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.**

- PacificSource Community Solutions (PCS) continues to annually convene with provider partners to educate on any new contracting requirements for the coming year (including those in the VBP Roadmap), negotiate the coming year's contract terms, and collaboratively determine quality metrics from the OHA's Aligned Measures Menu set (these metrics span the sectors of primary care, hospital, behavioral health, and oral health). In the second and third quarters of each year, the PCS contracting team for each CCO region meets to determine if there are any contract terms that need to be modified or added for the following year. The team proposes new terms, models, or metrics as appropriate and that adequately meet any OHA requirements for the upcoming year. We consult our regional VBP Roadmaps during this internal process. In the third and fourth quarters, we meet with provider partners to discuss what the internal contract team has proposed. Negotiations follow, often bi-weekly, until the agreement is finalized. Meanwhile, there is an additional quality team (as well as representation from our Analytics Department) and provider partners that meet to determine what quality metrics to propose for inclusion in the agreement, as well as to determine the targets and weights of each metric.
- PCS continues to contract directly with our provider network as well as through independent practice associations (IPAs), and we set arrangements with both upside and downside risk and aligned quality measures, consistent with the OHA guidance on the HCP-LAN classification for value-based payment (VBP) arrangements.
- PCS continues to offer optional PCPCH (Patient-Centered Primary Care Home) and Behavioral Health Integration (BHI) program participation to support non-billable services that have great value for OHP members with physical and behavioral health needs. The programs are tied to state criteria and evidence-based standards. Regional meetings, which include both internal stakeholders and provider partners, occur throughout the contract cycle to evaluate and discuss progress on quality metrics and other contract terms.
- PCS collaborates with partners to develop and align VBPs with our 5-year VBP Roadmap in key care delivery areas.
- PCS monitors and evaluates VBP models through monthly contract-based reports (known as "risk reports") that it sends to the contracted entities. These reports include performance on the financial model and performance measures, including Quality Incentive Measures.

- In early 2021, PCS added additional accountable care organizations and IPA primary care populations to Insight, our member analytics platform. The platform, which filters by provider groups, allows for further monitoring of contract performance in various areas, including inpatient and emergency room service utilization, disease prevalence, performance on gap-in-care measures, potentially wasteful care, and a host of other measures that supplement contract monitoring. Our Population Health team works with our provider partners to review reported performance.
- PCS also engages with stakeholders in regional and partner-specific committees, and reviews data such as quarterly cost of care and other trend reports.
- As part of the strategy to develop and evaluate VBP models, PCS maintains a VBP capabilities roadmap. As part of this roadmap work, PCS is currently assessing vendor VBP capabilities in order to further scale and expand its own VBP capabilities to meet VBP objectives. This project includes internal stakeholders such as Provider Network, IT, Analytics, Finance, and Actuarial.

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)

It should be noted that PCS already had a variety of primary care, behavioral health, dental, and hospital providers on capitated VBP payment arrangements prior to the onset of the COVID-19 pandemic, and as such the conversion of providers from fee-for-service to capitation was not a key strategy for provider support. Interactions with providers at the outset of the pandemic revealed that providers did not desire more/additional capitation, sometimes because they already were paid via a capitation methodology for a significant portion of the services they provide, or because they did not have an appetite to take on more upside/downside risk than already existed, or because other PCS provider relief mechanisms were deemed effective and addressed their concerns about providing care during the COVID-19 pandemic. PCS previously submitted provider support plans to the OHA, per the OHA's request.

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.

Yes, PCS expanded and continues to offer the availability of telehealth to members as a result of COVID-19. PCS notified all providers that all covered face-to-face

services usually done in an office setting, including evaluation and management codes, are eligible to be performed via tele-video and/or telephone when criteria is met. Additionally, primary care practices received information about the ability to see members for a variety of services not normally provided via telehealth (e.g., well-child checks).

Additionally, PCS made dollars available to providers to increase/optimize their telehealth capabilities through its Community Health Excellence (CHE) grant program. The CHE program typically funds care innovations brought to PCS's attention by providers. As a result of the pandemic, PCS made general innovation grant dollars available to providers in need of funding to expand or enable their provision of telehealth services. Many provider applied for and received funding, which allowed for practice transformation that enabled patients to receive their care virtually.

For PCS, telehealth services provided by physical and behavioral health providers have the same VBP impacts as in-person services. That is, services are considered with the same contract terms as if they were provided in person including aspects of risk withhold, and with the same expense impact on provider health care budgets. As such, and as 2020 represented increasing volume and intensity of telehealth services, these types of services represent a greater impact on the overall expenses that are calculated to determine budget performance, risk withhold return, and other financial performance incentives that can be earned by providers. It should be noted that PCS paid at parity for these services even prior to the pandemic.

