2021 AllCare CCO 2.0 VBP Interview Questionnaire

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.**

   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 2021 VBP cycle officially began in the last quarter of 2020. We initiated the cycle by conducting a virtual meeting respectively with each VBP Provider Planning Committee to present AllCare's suggestions and recommendations for changes to the programs for the 2021 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 Board of Governors also reviews progress on a quarterly basis to provide feedback and support.

   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 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) Currently N/A

☐ Waived performance targets

☐ Modified performance targets

☐ Waived cost targets

☐ Modified cost targets

☐ Waived reporting requirements

☐ Modified reporting requirements

☐ Modified the payment mode (e.g. from FFS to capitation)

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

d) If the CCO modified *maternity care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

☒ Waived performance targets

☐ Modified performance targets

☐ Waived cost targets

☐ Modified cost targets

☐ Waived reporting requirements

☒ Modified reporting requirements

☐ Modified the payment mode (e.g. from FFS to capitation)

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

e) If the CCO modified *oral health* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

☒ Waived performance targets

☐ Modified performance targets

☐ Waived cost targets

☐ Modified cost targets

☐ Waived reporting requirements

☒ Modified reporting requirements

☐ Modified the payment mode (e.g. from FFS to capitation)

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

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.**

AllCare CCO adopted the expanded provisions of telehealth to members as outlined by the Oregon Health Authority. All visits conducted via telehealth that meet OHA requirements are eligible for VBP metrics scoring.

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

AllCare is continuously monitoring the impacts of COVID-19 to ensure we make appropriate strategy adjustments. We have used a similar strategy in 2021 that we adopted for 2020 as the pandemic continues to have a significant impact on member engagement with providers. We will monitor the progress on each measure and analyze the need to change strategy as needed. Two areas that continue to be significantly impacted by COVID-19 are child/adolescent immunizations and dental screenings. Member engagement with primary care is down significantly and many children are missing annual well child visits where immunizations are administered. Also, many schools in the region have been either fully remote or hybrid in-person/remote and all schools have paused dental screenings in the schools for the entire school year. AllCare is trialing a program with providers and members to incentivize annual well child visits as COVID-19 transmission is declining and many are returning to some level of normal activity. As members engage in well child visits the goals is for them to also receive any necessary immunizations and dental screenings. We will consider further incentive programs specifically for immunizations and dental screenings as necessary.

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.

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.

<u>Criteria to Determine Unintended Consequences for a Measure</u>
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. (Vaccine hesitancy, non-compliant diabetics, patients who 'no show').
- Pull focus from other health issues not included in a measure (i.e.: 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).

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

We have reinstated measure targets for 2021 with the understanding that the VBP team will reassess measure targets for fairness as we see how big of an impact the pandemic has this year. 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. The AllCare Care Coordination team continues outreach to members with complex health needs to make sure they are receiving the care they need to optimize their health. We have continued a program with our contracted gyms to increase member outreach with the goal of getting increased engagement in health and wellness activities.

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

In 2020 we gave clinics and providers the risk stratified data to gather feedback. The risk stratified data will be presented to clinics so that they can better understand how they perform in relation to their peers. AllCare will conduct an internal review to understand implications and share findings and reach out to leaders to understand best practices and promote throughout network. Moving forward we will utilize actuarial sound analysis to understand outliers in the network and engage in outreach to work with outliers. We will also increase focus on social determinants of health considerations in all measures. As part of the risk adjustment strategy we are looking to incorporate patient turn over and grievance prevalence into the provider assignment algorithm. This consideration attempts to apply an even risk to member panels by ensuring that members with a history of frequent grievances and/or turn over are not assigned to one or a few providers.

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.**

We have continued to follow the model that was implemented in 2020 (payment for additional tiers, rural practice status, and panel size). In line with the 2020 model, the PMPM payments have been adjusted to reflect the 2021 payment structure (see table below). 2021 PMPM payments for recognized clinics have ranged from $2.50 (tier 3) to $6.60 (Tier 5 with >500 member and > 10 miles from a city center).

PCPCH Payout by Tier (Per Member Per Month)

Tier Level	2019	2020	2021	2022	2023	2024
Tier 1	$0.00	$0.25	$0.25	$0.25	$0.25	$0.25
Tier 2	$0.00	$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	$5.00	$5.75	$6.00	$6.25	$6.50
Clinics > 10 miles from a city center	$0.50	$0.50	$0.85	$0.95	$1.00	$1.10

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.

