2023 CCO 2.0 Value-Based Payment (VBP) & Health Information Technology Pre-Interview Questionnaire

Introduction

As described in Exhibit H, Section 6, Paragraph b of the 2023 contract, each Coordinated Care Organization (CCO) is required to complete this VBP Pre-Interview Questionnaire prior to its interview with the Oregon Health Authority (OHA) about VBPs.

OHA's interviews with each CCO's leadership will be scheduled for June 2023. Please schedule here. Staff from the OHSU Center for Health Systems Effectiveness (CHSE) will be conducting the CCO VBP interviews again this year. Similarly, they will be using information collected as part of the larger evaluation effort of the CCO 2.0 VBP Roadmap.

Instructions

Please complete **Section I** of this document and return it as a Microsoft Word document to OHA.VBP@dhsoha.state.or.us by **May 5, 2023**.

All the information provided in Section I is subject to redaction prior to public posting. OHA will communicate the deadline for submitting redactions after the VPB interviews have been completed.

Section II of this document describes the oral interview topic areas and suggestions for CCO preparation. CCO responses to oral interview questions will be de-identified in publicly reported evaluation results.

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

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Part I. Written VBP Pre-Interview Questions

Your responses will help OHA better understand your CCO's value-based payment (VBP) activities for 2023, including detailed information about VBP arrangements and HCP-LAN categories. A prior version of this questionnaire was collected from your CCO in May 2021 and 2022. Some questions will request an update on previously submitted information, which will be provided.

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

1) **In 2023, CCOs are required to make 60% of payments to providers in contracts that include an HCP-LAN category 2C or higher VBP arrangement. Describe the steps your CCO has taken to meet this requirement.**

AllCare has focused on case rates for services, along we downstream subcontractor compliance enforcement. For example, we have added a large Chiropractic, Acupuncture, and Physical Therapy vendor that has a case rate for the majority of our back pain benefit enrollees. Including VBP CCO language in CCO Subcontractor agreements has also been a critical priority.

2) **In 2023, CCOs are required to make 20% of payments to providers in arrangements classified as HCP-LAN category 3B or higher (i.e., downside risk arrangements). Describe the steps your CCO has taken to meet this requirement.**

AllCare has expanded our Primary Care Capitation agreements that have a 5% withholding to all counties. Previously they were only in Josephine County. AllCare is pursuing direct contractors in the Dental and Oral health networks to increase capacity and meet downside risk targets. Also ensuring that downside risk has been built into existing CBO agreements will be critical as the HRSN benefit is brought on.

3) **a. 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: The model is under contract, developing rates for other models

b. 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)?

AllCare has finalized the agreement for IV Drug users not able to discharge to an SNF (in place and under contract). We are developing a C-Section Case rate agreement in Jackson County being worked on. We are excited to be engaging OHSU on a car-t quality program.

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

We are developing a C-Section Case rate agreement in Jackson County being worked on. We are excited to be engaging OHSU on a car-t quality program. We are also developing a quality program for the expanded pharmacy services recently added to the CCO benefit. These agreements will be developed over the next 24 months.

4) a. 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

b. 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)?

Measures include: Timely Postpartum Visit, Documentation of Current Medications, Tobacco Use: Screening and Cessation Intervention, Utilization of Health and/or Community Information Exchange, Language Access, Timely Prenatal Visit, SBIRT

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

Click or tap here to enter text.

5) a. 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

b. 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)?

APM Measures Include: Appointment within 30 days of assessment, Mental Health Assessment for DHS Children, ED Visits for Substance Use Disorder (SUD), Follow up within 7 Days of SUD Discharge, Follow up within 30 Days of Mental Health Discharge, Follow up within 30 Days of Alcohol or Drug Inpatient Rehab Discharge, Assertive Community Treatment, Initiation and Engagement of AOD Treatment, Wraparound Program, Utilization of Health and/or Community Information Exchange, Language Access

Additional Incentive Measure for Options for Southern Oregon: Outreach to patients who are newly diagnosed with a mental health illness to schedule a behavioral health appointment.

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

Click or tap here to enter text.

6) a. 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

b. 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)?

Measures include: Oral Health exam for DHS Children within 60 days, Oral Evaluations for Diabetic Patients, Preventive Visits 1-5 Year olds, Preventive Visits 6-14 Year olds, Dental Services Utilization, Tobacco Use: Screening and Cessation Intervention, Language Access

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

Click or tap here to enter text.

7) a. 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

b. 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)?

Measures Include: Childhood Immunizations, Adolescent Immunizations, Well Child Visits, Smoking Prevalence, Depression Screening w/ Follow-up, SBIRT

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

Click or tap here to enter text.