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

The overall PCS strategy has been to maintain significant focus on Quality Incentive Metrics (QIMs) and limit expansion outside of QIMs for 2021 due to the providers' limited ability to focus on additional efforts. PCS continues to utilize OHA's targets for its CCOs' quality metrics. While target increases are slightly less challenging than in prior years in order to better accommodate challenges related to COVID-19, PCS still aims for providers to demonstrate a focus on quality, and thus has not waived performance requirements in 2021. All PCS's VBPs include performance targets, with payment contingent upon performance. Additionally, a continual evaluation of utilization and cost takes place via monthly reporting on VBP model performance, and we share this information with providers participating in those models.

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.**

   PCS does not believe any of the VBP instituted for 2021 have created any adverse effects on health equity nor for any specific population of members (racial, ethnic, LGBQT, disabled, limited language proficiency, immigrants, medical complexity, etc.).

   PCS is mindful of creating contract language that does not impede or exacerbate issues of health equity. We list the following examples to illustrate our processes designed to mitigate adverse effects:

   - PCS's Quality and Health Services teams negotiate performance measures that support health equity. Language currently exists in base provider agreements around health equity and Culturally and Linguistically Appropriate Services (CLAS) practices. PCS has updated this language for 2021 agreements. Some examples of measures that support health equity include Follow-Up after Emergency Department Visit for Mental Illness (2021), Assessments for Children in DHS Custody (2021), and the Language Access Measure (2021).

   - PCS monitors VBP arrangements to evaluate health outcomes, utilization, cost, and grievances and appeals, with reporting on a regular basis. We have expanded this monitoring to include monitoring of language access needs of primary care groups by the creating a set of health equity dashboards. Additionally, we have added filtering to our Insight platform to include accountable care organizations and IPA-specific groups.

   - When setting targets for contracted provider performance, PCS considers historical measure performance or benchmarks, and makes adjustments to provide the contracting entity with a target that is both achievable and meaningful. An example of this in the Central Oregon CCO, where we apply a higher benchmark to the Postpartum Care QIM to some providers, since the historical performance has been higher than the state benchmark. We continue to review our measure methodology in the VBP Roadmap workgroup to evaluate and improve our contracting measurement strategy to support health equity.

- In consideration of risk adjustment models for VBPs, PCS has been evaluating and considering various methods that could better match payment to risk. While we have done some preliminary research, the lack of commercially available models and the relative immaturity and incompleteness of the social complexity data continues to present significant challenges. We would encourage a workgroup or some level of partnership with OHA to work together to find an optimal solution.

  PCS currently uses rate category as a proxy to align payment with risk for both direct VBPs (i.e. capitation) as well as for risk-sharing settlements with providers. We base our risk sharing settlements on a budget-based expense target relative to revenue, with the revenue varying by the member's rate category, and adjust to the mix of adults versus children, duals versus non-duals, etc. Rate category captures several areas of social complexity, including dual eligibility, disability, and foster care. It would be informative to understand how much additional gain will be leveraged by layering on additional risk adjustment relative to the current status, in order to evaluate additional strategies.

  Since September 2020, PCS has chartered a multi-year work plan and launched an internal workgroup dedicated to better understanding social determinants of health (SDOH) data and its relationship to healthcare outcomes. To date, we have:

  - Conducted a preliminary literature review and research on models and factors.
  - Loaded extensive publicly available data sets for relevant external data to further analyze and have started running some statistical tests. We have developed enhanced logic to identify individual level SDOH indicators.
  - Worked closely with projects like Connect Oregon (Unite Us) to ensure that we will be able to leverage patient-level SDOH screening and referral data from that platform. We expect to start receiving data files from Connect Oregon in July 2021.
  - Participated in a pilot with Alliance of Community Health Plans and Socially Determined to learn more about the landscape among other carriers and commercially available products.

- In spring 2021, PCS representatives attended the Evidence-Based Strategies for Advancing Health Equity webinar and had a technical assistance session with Dr. Marshall Chin specifically around VBP and Health Equity to help inform our strategy.

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

Yes, PCS has returned to a pay-for-performance and risk withhold model in 2021.

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

As described in Question 6, PCS continues to use rate category as an effective proxy to align payment with risk for both direct VBPs (i.e. capitation) as well as for risk sharing settlements with providers. PCS bases risk-sharing settlements on a medical loss ratio budget target, with the revenue varying by the member's rate category, and adjusted to the mix of adults versus children, duals versus non-duals, etc. Rate category captures several areas of social complexity, including dual eligibility, disability, and foster care. Beyond rate categories, PCS is building capabilities to track our members' screening and referral for SDOH needs via implementation of the Connect Oregon Community Information Exchange platform across our CCO regions. Additionally, PCS is engaged in design architecture to store member and provider REAL+D data. We are in the development phase of this work, which moves from research/information gathering, to testing, to collaborating with our provider partners on such information, to creating pilots in which incorporation into VBP is possible.