As the table, 'PCPCH Payout by Tier' shows, AllCare CCO has developed a graduated payment structure for PCPCH PMPM reimbursement by tier level. We have taken the following factors into consideration as reimbursement rates were determined:

- PCPCH tier level – We have sought to encourage clinics to strive for higher tier level recognition by reimbursing them at increased rates for higher tier levels. The higher PMPM rates also reflect recognition and acknowledgement of the additional effort it takes for a clinic to achieve and maintain high tier level recognition. The table shows the payout plan for PCPCH PMPM reimbursement through 2024 (the CCO 2.0 time frame). The payments are modified over the course of this time frame in an effort to help clinics move into higher recognition tiers.
- Enrollment/panel size – Clinics with panel sizes greater than 500 AllCare CCO members receive an additional amount added to their base tier level PMPM amount. Access to primary care providers is essential to the health of our community. Increased access to PCPs helps with improved rates of preventive care, early detection of health concerns, lower emergency department utilization rates, and lower health care costs. All primary care providers in our network play a vital role in this. As with the increased PMPM rates for higher tier levels, the additional amount added to the rate for clinics with greater than 500 AllCare CCO members seeks to recognize the additional work it takes to manage a larger panel size. It also serves as an incentive for providers to increase their panel sizes.

- Clinic Location – AllCare CCO serves a large rural area in southern Oregon. Many people in our community do not live near a health care facility and can find it difficult to access primary care services. It is for this reason that we have added an additional incentive amount to clinics that are located in communities which are greater than 10 miles from a city center. For the purpose of this model, city centers in southern Oregon include Grants Pass, Medford, Central Point, Ashland, and Brookings.

In an effort to further support our network providers in their pursuit of PCPCH recognition, AllCare employs a 1.0 FTE Provider Programs Coordinator. This position is responsible for training providers and office staff on the various state and federal programs that they may participate in. Additionally, they coach medical groups in efficiencies and best practices in regard to these programs.

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 <u>behavioral health care</u> 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).

Currently behavioral health care payments are classified as 4N and 2C. Patients receiving treatment through a contracted Mental Health or Alcohol & Drug organization typically have a complex care issue associated with that area of care. The AllCare VBP measures are focused on improving access for these vulnerable patients with an emphasis on rewarding engagement in ongoing services of need.

The VBP 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 <u>maternity care</u> 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).

Currently maternity care payments are classified as 2C. Payment is primarily fee-for-service. With our largest maternal care provider Women's Health Center of S. OR (WHCOSO) we also have a Maternal Medical Home (MMH) program. Under this program they have primary responsibility of coordinating the care (both internal and external to WHCOSO) that a woman receives from conception through 60 days post-partum. Reimbursement for the enhanced care received under the MMH program is based on a PMPM payment reflecting the risk level of the patient. Metrics in this care delivery area are principally focused on maternal care.

Care for the most vulnerable women, as defined by AllCare, is coordinated appropriately and timely between internal and external partners.

- Co-located mental health services;
- Co-located Maternal Fetal Medicine physician;
- Medical High Risk OB Care Coordination

Metrics in the VBP program focus on timely delivery of important services during pregnancy with emphasis on reducing risk factors (smoking cessation, SBIRT, and medicine coordination).

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? 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).

We have initiated discussions with four key hospitals in our service area to move portions of care to a case rate reimbursement model. The areas of focus are emergency room care and maternal/newborn care. Partial implementation of the case rate will occur in July 2021 (at a Type B hospital) with the remainder being implemented in January 2022 In addition, modifications are being made to the inpatient/outpatient pricing model that is more closely correlated to rate of growth expectations and commitments. Timeline: July 2021 – Ashland, Jan 2022 – Asante/Providence

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.

Since September 2020, we have not developed any other VBP models outside behavioral health, maternity care, or hospital care. We are looking to expand our hospital care VBP model and refine our models in behavioral health and maternity care.

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. Currently N/A.

a) Describe the LAN category, payment model characteristics and anticipated implementation year 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.

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).

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?

- Moving toward risk adjustment models that account for social determinants of health, more assistance on integration of best practices of SDoH into these models would be appreciated.
- We are looking at a VBP model for pharmacy expense/PBM. Does OHA have any information or best practices in this area?

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

- How do we involve specialists (surgeons) at a more significant level?
    - Would like to find a universal VBP that is applicable to multiple specialty types.
- It would be helpful for OHA to share best practices for VBP models.

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?

- **Align VBP where there are overlapping CCOs**

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