8) a. Does your CCO still have in place any VBP contract modifications to reporting or performance targets that were introduced during the COVID-19 public health emergency?

☐ Yes, our CCO's VBP contracts retain COVID-19 modifications.
☒ No, all of our CCO's VBP contacts are back to pre-pandemic reporting and targets.

b. If yes, describe which modifications are still in effect, including provider categories and types of reporting or performance target that remain modified.

Enter description

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

9) In May 2021 and 2022, you reported the following information about how your CCO engages partners (including providers) in developing, monitoring or evaluating VBP models.

2021: 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

2022: No changes to note

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

No changes to note

10) 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 [optional]:

Provider offices and Hospitals continue to have significant staffing shortages of both clinical and administrative staff. Efforts to fully recover from the pandemic are still underway and it is difficult and burdensome for providers to undertake quality agreements during this time.

11) Have you had any providers withdraw from VBP arrangements since May 2022?

☒ Yes
☐ No

If yes, please describe:

DCO's had participated in a risk withhold agreement to increase utilization. They were unable to achieve the target during Covid and continue to struggle due to staffing and administrative issues and so have withdrawn from the agreement.

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 your CCO last reported this information.

12) In May 2021 and 2022, your CCO reported the following information about processes for mitigating adverse effects VBPs may have on health inequities or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally based communities; 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).

2021: 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. (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).

2022: Review of the quarterly stratified VBP reports indicated that fewer of our African American members have Primary Care visits compared to the rest of our CCO population. One of our Health Equity sub-committees has taken this on as a project. Some of the interventions they have implemented include: a cultural competency questionnaire for PCPs upon credentialing and re-credentialing, contracting with a new Family Nurse Practitioner who identifies as African American, panel discussion with members of the community who identify as African American and Hispanic to discuss their experiences in the community and community antiracism trainings.

Language Access has been added as a bonus measure in our Specialty, Dental and Behavioral Health VBPs. AllCare will stratify VBP performance by language spoken to further assist in identifying health disparities for our members with limited English proficiency

Please note any changes to this information since May 2022, including any new or modified activities.

No changes to note

13) Is your CCO planning to incorporate risk adjustment for social factors in the design of new VBP models, or in the refinement of existing VBP models? [Note: OHA does not require CCOs to do so.]

Not at this time.

Questions in this section were previously included in the CCO Health Information Technology (HIT) Roadmap questionnaire and relate to your CCO's HIT capabilities for the purposes of supporting VBP and population management. Please focus responses on new information since your last submission.

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

14) You previously provided the following information about the HIT tools your CCO uses for VBP and population management including:

a. HIT tool(s) to manage data and assess performance

2021: AllCare CCO administers VBP programs in several care delivery areas. Data extracts for each incentive measure that is based on administrative data (claims, eligibility) are generated by querying the core processing system using SQL. The extracts that are created via SQL are exported to Excel and then the files are imported into a reporting template. The reporting template is Excel based and has programmed macros that convert the imported data into a provider level quality report. The quality reports are exported to PDF files and distributed to program participants.

AllCare CCO hosts an EHR platform for a number of the primary care clinics in our service area. The service agreement with the clinics includes support of their required metric reporting. Reporting for incentive measures from the EHR is exported to Excel files and then imported into the reporting template using the same process as described for the administrative data extracts

2022: No changes to note

Please note any changes or updates to this information since May 2022:

No changes to note

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

2021: Population Management: AllCare CCO utilizes a care management platform, HMS' Essette. Essette can import data from outside sources to support population health reporting. In addition, AllCare CCO utilizes Milliman MedInsight for risk stratification, predictive modeling and support for VBP

2022: The Collective Medical platform is being utilized to track ER and Inpatient stays related to substance use disorder. This assists in timely follow up and tracking of outcomes relating to engagement in treatment.

Please note any changes or updates to this information since May 2022:

No changes to note

15) You previously provided the following information about your staffing model for VBP and population management analytics, including use of in-house staff, contractors or a combination of these positions who can write and run reports and help others understand the data.

2021: AllCare CCO has a VBP/Population health department headed by the Value Based Payment Manager and supported by Quality Analysts, Health System Analysts and Provider Network Management. This position is supported by the Chief Operations Officer and Director of Provider Contracting and Director of Health Equity. The VBP department interfaces with virtually every department within AllCare CCO including Claims, eHealth Services, Health Information Technology and Clinical Areas. This department regularly interfaces with Providers in supporting their success with VBP and Population Health

2022: The VBP team has been divided into two separate departments; Practice Operations and Data Science. These two departments continue to work closely together and interface with Population Health, Claims, eHealth, Finance, Health Equity and Clinical Areas on a regular basis. This arrangement is supported by the Sr. Director, IPA & Practice Operations, Sr. Director Provider Network and Health Equity and the Chief Financial Officer.

