2020 CCO 2.0 VBP Interview Questionnaire and Guide

August 24, 2020

Introduction

As noted in the July 7 CCO Weekly Update, the contractually required Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, were rescheduled for the week of September 14. Please see Appendix A for the interview schedule. Staff from the OHSU Center for Health Systems Effectiveness (CHSE) will be conducting the interviews and using information collected as part of a 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, September 4, 2020**. 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.

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

Lisa Krois, MPH (she/her/hers)
Transformation Analyst, OHA Transformation Center

Section I. Written Interview Questions

Your responses will help OHA better understand your VBP activities this year, including detailed information about VBP arrangements, HCP-LAN categories and how these compare to what had been planned.

1) Describe how your CCO engages stakeholders, including providers, in developing, monitoring or evaluating VBP models. If your approach has involved formal organizational structures such as committees or advisory groups, please describe them here.

AllCare CCO has constituted Provider Planning Committees for each of our VBPs. We currently cover the following care delivery areas with existing VBP's: Primary Care/Pediatrics (children's care); Specialty - OB/GYN (maternal), medical, and surgical subgroupings; Oral Health; and Behavioral Health. The committees consist of a cross-section of network providers/stakeholders as well as AllCare senior leadership, Medical Directors and our VBP team.

As in prior years, the 2020 VBP cycle officially began in the last quarter of 2019. We initiate the cycle by meeting respectively with each VBP Provider Planning Committee to present AllCare's suggestions and recommendations for changes to the programs for the 2020 program. The presentations by AllCare staff to the committees include a recap of program history, overview of AllCare's strategic priorities, graphic displays of measure level performance results, and the recommendations of changes to the program for the coming year.

Once the committees have formalized their recommendations for the next year, those recommendations are presented to the AllCare Board of Governors for final approval. In addition, progress on VBP measure performance is presented to the AllCare Board of Governors on a quarterly basis. Last, our VBP team works directly with providers on an on-going basis to educate, coach and keep them informed of their progress.

AllCare has developed an evaluation process within the VBP team that consists of reviewing performance of each measure within the program to determine inclusion/exclusion recommendation status for the upcoming year. The criteria used to determine a recommendation for future inclusion are measure relevancy, overall achievement trajectory of existing measures, AllCare CCO strategic priorities, and alignment with OHA, HPQMC, and the Governor's priorities. The VBP team uses the results of these indicators to formulate the recommendations we then present to our VBP Provider Planning Committees.

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

☐ CCO did not modify any existing VBP contracts in response to the COVID-19 outbreak. *[Skip to question 5].*

☒ CCO modified all existing VBP contracts due to the COVID-19 outbreak, and we used the same rationale and process for all modifications. *[Proceed to question 3]*

☐ CCO modified all existing VBP contracts due to the COVID-19 outbreak, but we used different rationales and processes for some modifications. *[Skip to question 4]*

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

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

a) Describe the rationale for modifying existing VBP contracts in 2020.

In alignment with OHA, we removed measures that, due to COVID-19 were unrealistic to achieve, and eliminated standard benchmarks for other measures. However, we continue to require reporting of all OHA technology plan measures. Engagement with the program and compliance with measure reporting throughout 2020 will be the key determinants for attainment of an incentive payout. We have historically based annual incentive payouts on a scale similar in design to OHA's, however, we feel that maintaining provider engagement in the program during the pandemic is our paramount concern. Thus, we are proceeding with reporting and engagement as the primary factors in a pass/fail scoring system for the 2020 performance year.

b) Describe the process you used for modifying VBP contracts, including your key activities, stakeholder engagement and timeline.

As the landscape with COVID-19 became clearer during the year the AllCare VBP team met to decide how we should modify the programs to recognize the unique circumstances we were operating in. The universal sentiment was that we wanted to continue with the programs on some level despite the difficult situation. We strongly felt that a one-year hiatus in the program due to COVID-19 could potentially set our VBP model back; only to make it difficult to get going again in the future at the same level of engagement we've enjoyed in the past.

