2025 Value-Based Payment (VBP) Questionnaire

Introduction

As described in Exhibit H, Section 6, Paragraph a of the 2025 contract, each Coordinated Care Organization (CCO) is required to complete this Value-based Payment (VBP) Questionnaire (previously VBP Pre-Interview Questionnaire).

Beginning in 2025, OHA will no longer be pre-filling a version of this document with previous years' responses. The intent of this change is to (1) streamline submissions, given that there are now several years of information included in previous responses, and (2) provide a new "baseline" to pre-fill over the next couple of years.

Your responses will help OHA better understand your CCO's VBP activities for 2024-2025, including detailed information about VBP arrangements and Healthcare Payment Learning and Action Network (HCP-LAN) categories.

Instructions

Please complete and return this deliverable as a Microsoft Word document, via the Contract Deliverables portal located at https://oha-cco.powerappsportals.us/, by **May 2, 2025**. The submitter must have an OHA account to access the portal.

- Please be thorough in completing each section of this document. Incomplete submissions will be returned for revision.
- Please provide responses for all required questions. Questions #3, #4, #10, and #31 are optional.
- All the information provided in this document is subject to redaction prior to public posting. OHA will communicate the deadline for submitting redactions after reviewing your submission.

If you have questions or need additional information, please contact:

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Section 1: Annual VBP Targets

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements.

1. **In 2025, CCOs are required to make 70% of payments to providers in contracts that include an HCP-LAN category 2C or higher VBP arrangement.**

   How confident are you in meeting the 2025 requirement?

   ☐ Very confident
   ☒ Somewhat confident
   ☐ Not at all confident
   ☐ Other: Enter description

   Describe the steps your CCO has taken to meet the 2025 requirement since May 2024:

   YCCO continues to expand its Pay-for-Performance initiative to include additional PCPCH and specialty care clinics. Additionally, we've expanded the Behavioral Health Pay-for-Performance model in 2024 to include higher utilizing fee-for-service clinics.

   Describe any challenges you have encountered:

   VBP projections continue to be challenging due to the significant impact of benefit and programmatic changes to OHP including Behavioral Health Directed Payments and Indian Health Care Provider (IHCP) reimbursement structures as well as increasing pharmacy trends. Key programmatic additions and changes like the Behavioral Health Directed Payments and IHCP reimbursement changes are critical for improving member engagement to preventative services, but also adversely increase and incentivize the use of fee-for-service only cost structures. This dynamic can and does increase the CCO denominator for evaluating VBP performance disproportionately to the numerator.

2. **In 2025, CCOs are required to make 25% of payments to providers in arrangements classified as HCP-LAN category 3B or higher (i.e., downside risk arrangements).**

   How confident are you in meeting the 2025 requirement?

   ☒ Very confident
   ☐ Somewhat confident
   ☐ Not at all confident
   ☐ Other: Enter description

Describe the steps your CCO has taken to meet the 2025 requirement since May 2024:

YCCO renewed its agreement with a local hospital on an enhanced VBP arrangement that includes expanded upside risk equivalent to [redacted] of total contract value and downside risk equivalent to [redacted] of total contract value. Additionally, we continue to hold three PCP capitation agreements with our largest providers that include the integration of a total cost of care quality incentive program within the model.

Describe any challenges you have encountered:

VBP projections continue to be challenging due to the significant impact of benefit and programmatic changes to OHP including Behavioral Health Directed Payments and IHCP reimbursement structures as well as increasing pharmacy trends.

3. **Optional: Can you provide an example of a VBP arrangement your CCO has implemented that you consider successful? What about that arrangement is working well for your CCO and for providers?**

   Click or tap here to enter text.

4. **Optional: In questions 1-2, you described challenges that you have encountered in meeting annual VBP targets. How has your CCO responded to and addressed those challenges?**

   Click or tap here to enter text.

Section 2: Care Delivery Area VBP Requirements

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements.

5. **What is the current status of the new or enhanced VBP model your CCO is reporting for the hospital care delivery area requirement? (mark one)**

   ☒ The model is under contract and services are being delivered and paid through it.
   ☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
   ☐ The model is still in negotiation with provider group(s).
   ☐ Other: Enter description

   What attributes have you incorporated, or 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)?

The hospital VBP of focus includes a LAN category 3B structure, with upside risk equivalent to [redacted] of total contract value and downside risk equivalent to [redacted] of total contract value being tied to quality performance metrics. The VBP also includes quality metrics focused on maternal care.

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

6. **What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>maternity</u> care delivery area requirement? (mark one)**

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

What attributes have you incorporated, or 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)?

The maternity focused VBP model includes a LAN category 3A VBP with two participating OB/GYN providers, that include both Pay-For-Performance incentives and case rate payments based upon and incentivizing early prenatal engagement rates.

