN, 100% of the providers participating in VBP arrangements had access to the data referenced in the above section. Providers that participate in the ICNs risk agreements (TCOC, MLR) also have access to the Wakely financial model providing additional data regarding utilization patterns, and costs of services provided by other providers in the network.

The BH composite score quality payment methodology Health Share has adopted remains in place supported by CareOregon's data warehouse and associated analytics tools. This methodology offers quality incentive payments to providers for performance relative to a set of Behavioral Health quality metrics. In the future, the CCO plans to continue to update this program structure to incorporate downside risk, and augment quality metrics with outcomes-related metrics. The current iteration of the program should meet the BH CDA requirement.

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

Health Share's most substantial accomplishment in using HIT to administer VBP arrangements was completion of the significant shift to a new EDW in Q4 2021. This environment should prove more flexible to meet CCO and partner needs in quality metrics and related reporting.

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

As noted above, many of the typical developments related to quality metrics data sharing to support VBP arrangements were necessarily delayed due to critical COVID response. However, over the course of 2020, the ICN nevertheless implemented a quality metric based VBP with a hospital partner that includes both up and downside risk for quality metric performance. This was particularly challenging as it required engaging with the system to determine metrics both parties felt they could influence with membership where their assigned PCP resides outside of that system and where the system does not have a direct connection with that member as it relates to their preventive care needs. This arrangement will satisfy the Hospital CDA requirement and is being implemented with other systems for 2021 and beyond.

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

Critical COVID response (vaccination) was a priority that required significant analytic resources in 2021, and the COVID EOT measure became part of the CCO's VBP arrangements. This, combined with the aforementioned workforce challenges were the largest barriers.

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.

Health Share has three primary mechanisms for sharing critical data and information (1) through Health Share Bridge, we have a number of Tableau dashboards and member lists in which plans, and providers can access, (2) we have secure Health Share Bridge SharePoint pages in which reports, and member information can be shared with providers, plans and the community at large, and (3) sending data to Collective Medical Technologies' which allows providers, plans and care coordinators to access critical patient information real time.

Access to aggregated data down to specific member attribution and PHI via Health Share's Bridge site is controlled through a rigorous security layer that complies with HIPAA and assurances of appropriate data sharing agreements. At a high level, we ensure that our partners have access they need to regularly refresh reports, including aggregate and member level on all calculatable measures. We also deliver data like ALERT, DHS measures, etc. The types of data we have available on our Health Share Bridge sites are as follows:

- Detail claims data.
- Patient medical summary which includes such things as demographics, current medications, conditions, PCP, ED visits, inpatient visits and more.

- CCO metric leading indicators and member lists which is sent out each month and details members in the denominator, members in the numerator and members not meeting expectations.
- Member risk stratification tools that allow the user to define what attributes are of interest in calculating 'population at risk'. Attributes available for selection include number of chronic conditions, age, rate code, utilization and 15 others. Once risk attribution has been selected member lists can be generated in order to enable better care coordination and outreach.

Information that we send to Collective Medical Technologies includes TOC eligibility and risk level, care plans for TOC members, diabetic flag etc.

CareOregon subcontracts with a network of PCPCHs, BH providers and oral health providers and as such regularly shares data, at least quarterly, with its providers. They are currently expanding this capability to ensure that data provided to clinics is specific to VBP arrangements in which they participate. Our ICN's existing analytics infrastructure and software tools allow us to deliver Oregon's CCO incentive metrics and select HEDIS–NCQA measures to providers on a regular basis. Enhancements will continue to expand their ability to deliver additional measures and metrics, as appropriate based on VBP arrangement participation, to providers on a regular and automated basis. Providers will be able to view a broad menu of measures, as well as those applicable only to their payment arrangements. Scorecards include both aggregate (clinic-level) and member-level information, making data more actionable for intervention.

CareOregon has launched enhanced capabilities which include access to expanded data and scorecards as well as the ability to receive provider scorecards via secure email. These will be tailored to a clinic's VBP program participation and population needs. Their enterprise data warehouse will continue to evolve to support deeper integration of data between financial, clinical, contracting, and claims systems. As richness of information in the underlying data warehouse grows with elements such as SDoH, it will open further opportunities for partnering with CareOregon's providers to drive improved performance and care. In the event that their current reporting applications do not include measures that are applicable to the VBP programs implemented future years, they will upgrade our reporting platforms to ensure that reports are comprehensive.

In addition to supporting performance analytic capabilities, CareOregon provides access to the GSI care coordination platform available to our provider partners which will further support care activities needed to succeed in a VBP environment.

Health Share collects and stores current and historic information regarding the PCP/PCPCH, PDP, and Behavior Health provider in which a member is paneled (in the case of PCP/PCPCH and PDP) or has an extended prior authorization (in the

case of BH provider), and the dates associated with each panel assignment. The historic panel information allows us to ensure that the plans and current providers in which a member is associated has access to all critical clinical information and full member attribution current and historic.

Health Share's Bridge SharePoint site contains Tableau dashboards that provide full member attribution both current and historic. The member attribution information consists of current and historic PCP, PDP, and behavior health provider, the dates in which the member was associated to each of the providers, and the associated medical, dental and behavior health plans. Using the attribution information our dashboards show utilization by visits and cost categorized into primary care, specialty care, emergency care, pharmacy, hospital, metal health, SUD, and dental.

In addition to providing access on member attribution through Health Share Bridge, we also send out current member attribution information once per week to each plan for all of their currently active members.

Complementary to the work at Health Share, our ICN also has a reporting platform includes data on patient assignment and utilization. For purposes of VBP arrangements, they calculate performance on an "assigned" basis. In instances where members are inappropriately assigned, CareOregon has staff that work to quickly reconcile and reassign as appropriate. Information on patient assignment is available both through their data reporting platform as well as their provider portal. Transparency of this information allows for productive conversations around population health management expectations under our VBP arrangements.