Once the decision/recommendation was made to continue with our VBP programs for the duration of 2020, the AllCare VBP team reviewed the

parameters of our current programs to decide what a fair and equitable approach might look like. The basic framework we decided on was similar in approach to the modified OHA CCO incentive program. We recognized continued reporting in support of the technology plan measures to be a core requirement. In addition, we reviewed all existing measures to determine any that may not be appropriate given the pandemic. Last, we determined that individual measure attainment relative to benchmark targets was not feasible. Thus, we decided that continued engagement in the program was the second core requirement for meeting program expectations in 2020.

Once we had the changes decided upon we took them to the AllCare Board of Governors for approval. After approval from the AllCare Board of Governors we rolled the revised program out to our provider network in tandem with the second quarter VBP Quality Reporting.

c) Describe the payment model/s you have revised (or are revising) this year, including LAN category, payment model characteristics, and implementation date/s.

Described above are the basic changes we have formally made to the program for 2020. We are essentially continuing with our current VBP programs that represent upside risk based on quality performance. We have these models categorized as LAN 2C when paired with fee-for-service base payment; and LAN 4B when paired with capitation.

AllCare had a facilities (i.e. hospitals, SNFs, surgery centers) VBP that we terminated as of the end of 2019. We decided that the scope and financial impact of the program wasn't at a level that drove significant commitment to change. As a result, AllCare is currently looking at the hospital care delivery area as a priority for a new VBP. We have entered into contract negotiations with a local hospital organization and VBP is one of the critical components in that dialogue.

Due to COVID-19, enhancements to our programs (Risk Stratification and Downside Risk) have been delayed. We did pilot a new Risk Stratification report in 2020 that introduces the concept and reporting to our primary care network. The expectations we have for this initial year with risk stratification is that they get familiar with the data provided and how they can use it in putting together a population health management strategy. We will send out a survey to the providers a little later in the year to get feedback on the value of the data included in the report, additional data elements they'd like included, and a narrative on how they plan to use the

information to help manage their panel from a population health management perspective. Sharing of this information with program participants will be a priority as we identify best practices and lessons learned. Moving ahead, we intend to look into developing a shared-risk arrangement attached to risk stratification but at this point we don't yet have that definitively set.

We had considered entering into some form of risk-based VBP for 2021, but with the financial uncertainty that prevails in the industry this year we have decided to wait until it settles down before talking to providers about taking on downside risk. We expect to renew this effort in 2021, with an expectation that in 2022 we will have additional deals in place that will meet the criteria for LAN 3B or higher status.

4) <u>If you indicated in Question 2</u> that you made modifications to some (but not all) existing VBP contracts, or that your rationale and process varied by VBP model, please respond to d–g:
   d) Among the existing VBP contracts that have been modified due to COVID-19, which payment models included the largest number of members?
   e) Describe your rationale for modifying this existing VBP model in 2020.
   f) Describe the process you used for modifying this VBP model, including your key activities, timeline/s and stakeholder engagement.
   g) Describe how you modified this VBP model, including changes in LAN category, payment model characteristics, or implementation dates.

The following questions are to better understand your CCO's plan for mitigating adverse effects of VBPs and any modifications to your original plans.

5) Describe in detail any planned processes for mitigating adverse effects VBPs may have on health inequities or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally based communities; lesbian, gay, bisexual, transgender and queer [LGBTQ] people; persons with disabilities; people with limited English proficiency; immigrants or refugees; members with complex health care needs; and populations at the intersections of these groups).

   Our current VBP programs are upside sharing based on quality performance so withholding of services hasn't been a major concern to date. Having said that, our Health Equity Committee receives a quarterly report of VBP performance by measure that is stratified by race and ethnicity. The committee reviews the report with an eye toward any observed disparities. For example, our ED data indicated that we were experiencing much higher utilization amongst a couple disadvantaged populations. Having observed that, it was decided to hold listening sessions with

members from those populations to get a better understanding of the barriers to care that might be driving people to seek care in the ED as opposed to their PCP. Our network providers were then given insight and training on the barriers that had surfaced in the sessions as a response to help better meet the needs of those populations going forward.