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

7. **What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>behavioral health</u> care delivery area requirement? (mark one)**

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

What attributes have you incorporated, or 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)?

The behavioral health focused VBP includes a LAN category 3A VBP with key network providers of mental health outpatient care. VBP payments include monthly capacity payments for direct outpatient mental health services providing access and services to all YCCO members. In addition, a Quality Incentive VBP Payment in place for meeting set of metric benchmarks, inclusive of focusing on co-occurring disorders and meaningful language access.

YCCO also rolled out an expansion of Behavioral Health Pay-for-Performance model (including a newly formed IPA) in 2025 to higher utilizing fee-for-service clinics.

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

8. **What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>oral health</u> care delivery area requirement? (mark one)**

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

What attributes have you incorporated, or 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)?

YCCO has restructured the VBP arrangement with our primary oral health provider (LAN Category 4A), with greater shifts of funding from capitation to quality performance incentives.

YCCO is also evaluating future options for oral health integration into our PCP cap pilot program, inclusive of integration of care and managing Total Cost of Care.

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

9. **What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>children's health</u> care delivery area requirement? (mark one)**

☒ The model is under contract and services are being delivered and paid through it.

☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

What attributes have you incorporated, or 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)?

The VBP of reference is a primary care capitation (LAN category 4A) VBP, with a Total Cost of Care quality component currently consisting of upside only payment potential. The VBP has been developed with a specific Children cohort of focus, inclusive of payment, risk stratification, Total Cost of Care tracking, and engagement reporting functions.

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

10. **Optional: In designing new or enhanced VBP models in additional care delivery areas, what have you found to be most challenging? What is working well?**

    Click or tap here to enter text.

Section 3: PCPCH Program Investments

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements.

11. **OHA requires that PCPCH infrastructure, or per-member per month (PMPM), payments made by CCOs to clinics are independent of any other payments that a clinic might receive, including VBP payments tied to quality. In September 2023, OHA provided updated guidance on this in the VBP Technical Guide.**

    Are the infrastructure payments made to your PCPCH clinics independent from other payments made to those clinics?

    ☒ Yes
    ☐ No

    If no, explain your plan to meet this requirement going forward:

N/A

12. **If a clinic meets the requirements to be recognized as a PCPCH clinic at a given tier level, the baseline PMPM payment made to that clinic should not be contingent upon meeting any additional requirements (e.g., VBP quality metrics, added clinic integration or functionality, etc.). CCOs may use VBP arrangements and other quality incentives to supplement baseline PMPM payments made to clinics (p. 12, VBP Technical Guide).**

    Are the infrastructure payments made to your PCPCH clinics contingent upon meeting any additional requirements?

    ☐ Yes
    ☒ No

    If yes, explain:

    N/A

Section 4: Engaging with Providers on VBP

These questions address your CCO's work engaging with providers and other partners in developing, managing, and monitoring VBP arrangements.

13. **How does your CCO engage partners (including providers) in developing, monitoring, and evaluating VBP models? Note any formal organizational structures such as committees or advisory groups involved in this process.**

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

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

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

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

Joint Operations Committee (JOC) meetings with hospital system(s) designed to reduce disconnects between the two organizations; eliminate unnecessary delays in patient care and associated costs; and maintain patient outcomes and satisfaction.

Patient and Population Centered Primary Care (PC3) Learning Collaborative to facilitate clinic to clinic sharing of best practices with the goal of achieving improved clinic and member outcomes.

Incentive Metrics Subcommittee held monthly with contracted providers including OHA-designated Patient Centered Primary Care Homes (PCPCHs) to discuss quality incentive data and strategies.

Immunization Workgroup meets regularly with the goal of improving access to and administration of vaccines with the goal of meeting OHA child and adolescent immunization benchmarks.

YCCO also continue to utilize a Total Cost of Care (TCOC) web-based and extract-based reporting tool for its primary care capitation clinics.

14. In your work responding to requirements for the VBP Roadmap, how challenging have you found it to engage providers in negotiations on new VBP arrangements, based on the categories below?