Please note any changes or updates to this information since May 2022:

No changes to note

16) You previously provided the following information about your <u>strategies</u> for using HIT to administer VBP arrangements. This question included:

a. How you will ensure you have the necessary HIT to scale your VBP arrangements rapidly over the course of the contract,
b. spread VBP to different care settings, and
c. Plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract.

2021: AllCare CCO currently has the capability to generate quality reporting for our VBP arrangements with a frequency of quarterly updates. The current process in place is as described above in the response to HIT Tools for VBP and Population Management.

2022:
a. No changes to note
b. No changes to note

c. AllCare's goal is to streamline reporting so that providers are able to access their performance data more frequently and/or in real-time once the measure programming has been completed

Please note any changes or updates for each section since May 2022.

a. How you will ensure you have the necessary HIT to scale your VBP arrangements rapidly over the course of the contract.

The contracts team has built out a LAN and HCP definition document and is planning to build a dashboard to use for new and existing VBP contracts to track what LAN and RBC category it falls under to ensure we are meeting requirements.

b. How you will spread VBP to different care settings.

Pharmacist encounters related to programs such as Smoking Cessation, and medication reconciliation is the primary focus at this time.

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

No changes to note

17) You reported the following information about your <u>specific activities and milestones</u> related to using HIT to administer VBP arrangements.

For this question, please modify your previous response, using underlined text to add updates and strikethrough formatting to delete content from your previous responses from May of 2021 and 2022. If the field below is blank, please provide updates on specific milestones from your 2021 HIT Roadmap submission.

2021: We began a transition of the data capture for the VBP programs in 2020 to consolidate it under a single platform. In developing the VBP programs over the prior several years we ended up with a situation where the administrative data used in support of the programs was derived from multiple sources. The goal of the consolidation initiative is to house the data extraction exclusively within our HIT team. With that change we feel we will be better positioned with the resources needed to keep the measure coding up-to-date, and to maintain more reliable support with a higher level of confidence in the accuracy and consistency of the data.

AllCare CCO planned on getting the data extraction consolidation completed in time for 2021 reporting. Progress on that front didn't proceed according to plan and we are now

looking at a 2022 timeframe to get that work completed. Once we have all of the programming for the measures transitioned to HIT we will focus on building a reporting module that is directly linked to the measure level data. This enhancement will reduce the amount of manual intervention currently involved in the generation of quality incentive reports. Another desired outcome of the more automated approach in reporting will be a change in frequency of reporting from quarterly to at least monthly, with the ultimate desire to achieve real-time reporting.

2022: The project of transitioning measure programming has been assumed by the newly formed Data Science team. We are on track to transition measure programming by the end of 2022. Some measures have already been transitioned and work continues to be done to complete the project by end of year reporting for 2022

Briefly summarize updates to the section above:

Work continues to be done to fully transition measure programming. The majority of measures have been completed but there are some with complicated specs or that are "home grown" internal metrics that are still being worked on.

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

2021: VBP Analytics Staff worked with HIT staff throughout 2020 on the project of coding development for the administrative data-based measures. There are 27 distinct deliverables with this phase of the project, 5 of them have been completed, with partial completion on several others. The combined progress represents about a 25% overall completion rate currently.

With the VBP and HIT teams working closely in tandem on the measure development project we have tightened up the coding on some measures. The expertise HIT has regarding our data capabilities has brought solid recommendations to the table on how the data can be queried to maximize accuracy.

A significant program enhancement in 2020 was setting up gap list distribution to VBP participants through our provider portal. Previously we sent the gap lists out via secure email in PDF files. By using the portal, the risk of sending member level data to the wrong clinic is eliminated. Also, the data is stored in a known location so the information is more easily found by clinic staff at time of need.

AllCare began an EHR transition from PrimeSuite to AllScripts in 2020. Data migration from the old to new platform didn't occur successfully. Our EHR reporting specialist has developed a process to merge the member level reporting from the two systems to produce an aggregate report for the full measurement year. This requires manual intervention but

with several clinics yet to begin the transition to AllScripts this process will allow us to continue reporting for those clinics during the transition.

2022: As stated above, the Data Science team has taken over the responsibility of transitioning programming for the measures. The EHR reporting specialist was able to successfully merge year-end reporting but has sought assistance from the VBP team to make data extraction and reporting a less manual intervention.

Please note any changes or updates to these successes and accomplishments since May of 2022.