PCS currently has multiple clinical risk methods to assess and stratify population risk that are foundational steps to incorporating such models in to a VBP methodology. The models are as follows: multiple DxCG risk models, Seattle Children's Medical Complexity Algorithm, and Charlson Comorbidity index. We have also been evaluating data collection and data completeness of social risk factors such as incorporating those factors into our risk stratification algorithms and into various reporting such as demographic, utilization, and performance reporting. These steps help inform future plans around integration of different methods of risk adjusting VBP models.

PCS continues to work on its Integrated Care for Kids (InCK) cooperative agreement in its Central Oregon and Marion-Polk CCOs which will have risk stratification that includes medical and social complexity to identify children who may benefit from interventions.

Additionally, we are capturing available social factors within a member's rate category (e.g., dual eligibility, disability, and foster care) for overall payments and risk sharing. We continue to evaluate other factors and models to determine if they provide further enhancement beyond rate category.

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 <u>the process</u> 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.

In 2021, PCS continued offering differentiated base payments according to PCPCH tiers to all PCPCH organizations, based on designations as provided by OHA's monthly PCPCH status report. PCS continues to offer a higher level of PMPMs for those organizations attesting to our own PCPCH Program requirements; these include staffing ratios for adequate care coordination, monitoring closed-loop referrals, and availability of acute-care hours. Additionally, PCS offers a higher level of PMPMs (as published in our CCO 2.0 application) for those organizations that meet BHI standards as part of our PCPCH Program requirement; these include population reach of members seen by a behavioral health consultant, access to same-day behavioral health services, and identification and intervention with target sub-populations (e.g., substance use, chronic pain, diabetes). Payments are bundled along with regular monthly capitation payments. PMPM payments by tier level increased in 2021 from 2020 rates, and PCS will increase these annually as stated in its 5-year VBP Roadmap. With the goal of being informed of provider needs pertaining to PCPCH, PCS regularly engages provider partners through the contracting process (as described in response to Question 1) and the provision of monthly capitation reports. This two-tiered approach to payment (base and program) has been in effect in the Columbia Gorge CCO since 2019, and in Central Oregon, Lane, and Marion-Polk CCOs since January 2020.

10) Please describe <u>your CCO's model for</u> 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, above. Additionally, PCS is paying higher levels of PMPM payments for the same PCPCH tier in 2021 compared to 2020 per OHA requirements, and will begin a program and payment evaluation in mid-2021 in order to update our program and potentially increase PCPCH payments for 2022. PCS intends to collaborate with provider partners on the impact and sufficiency of PCPCH PMPM payments and will use such feedback to inform payment increases. Any such increases are required to be part of provider contracts, which PCS will

likely not implement until late 2021. These increases will become part of providers' overall VBP arrangements with PCS.

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).

Central Oregon: PCS has incorporated a VBP arrangement with the region's inpatient psychiatric hospital. Providers may earn back newly implemented risk withholds and realize shared savings depending on performance on metrics aligned with the hospital metrics from the OHA's Aligned Measures Menu. At the time we reconcile contract performance for the prior measurement year, PCS will calculate quality performance and distribute withhold and quality-based performance payments.

Columbia Gorge: PCS has collaborated with county health departments to fund a Universal Home Visiting program for postpartum visits for mothers, which includes screening for postpartum depression and assessing for a variety of other conditions.

Lane: PCS has developed funding and performance metrics for providers to integrate behavioral health services into primary care settings via its BHI program for those providers who wish to have integrated behavioral health services as an adjunct to their PCPCH model.

Marion-Polk: PCS has developed funding and performance metrics for providers to integrate behavioral health services into primary care settings via its BHI program for those providers who wish to have integrated behavioral health services as an adjunct to their PCPCH model.

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).

Central Oregon: PCS will implement by January 1, 2022 a suite of quality metrics (which determine upside payout and a portion of provider downside risk), which

includes the OHA Aligned Measure Set metric of percentage of patients getting post-partum care in eight weeks. The inclusion of this maternity metric into community contracts of primary care providers (PCPs) (who do some maternity care in the community) and all the obstetric providers in the community will have a profound impact with many thousands of dollars of risk withhold and return dollars dependent on performance in this arena consistent with OHA specifications.

Columbia Gorge: PCS implemented a maternity VBP in 2020 for universal screening and a referral hub for home visiting for pregnant women and families with young children. This arrangement continues in 2021 and 2022.