Primary care		
☐ Very challenging	☐ Somewhat challenging	☒ Minimally challenging
Behavioral health care		
☐ Very challenging	☒ Somewhat challenging	☐ Minimally challenging
Oral health care		
☐ Very challenging	☐ Somewhat challenging	☒ Minimally challenging
Hospital care		
☐ Very challenging	☒ Somewhat challenging	☐ Minimally challenging
Specialty care		
☐ Very challenging	☒ Somewhat challenging	☐ Minimally challenging

Describe what has been challenging, if relevant [optional]:

One of the biggest challenges has been getting providers and health systems to take downside risk and finding quality metrics that are both relevant to and administratively viable to implement for specialty care providers. Other challenges include engaging providers who are now receiving competing incentives increasing reimbursement and focusing on fee-for-service only payment mechanisms, as seen with IHCP (reimbursement changes) and new

behavioral health providers (due to directed payments). Challenges with hospital VBPs are now isolated to specific hospitals unwilling to engage in any VBP contract considerations at this time. Other simpler challenges with primary care is that VBPs are in place with all clinics with viable membership to consider engagement in VBPs, as YCCO currently has VBPs with primary care clinics responsible for over 90% of our total membership.

15. **Have you had any providers withdraw from VBP arrangements since May 2024?**

☐ Yes
☒ No

If yes, describe:

N/A

Section 5: Health Equity & VBP

The following questions are to better understand your CCO's plan for ensuring that VBP arrangements do not have adverse effects on populations experiencing or at risk for health inequities.

16. **How does your CCO mitigate possible adverse effects VBPs may have on health outcomes for specific populations (including racial, ethnic and culturally diverse communities, LGBTQIA2S+ people, people with disabilities, people with limited English proficiency, immigrants or refugees, members with complex health care needs, and populations at the intersections of these groups)?**

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

YCCO provides Continuing Education for providers to better manage and interact with diverse Members within YCCO. YCCO has a policy that providers must follow to reassign or

"fire" a Member. In the event that this occurs, a YCCO Community Health Worker (CHW) and our internal Care Management team do outreach to the Member.

YCCO staff meet with PCPCH VBP clinics on a bi-annual basis to review clinic performance under VBC arrangements. As part of these visits, provider education and discussions take place regarding each clinic's ability to provide appropriate language access and understand barriers clinics were facing providing language access. Discussions with clinics include how APM payments can help support clinic staff in facilitating appropriate access to language services. Technical assistance is offered to clinics to understand language access tracking and interpreter services supported by YCCO.

Additionally, YCCO holds regular internal APM workgroup meetings that explore options for evolving incentive metric-related payments to clinics, and is develops workplans to incentivize utilizing and reporting language service provision for YCCO members, ensuring that the VBPs are structured in a way that not only limits restricting access (e.g. turning a patient away when language services cannot be provided) but incentivizing clinics to offer appropriate services to patients of any language.

17. **Is your CCO <u>currently</u> employing medical/clinical and/or social risk adjustment in your VBP payment models?** (Note: OHA does not require CCOs to do so.)

☐ Yes
☒ No

If yes, describe your approach.

N/A

Describe what is working well and/or what is challenging about this approach.

Click or tap here to enter text.

18. **Is your CCO <u>planning</u> to incorporate new medical/clinical and/or social risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?** (Note: OHA does not require CCOs to do so.)

Ideal state would be to integrate social factor risk adjustment into certain capitated agreements, likely starting with primary care once viable and reliable models are available.

Section 6: Health Information Technology and VBP

Questions in this section were previously included in the CCO Health Information Technology (IT) Roadmap questionnaire and relate to your CCO's health IT capabilities for the purposes of supporting VBP and population management.

Note: Your CCO will not be asked to report this information elsewhere. This section has been removed from the CCO HIT Roadmap questionnaire/requirement.

19. What health IT tools does your CCO use for VBP and population health management, including to manage data and assess performance?

YCCO continues to collaborate with its strategic partner, [redacted], to model existing VBP arrangements and administer related payments through CIM while also relying upon the use of [redacted] to administer other VBP arrangements.

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

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

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

Providers continue to have real time access to analytics via the [redacted] tool housed in the CIM provider portal. The metrics are adjusted as needed on an annual basis. In addition, YCCO also continues to engage with Wakely consultants to deliver cost and utilization reporting and data to key provider partners.

20. Describe your strategies and activities for using health IT to administer VBP arrangements, noting any changes since May 2024.

YCCO has cloud-based MS Azure Tableau Server and SQL Server infrastructures.

YCCO is continuing to build out our Tableau server capabilities, improving our Tableau dashboard development expertise, and implementing collaborative Teams sites with key provider partners. This will allow for more meaningful data exchanges and analysis of our VBP program. In addition, we will continue to maintain and improve the analytics available to providers via [redacted] on the CIM provider portal.

21. Describe your strategies and activities for using health IT to effectively <u>support provider participation</u> in VBP arrangements, noting any changes since May 2024.

a. How do you ensure that providers receive accurate and timely information on patient attribution?

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

b. How do you ensure that providers receive timely (e.g., at least quarterly) information on measures used in their VBP arrangements?