In our current environment (upside VBP programs) we have outlined the below as criteria for identifying unintended consequences. As we enter into downside risk programs we will expand our criteria for examining unintended consequences to make sure that services aren't being withheld from certain populations.

Criteria to Determine Unintended Consequences for a Measure

Cause undue burden for provider offices:

- Costly technology required
- Additional staffing required
- Significant adjustment to current processes and workflows
- Staff needs additional training or resources to meet measure

Alienate specific patient population:

Offices "firing" or shaming patients that refuse measure qualifying care. (Non-vaxxers, non-compliant diabetics, patients who 'no show').

Pull focus from other health issues not included in a measure (ie: providers making sure diabetics get their A1c but not diabetic eye exam.

Reducing access for patients outside the measure parameters (well care visits for those older than age 6, dental visits for children vs. adults).

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

   We have modified our VBP programs this year, as described above, to relax the standards. This was done to keep the programs relevant during the pandemic and to keep the network engaged until we are back in a more stable environment.

   In response to COVID-19 we have ramped up outreach to our members in a couple ways to enhance care. First, the AllCare Care Coordination team has increased outreach to members with complex health needs to make sure they are receiving the care they need to optimize their health. Second, we have initiated a program with our contracted gyms to increase member outreach with the goal of getting increased engagement in health and wellness activities.

7) What approaches are you taking to incorporate risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?

AllCare currently applies risk adjustment in our primary care capitation model. We vary payment based on member level risk factors that are calculated using the Chronic Illness & Disability Payment System (CDPS). The CDPS risk factor is also one of the data points on the Risk Stratification report that we've rolled out to the primary care network this year. We are considering linking risk to targeted annual changes in the CDPS risk factor but need to get Actuarial validation for this approach. The initial thought is that a targeted group would be identified by the provider/clinic and then a metric will be set around improving the risk factor over time for that target group.

8) Have you considered social factors in addition to medical complexity in your risk adjustment methodology?

   Yes, we included social factors on the risk stratification report that were obtained from data that is available through traditional sources. Those factors include: gender, age, race/ethnicity, preferred language, and OHA rate category (e.g. Old Age Assistance with Medicare Part A or A & B). We considered additional social factors for the risk stratification report, but didn't have the required datasets available to include these factors in a reportable format yet. Moving ahead, homelessness and food insecurity are additional key social factors that we would like to incorporate into the model. Our Care Coordination team is currently participating in an OHSU study that may prove fruitful as a source of Social Determinate data that will be incorporated into our reporting going forward. We will pursue that as an option when the information becomes available and we can assess the reporting capability. The other option that will be looked into for obtaining this data is to pull it in from the Health Risk Surveys (HRS) campaign that is being conducted by Care Coordination. The reporting of this data would come out of our Population Management platform Essette and will require special programming.

   If yes, please describe in detail your use of social risk adjustment strategies in your VBP models, including the following:

   a) Whether social risk adjustment is applied to quality metrics, overall payment (for example, capitation), or both;

      Currently, we include a Health Equity measure in all of our VBP programs. This measure is designed to increase knowledge of health equity and cultural awareness throughout the network via a requirement of clinic staff to participate in trainings. Qualified training classes are identified in VBP Handbooks we send out to all program participants.

   b) Specific social factors used in risk adjustment methodology (for example, homelessness); and

Current and future desired risk factors we are using are detailed in the opening response to question #8.

c) Data sources for social factors, including whether data is at the individual/patient or community/neighborhood level.

Currently, we are using data from standard eligibility sources. As discussed above, we want to bring in additional member level data from either: 1) OHSU study mentioned above, if feasible, and it looks to be an ongoing viable source of data; or 2) information as captured in the HRS process by our Care Coordination team.