Lane: PCS will implement by January 1, 2022 a suite of quality metrics (which determine upside payout and a portion of provider downside risk), which includes the OHA Aligned Measure Set metric of percentage of patients getting post-partum care in eight weeks. The inclusion of this maternity metric into community contracts of PCPs (who do some maternity care in the community) and all the obstetric providers in the community will have a profound impact with many thousands of dollars of risk withhold and return dollars dependent on performance in this arena consistent with OHA specifications.

Marion-Polk: PCS will implement by January 1, 2022 a suite of quality metrics (which determine upside payout and a portion of provider downside risk), which includes the OHA Aligned Measure Set metric of percentage of patients getting post-partum care in eight weeks. The inclusion of this maternity metric into community contracts of PCPs (who do some maternity care in the community) and all the obstetric providers in the community will have a profound impact with many thousands of dollars of risk withhold and return dollars dependent on performance in this arena consistent with OHA specifications.

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).

Central Oregon: PCS has incorporated a VBP arrangement with the region's inpatient psychiatric hospital. Providers may earn back newly implemented risk withholds and realize shared savings based on performance on metrics aligned with the hospital metrics from the OHA's Aligned Measures Menu. At the time we reconcile contract performance for the prior measurement year, PCS will calculate

quality performance and distribute withhold and quality-based performance payments.

Columbia Gorge: PCS has enacted a VBP arrangement with St. Charles Health System, which operates four hospitals that serve as the care facilities for CCO members in the southern half of the Columbia Gorge CCO. This Health System is key in providing care to the residents of the Warm Springs Indian Reservation. St. Charles has new risk withhold starting in 2021 for all services provided to Columbia Gorge CCO members, and it can achieve some amount of risk withhold and return depending on (a) Columbia Gorge CCO quality performance, and (b) the financial performance of risk models in the Columbia Gorge region.

Lane: PCS has negotiated contracts with McKenzie-Willamette Medical Center, PeaceHealth RiverBend Medical Center, and PeaceHealth University Medical Center, with risk withhold (downside) and shared savings opportunities (upside) that are contingent on quality aligned with the hospital metrics from the OHA's Aligned Measures Menu.

Marion-Polk: PCS has negotiated contracts with Salem Health, Legacy Silverton Hospital, and Santiam Memorial Hospital, with risk withhold (downside) and shared savings opportunities (upside) that are contingent on quality aligned with the hospital metrics from the OHA's Aligned Measures Menu.

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.

Central Oregon: PCS is in development of VBPs with community pediatric providers associated with the PCS/provider collaborative role in the InCK initiative in Central Oregon communities. In addition, some providers who were historically resistant to VBP models in the provision of their primary care (with integrated behavioral health care) are now in VBP models.

Columbia Gorge: PCS was successful in engaging with some providers who were historically resistant to VBP models and have agreed to new VBP models. For the Columbia Gorge CCO, this includes health systems located both in and outside of the CCO service area. In the past, payments for services were fee-for-service only (Category 1 in the LAN framework). As of 2021, those services are value based at Category 3B in the LAN framework.

Marion/Polk: PCS is in development of VBPs with community pediatric providers associated with the PCS/provider collaborative role in the InCK initiative in Marion/Polk communities.

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.

Our answers to Questions 11-14 address this question for 2021. Beyond 2021, PCS feels its VBP models are successful, and build on the experiences of innovative payment models that date back to 2010. Our organization is in continual dialogue with our provider partners on the topic of evolving the models currently in place, to promote more care integration, incentives around quality care, and to meet the OHA goals for aggregate dollars that are part of LAN 2C and 3B levels of alignment. We will soon be discussing 2022 contract with providers, and will gain feedback and insights that will make our VBP arrangements even stronger and more effective for PCS, providers, and CCO members.

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).

PCS's approach to developing payment models in response to Question 15a is similar that what it reported in September 2020.

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?

PCS appreciates the support OHA is providing around VBPs such as the webinar and one on one call with Dr. Marshall Chin, as well as OHA's proposed work exploring alternative risk factors in the CPDS risk weight project. We would encourage continued joint exploration around social risk including its potential

intersection with mitigating adverse effects and would welcome any additional TA that might be available in this newly emerging area of social risk measurement.

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

PCS will improve its ability to enter into VBP arrangements if OHA no longer uses and publishes charge-based reimbursement for A/B and non-contracted hospitals. It is our belief that reimbursement of these entities based on fixed payment methodologies would eliminate a preferable payment methodology for such providers, and lead to more possibilities of VBP methods.

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?

None at this time.

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

PCS would find it helpful for the OHA to outline questions that align directly with contract requirements so that we may align our work plans and existing strategies with the interview format. We would also like to be clear that we are meeting the OHA's expectations for VBPs in terms of conforming our actions to contractual expectations.

Part II. Oral Interview

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

Purpose

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