CareOregon continues to use an authorization-based methodology for behavioral health member attribution for VBP performance measurement. This provides a fair and consistent way to align patient responsibility with behavioral health providers and enables comprehensive measurement of provider performance to produce a "composite score" crucial to our VBP incentives for our Behavioral Health providers.

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.

These functions remain largely unchanged. The CCO continues to use SharePoint and Tableau as primary vehicles to distribute dashboards and member level data relevant to VBP arrangements with IDS/ICN partners.

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

No significant change to above.

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

The only significant change to HIT tools available is that with the migration from one EDW to another, Health Share has had to revisit which dashboards are supported for broader partner use. We have maintained almost all dashboards related to quality metrics and VBP arrangements those support, but other dashboards related to patient care and population health are being revisited to ensure they meet current need and contain valid information.

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.

Our IDS/ICN's leverage the Collective Platform for transparency of ADT data and sponsor their providers and provide Community of Practice sessions through their network to support teams to leverage the tool more in their day-to-day operations as well as identify unique contracting to include the tool in their practice. The Health Share partners, exchanges member care plans with each other through Collective when a member transfers from one partner to another.

Health Share maintains a comprehensive enterprise data warehouse combining data from administrative, care coordination, claims, SDOH, and analytic sources. We provide access to our Health Share Bridge platform to all of our plan's Population Health teams which can utilize the Population Health Explorer dashboard, utilization dashboards, and population segmentation built on this platform, to create interventions and programs.

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

As noted above, the methodology for sharing this information has not changed significantly. With a shift to a new EDW we are undertaking a review of which dashboards to rebuild, though almost all dashboard related to VBP quality metrics and individuals requiring intervention have been maintained.

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.

In addition to the data sharing described above, where Health Share Bridge is used to convey a significant amount of patient health, risk and metric-related information, Health Share currently shares claims detail and member attribution data in an Epic consumable layout for providers interested in receiving a more complete picture of member engagement across systems. Two large FQHC systems are currently the recipients of this data which is then ingested into Epic's Health Planet application specifically designed to support VBP analytics.

Our ICN CareOregon makes reports and interactive dashboards available to providers on VBP arrangements on a continual basis with data refreshes at least quarterly for risk stratification and more frequently for other data elements. Member-level data is available using these tools to identify risks and interventions needed. Our ICN is actively deploying a new web-based analytics and report delivery system we call FIDO Web (Fully Integrated Data Organizer). FIDO Web uses newer technology and a more robust platform which enables them to provide single sign-on, enhanced dashboard functionality and expand the types of dashboards available to external users in the future. Rollout will be complete by the end of the second quarter of 2021.

Our IDS/ICN partners also broadly leverage the Collective Platform for transparency of admission/discharge/transfer data and sponsors providers to obtain access. They facilitate Community of Practice sessions through our network to support teams in leveraging the tool in their day-to-day operations as well as identify unique contracting to include the tool in their practice.

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

The practices described above are still largely in place.

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

In 2020, as part of its CCO 2.0 redesign, Health Share moved away from the 5 medical health plan, 5 dental plans and 3 behavior health plans to a completely different model. The CCO shifted to a model with 4 Integrated Delivery Systems (IDS) and an Integrated

Community Network (ICN), with oral health, behavioral health and NEMT services managed under that network. This shift was considerable and was driven to create a more tightly integrated system, with stronger risk sharing arrangements among all of the local hospital systems and the majority of outpatient clinics in the region. The late stage of 2019 and the initial phase of 2020 was spent refining both data sharing and information flow to ensure the successful shift to this model and we are proud of what we have accomplished in standing up this model. Health Share is confident it will be better for our members and community.

In the new CCO structure we regularly share data, at least monthly, with our new ICD/ICN partners and some providers. Our existing analytics infrastructure and software tools allow them to deliver Oregon's CCO incentive metrics and select HEDIS–NCQA measures to providers on a regular basis.

The CCO's contract with CMT/Collective allows all provider networks to access the platform. The collaborative of partners continue to engage with providers to leverage data from the platform, including reports and dashboards that combine data gathered from Collective with internal information, to assist providers in improving quality and VBP performance.

With respect to behavioral health specifically, CareOregon contracted with OHLC to onboard and train 8 new BH providers in the use of the Collective platform, as well as training CareOregon staff to be able to provide ongoing technical support to current and new providers on the platform.

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

Health Share continues to leverage its data sharing and analytics infrastructure to regularly share information with IDS/ICN partners and certain providers. SharePoint provides secure data delivery and user access controls and Health Share continues to monitor user permissions to ensure ready access as needed.

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

Provider capacity due to COVID impacted their ability to engage in this work.

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

Provider capacity has been consistently stretched due to COVID and workforce shortages. This impacts engagement in VBP programs generally, as well ability to embrace new HIT options related to population health management, health information exchange, or analytics.

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

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

Click or tap here to enter text.

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

We would suggest decoupling questions about HIT for VBP arrangements from questions about population health management broadly. These were combined in the original HIT Roadmap reporting, but because the questions expanded beyond VBP arrangements it was confusing to determine who was best to answer sections in this report. Perhaps questions related to Population Health would be better incorporated into the HIT Roadmap submission rather than necessarily combined with VBP questions.

Also, most questions in this template presented the CCO's previous response from the HIT Roadmap and offer room to share any relevant changes below. One question asked for edits directly in the previous response, in a different text color, which wasn't easily done given the extensive narrative from the HIT Roadmap. We would suggest having a consistent method of offering updates or new information to support these questions whenever possible.

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.