We would like to obtain more information on how other CCOs have been able to incorporate social determinate information from external sources.

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

9) Describe the process your CCO has used in 2020 to address the requirement to implement per member per month (PMPM) payments to practices recognized as PCPCHs (for example, region or risk scores), including any key activities, timelines and stakeholder engagement.

We have used a pmpm payment for PCPCH historically and modified the model for 2020 to include the following factors: payment for additional tiers, rural practice status, and panel size. This change was designed in Q4 2019 and presented to the AllCare Board of Governors for approval for a 1/1/2020 effective date.

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

☒ Yes

☐ No

If yes, describe the characteristics of new or revised PMPM payments to PCPCHs.

On the next page is a grid outlining the tier level breakout and associated pmpm payments that AllCare implemented beginning 2020. Changes from 2019 payments include an increase in pmpm amounts, additional tiers, rural practice status and panel size.

PCPCH Payout by Tier

Tier Level	2019 pmpm	2020 pmpm	2021 pmpm	2022 pmpm	2023 pmpm	2024 pmpm
Tier 1	**$0**	**$0.25**	**$0.25**	**$0.25**	**$0.25**	**$0.25**
Tier 2	**$0**	**$0.50**	**$0.50**	**$0.50**	**$0.50**	**$0.50**
Tier 3	**$3.00**	**$2.75**	**$2.50**	**$2.25**	**$2.00**	**$1.75**
Tier 3 with > 500 members	**$3.00**	**$3.25**	**$3.25**	**$3.50**	**$3.50**	**$3.50**
Tier 4	**$4.00**	**$3.75**	**$3.50**	**$3.50**	**$3.50**	**$3.50**
Tier 4 with > 500 members	**$4.00**	**$4.50**	**$4.75**	**$5.00**	**$5.25**	**$5.50**
Tier 5	**$5.00**	**$4.75**	**$4.50**	**$4.50**	**$4.50**	**$4.50**
Tier 5 with > 500 members	**$5.00**	**$5.50**	**$5.75**	**$6.00**	**$6.25**	**$6.50**
Clinics > than 10 miles from a city center	**$0.50**	**$0.50**	**$0.85**	**$0.95**	**$1.00**	**$1.10**

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

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?

AllCare currently has a VBP in place for our contracted Mental Health Organizations and Substance Use Disorder Agencies. The program is an incentive program based on quality metrics. Funding of the program is through OHA Quality Pool funds earned by the CCO as well as shared savings generated by the VBP programs. We plan to continue forward with this approach for behavioral health moving into 2022. We will review the program annually and make changes to the program (i.e. measures, structure, etc.) as conditions warrant.

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?

AllCare currently has a VBP in place for our contracted OB/GYN (maternal care) clinics. The program is an incentive program based on quality metrics. Funding of the program is through OHA Quality Pool funds earned by the CCO as well as shared savings generated by the VBP programs. We plan to continue forward with this approach for maternity care moving into 2022. We will review the program annually and make changes to the program (i.e. measures, structure, etc.) as conditions warrant.

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?

AllCare is currently in early discussions with a key hospital system for a new contract that will include a revamped VBP model. We had a VBP program for hospitals prior to 2020 but chose to eliminate that model in favor of a more substantial program, including increased funding and a risk component. Given the preliminary status of discussions with the hospital we don't yet have concrete details on how the new model might look.

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

☒ Yes (please respond to a–c)

We have added risk stratification to our Primary Care and Pediatric VBP in 2020. Other care delivery areas with payment models required by 2023 and 2024 are currently in place and are addressed in items (d-e) below.

☒ No (please respond to d–e)

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

AllCare introduced risk stratification to our primary care/pediatric providers in 2020. Our goal in 2020 is to get the providers familiar with the concept and incorporate their feedback in improving the risk stratification reporting moving into 2021.

b) Describe the LAN category, payment model characteristics and anticipated implementation dates (2021, 2022, etc.) of new payment models you have developed (or are developing) this year. If you have developed multiple new value-based payment models this year, please provide details for each one.