The Data Science team has expanded knowledge of the databases used to create the performance reports. The IT department is working to set up a user interface for the Data Science team to better streamline reporting going forward.

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

2021: Our biggest challenge has been the fragmentation of our administrative data sets across multiple platforms. As described above we have undertaken a project with HIT to consolidate the data extraction under a single point of contact.

A couple challenges surfaced during our work with HIT in 2020 that have slowed down the project:

- HIT developers have good coding skillsets but aren't familiar with the business end of the measures. This knowledge gap can lead to delays due to multiple iterations of development and quality assurance required to get to an accurate result.
- HIT resources are a finite quantity and the business demands are ever increasing for their services. Thus, higher priority projects took resources away from our project at times limiting the ability to stay on track with the project.
- Response to the pandemic temporarily derailed important feedback between developers, providers and VBP staff. Resources were re-deployed to support COVID guidelines.
- Aggressive timelines related tin Interoperability Final Rules proved to be significant HIT resource consumer

2022: Due to the challenges listed above, the decision was made to transition the project to the Data Science department. It is challenging to make strategic decisions based on OHA measure performance data that is delayed more than four months. We have worked to create internal programming that will give us more real-time data but it has been difficult to recreate measure results for the OHA incentive measures without access to all measure value sets or measure programming

Please note any changes or updates to these challenges since May of 2022.

No Changes to note

20) You previously reported the following information about your <u>strategies, activities and milestones</u> for using HIT to effectively support provider participation in VBP arrangements. This included how your CCO ensures:

a. **Providers receive timely (e.g., at least quarterly) information on measures used in the VBP arrangements applicable to their contracts.**
b. **Providers receive accurate and consistent information on patient attribution.**
c. **If applicable, include specific HIT tools used to deliver information to providers.**

2021: AllCare CCO provides quarterly reporting to the contracted providers that are participating in our VBP programs. Quality reports are produced that reflect measurement year-to-date progress relative to established targets. Quality reports are distributed via secure email. Gap lists are also distributed on a quarterly basis that provide member level detail on numerator compliance for each of the measures. Gap lists are loaded to the provider portal for access.

AllCare CCO has transitioned to an attribution methodology that is based on member assignment as of the end of the reporting period. This applies for the programs where member assignment occurs – Primary Care, Pediatrics, Oral Health. For VBP programs where provider assignment doesn't occur (i.e. Behavioral Health, Specialty – maternity, medical, surgical) attribution is based on the provider who renders services to a member.

2022:

a. The gap lists that are now available on the provider portal provide real-time performance results for the offices to access and act upon
b. No changes to note
c. No changes to note

Please note any changes or updates to your strategies since May of 2022.

a. **Providers receive timely (e.g., at least quarterly) information on measures used in the VBP arrangements applicable to their contracts.**

The gap lists available on the provider portal reflect results for claims-based measures only. Several OHA measures have moved toward EHR based or CCO level measures so it is difficult to provide performance results more often than quarterly for those measures included in the VBP arrangements.

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

No changes to note

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

No changes to note

How frequently does your CCO share population health data with providers?

☐ Real-time/continuously
☐ At least monthly
☒ At least quarterly
☐ Less than quarterly
☐ CCO does not share population health data with providers

21) You previously reported the following information about how your CCO <u>uses</u> data for population management to identify specific patients requiring intervention, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes.

2021: In 2020, AllCare CCO began to produce and distribute to our primary care network a risk stratification report. With the disruption of normal operations in the industry due to Covid-19 the impact and value of that data was minimized. We are gathering feedback from the provider community on their perceived utility of the risk stratification report and will develop an outreach campaign designed to address the themes that emerge from that feedback.

The risk stratification data reported to the primary care network has also been shared with AllCare CCO's Care Coordination department. Targeted reporting of specific patient populations (e.g. non-compliant A1c patients) is referred to Care Coordination with their associated risk stratification data to help them identify those patients that need priority intervention

2022: No changes to note

Please note any changes or updates to this information since May 2022.

Risk Stratification reports have been discontinued at the clinic level due to feedback from providers that they were not finding value in the reports. We intend to use the reports at the CCO level to identify trends and focus areas within the data.

22) You previously reported the following information about how your CCO <u>shares</u> data for population management to identify specific patients requiring intervention, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes.

2021: AllCare CCO provides rosters of patients where VBP measures are identified as a gap to participating providers. This information helps them target patient outreach to achieve better VBP results and to increase the number of patients getting those targeted preventive services. Gap lists are housed on the provider portal and reflect current member level compliance status by measure.