YCCO provides all measure information to providers via CIM and [redacted]. YCCO will continue to initiate site visits with providers and encourage/confirm their ability to access CIM and [redacted].

c. What specific health IT tools do you use to deliver information to providers (list and provide a brief description of each)?

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

22. One way to support providers in meeting the quality metrics used in VBP arrangements is by helping to identify patients who require intervention. Describe how your CCO uses 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. Note any changes since May 2024.

Member specific data intended to inform and enable population health management activities is shared with providers within whom VBP contracts have been established in the context of [redacted]. In addition, YCCO's Care Management team pro-actively

communicates with and shared information about members engaged in care / case management via phone, fax, and the CIM provider portal.

23. **Does your CCO routinely provide transaction-level cost and utilization data ("raw claims data") for attributed patients' total cost of care to providers participating in risk-based VPB arrangements? If so, do you provide this data automatically to all providers participating in risk-based VBP arrangements or only upon request?**

    Yes.

24. **Using the table below, indicate (a) which types of data files, prepared reports, or dashboards you make available to providers in each type of HCP-LAN VBP arrangement, (b) how often you make the data available, and (c) how the information is provided (please include the name of the tool).**

    For reference: Online interactive dashboards are websites where providers can configure settings to view performance reporting for different CCO populations, time periods, etc. Shared bidirectional platforms integrate electronic health record data from providers with CCO administrative data (such as: Arcadia, Azara, Epic Payer Platform).

	HCP-LAN 2C	HCP-LAN 3A/B	HCP-LAN 4	Frequency	How is this information being provided?
Attribution files, including dates of coverage	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☐ Monthly ☒ Quarterly ☐ Other	☐ Excel, static reports ☒ Interactive dashboard ☐ Bidirectional platform Tool: [redacted]
Quality performance & gap reports	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☐ Monthly ☒ Quarterly ☐ Other	☐ Excel, static reports ☒ Interactive dashboard ☐ Bidirectional platform Tool: [redacted]
Performance reports with numerator/ denominator details	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☐ Monthly ☒ Quarterly ☐ Other	☐ Excel, static reports ☒ Interactive dashboard ☐ Bidirectional platform Tool: [redacted]
Total cost/utilization data with transactional details	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☐ Monthly ☒ Quarterly ☐ Other	☐ Excel, static reports ☒ Interactive dashboard ☐ Bidirectional platform Tool: [redacted]

Member-level risk score details	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other	☐ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: Click or tap here to enter text.
Total premium data with member-level details	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other	☐ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: Click or tap here to enter text.

25. Are there any significant operational details about the way you share data with providers that are not captured in the chart above? Are there any additional types of data or reports that you make available to providers in VBP arrangements to support their success?

No, however, we do our best to accommodate ad-hoc requests that may come from providers.

26. Describe your <u>accomplishments</u> related to using health IT to administer VBP arrangements and support providers.

YCCO continues to work closely with [redacted] and internal YCCO experts to enhance reporting and analytics; and make them available to our providers.

27. What <u>challenges</u> are you experiencing related to using health IT to administer VBP arrangements and support providers?

Resources to get the work done and slow/resistance to adopt change primarily due to workflow impact(s).

Section 7: Technical Assistance

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

28. What TA can OHA provide that would support your CCO's achievement of VBP requirements outlined in Exhibit H of the CCO Contract?

Development and roll out of additional quality measures within specialty care areas to both CCOs and providers, inclusive of basic reporting requirements, improvement targets, and scalability for varying sample sizes. YCCO appreciates the current efforts to pursue and collaborate on this matter via the CCO VBP Workgroup.

29. Aside from TA, what else could support your achievement of VBP requirements outlined in Exhibit H of the CCO Contract?

1) Development and expansion of the complete list of aligned quality metrics as part of the VBP roadmap, with a specific focus on expanding/adding common metrics within specialty care areas.
2) Clarification and refined definitions on what is included or excluded from evaluating VBP performance. More specifically, consideration for excluding certain costs such as pharmacy and directed payment spending. Pharmacy spending in particular will have little to no potential for VBP contracting. Directed Payment spending in particular is designed and built primarily on a fee-for-service basis, with regimented payment requirements.
3) A review and reset of the outlined VBP targets for CCOs, considering the multitude of programmatic and benefit changes that have transferred to CCOs since the original targets were developed. Key examples include but are not limited to behavioral and dental directed payments, IHCP reimbursement changes, DRG reimbursement changes, HRSN benefits, mobile crisis services expansion, handicapping malocclusions benefit expansion, and any other significant changes in coverage driven by the HERC inclusive of pre and post Prioritized List removal.

30. <u>Optional</u>: Do you have any suggestions for improving the collection of the information requested in this questionnaire in future years? If so, what changes would you recommend?

Click or tap here to enter text.

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