Contingent upon developing an actuarially sound approach, our multiple-year objective with risk stratification is to set up a risk based measure tied to quantifiable changes in health status of targeted groups. At this time we are targeting a 2022 implementation of a risk based approach.

c) Describe whether your approach to developing these payment models is similar to, or different from, what you had originally intended in 2020; if different, please describe how and why your approach has shifted (for example, please note if elements of your approach changed due to COVID-19 and how you have adapted your approach).

Our approach hasn't changed considerably from prior to 2020 at this time. We have slowed down on pursuing risk based deals with providers due to the COVID-19 impact on financial stability throughout the industry.

If no, please respond to d–e:

d) Describe any decisions made to date regarding the eventual design of your payment models, including the care delivery area(s) or provider type(s) that VBPs will cover, LAN category, payment model characteristics, and implementation dates.

AllCare currently has VBP programs in the remaining two care delivery areas that are targeted for implementation after 2022. The programs are for our contracted Dental Care Organizations and our Pediatric (children's health care) network. Both models are similar in design to the models outlined above for behavioral health and maternity care.

e) Describe whether your approach to developing these models will be similar to, or different from, what you had originally intended in 2020, and why.

We would like to consider potentially moving towards risk-based VBP programs that involve use of withhold from base payment. AllCare currently uses a withhold arrangement for some of the entities participating in our VBP programs. Return of withheld funds is based on satisfying reporting requirements and meeting utilization targets. The withhold arrangement is separate from the VBP quality payments currently. Moving towards downside risk rated as LAN 3B or higher is a priority for AllCare. We want to discuss with OHA the merits of a risk deal tied to withhold from base payment as a deal that would elevate LAN status from 2C to 3B.

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

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

AllCare could benefit considerably from a TA review process that vets our proposed risk deals relative to compliance with OHA's expectations.

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

A forum with other CCOs to share insight on downside risk concepts in a best practices discussion.

Optional

These optional questions will help OHA prioritize our interview time.

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

High level discussion of our basic VBP programs specific to LAN rankings.

Insight about other CCO's relative to risk stratification initiatives undertaken.

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

None at this time.

Part II. Oral Interview

This information will help your CCO prepare for your VBP interview, and 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, although they will tailor the questions to each CCO after reviewing written interview responses.

Format

Oral interviews will be conducted via a video conference platform such as Zoom. These interviews will be recorded, transcribed and de-identified for further analysis. This analysis may include overarching themes and similarities or differences in how CCOs are engaging in VBP-related work. Results may be publicly reported in a de-identified and aggregated way that will be made available 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 2020, 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.

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.

Appendix A. CCO VBP Interview Schedule

Date/Time	Time (Pacific Time)	CCO
Mon 9/14/2020	9 AM - 10:30 AM	PacificSource Community Solutions
Mon 9/14/2020	1 PM - 2:30 PM	Yamhill Community Care
Mon 9/14/2020	3 PM - 4:30 PM	Columbia Pacific CCO
Tue 9/15/2020	8:30 AM - 10 AM	Trillium Community Health Plan
Tue 9/15/2020	1 PM - 2:30 PM	Jackson Care Connect
Tue 9/15/2020	3 PM - 4:30 PM	Cascade Health Alliance
Wed 9/16/2020	9 AM - 10:30 AM	Advanced Health
Wed 9/16/2020	3 PM - 4:30 PM	Eastern Oregon CCO
Fri 9/18/2020	9 AM - 10:30 AM	InterCommunity Health Network CCO
Fri 9/18/2020	11 AM - 12:30 PM	AllCare CCO
Fri 9/18/2020	1 PM - 2:30 PM	Health Share of Oregon
Fri 9/18/2020	3 PM - 4:30 PM	Umpqua Health Alliance