Risk Stratification reports have been sent via secure email during 2020 on a quarterly basis to our primary care providers. Beginning with 2021 reporting we are planning on uploading these reports to our provider portal. This enhancement will improve the timing of delivery and provide for a consistent home for the data.

2022: The Risk Stratification reports continued to be distributed to providers via secure email in 2021. We will revisit the goal of making them available via the provider portal in 2022.

Please note any changes or updates to this information since May 2022.

As stated above, Risk Stratification reports have been discontinued at the clinic level. Gap lists continue to be provided via the provider portal as well as via secure email for offices to perform patient outreach for necessary interventions.

23) Estimate the percentage of VBP-related performance reporting to providers that is shared through each of the following methods:

Estimated percentage	Reporting method
100%	Excel or other static reports
	Online interactive dashboard that providers can configure to view performance reporting for different CCO populations, time periods, etc.
	Shared bidirectional platform (example: Arcadia) that integrates electronic health record data from providers with CCO administrative data.
	Other method(s): Click or tap here to enter text.
[Total percentages should sum to 100%]	

How might this look different for primary care vs. other types of providers (hospital care, behavioral health care, maternity care, oral health care, children's health care)?

Reporting method is the same for all provider types at this time.

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

2021: AllCare CCO now is able to upload gap list files to the provider portal enabling the clinics to access more current information than the prior process in place that involved emailing secure files on a quarterly basis.

AllCare CCO has taken the lead in supporting EHR reporting for those clinics that are transitioning from our hosted platforms. This eases the burden on those clinics in producing credible reporting across two different EHR platforms. We also have representation on the CQM technical assistance program and will cascade information from that forum out to our contracted entities.

2022: No changes to note

Please note any changes or updates to this information since May 2022.

No changes to note

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

2021: The most significant challenge we're facing is in developing an efficient methodology to bridge CQM reporting across two platforms as we transition EHR systems for the clinics we host and support EHR services. Clinics are migrating platforms throughout the year and the patient history is not transferring properly. Thus, reporting is being pulled from both systems and then we merge that data that requires more manual effort that is optimal.

2022: The VBP team is assessing ways to alleviate the burden of reporting across two platforms and to make data extraction and reporting a less manual process.

Please note any changes or updates to this information since May 2022.

Data extraction and reporting for the EHR measures continues to be a manual process due to the variability of EHR platforms and reporting formats being utilized by provider offices.

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

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

Continue the VBP meetings, provide examples or best practices for models that have been successful in obtaining and utilizing health equity data. Additional guidance on how to make the most out of health equity data to decrease disparities.

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

Access to value set dictionary for all measures

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

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

Click or tap here to enter text.

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

Click or tap here to enter text.

Part II. Oral Interview

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

Purpose

The purpose of the CCO 2.0 VBP interviews is to expand on the information CCOs report and have provided in the written questionnaire; provide CCOs an opportunity to share challenges and successes; and discuss technical assistance needs. OHSU staff will ask these questions of all CCOs, tailoring the questions to each CCO based on written interview responses.

Format

Oral interviews will be conducted via a video conference platform (such as Zoom) and will be recorded, transcribed and de-identified for further analysis. Analysis may include overarching themes and similarities or differences in how CCOs are engaging in VBP-related work. OHA may publicly report de-identified and aggregated results next year. Before we begin, participants will have an opportunity to ask about the interview format. CCOs are encouraged to send questions to OHA *prior to* the interview, as discussion time will be limited.

Interview topics

Question topics will include your CCO's VBP activities and milestones in 2022, 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 three primary areas:

1) Provider engagement and CCO progress toward VBP targets. These questions will explore what has been easy and difficult about your CCO's VBP efforts so far, recognizing that each CCO operates within a unique context that must be considered when designing new payment arrangements. We may ask questions about your perception of provider readiness for or receptivity to VBP arrangements, factors affecting your progress toward VBP targets for future years, and how to make OHA technical assistance most relevant to your needs.

2) Implementation of VBP models required in 2022 and 2023. These questions will address how your CCO is making decisions about and designing required VBP models. We may ask about factors influencing the design and scale of your PCPCH infrastructure payment model and models to meet the Care Delivery Area requirements. These questions may address your experience designing quality strategies in hospital, maternity, behavioral health, oral health, and children's health VBP arrangements, as well as your progress developing HIT capabilities with providers to implement these VBP arrangements.

3) Promoting health equity through VBP models. These questions will explore how your CCO's work on health equity relates to your VBP efforts. We may ask about your CCO's progress with collecting social needs data; how health equity informs

your VBP planning in specific areas such as maternity care; and whether you have identified opportunities to use VBPs to address other CCO 2.0 priorities or requirements.