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.

   EOCCO engages the quality measure subcommittee of its board to develop, monitor and evaluate VBP models. The subcommittee is made up of hospital, primary care, behavioral health and public health representatives across EOCCO's geography. EOCCO also discusses VBP models with its Clinical Advisory Panel (CAP) and its contracted providers taking their input and suggestions into consideration when developing new or modifying existing VBP models.

   Any changes or modifications to VBP models or implementation of new VBP models are taken to the EOCCO Board of Directors for approval.

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

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

4) If you indicated in Question 2 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?

Modifications made to the quality measure portion of all primary care VBP contracts.

e) Describe your rationale for modifying this existing VBP model in 2020.

As a result of OHA's decision to suspend the requirement for CCO's to meet CY 2020 performance targets on CCO quality measures, EOCCO did not feel it was fair to hold primary care practices accountable for meeting CY 2020 performance targets as outlined in their existing VBP contracts.

As a result, we will be modifying VBP contracts that remove the requirement for primary care practices to meet CY 2020 quality measure targets in order to earn an incentive payment. Instead, providers will be able to earn an incentive for reporting performance on selected non claims based CCO quality measures. Providers will also be able to earn an incentive based on prior year performance and assigned membership.

f) Describe the process you used for modifying this VBP model, including your key activities, timeline/s and stakeholder engagement.

EOCCO's quality measure subcommittee met on 6/29/20 to review staff recommendations for how best to distribute 2020 quality funds and the decision to modify EOCCO's VBP contracts with primary care providers to move from a performance-based incentive to a payment for reporting incentive for CY 2020 only. At the 6/29 meeting the subcommittee approved its recommendations as noted above and sent it along to the EOCCO board for review and approval. The board met on 7/23/2020 and approved the subcommittee's recommendations to modify the primary care VBP contracts. Contract amendments will go out in September 2020 that will be retro to 1/1/2020.

g) Describe how you modified this VBP model, including changes in LAN category, payment model characteristics, or implementation dates.

The core foundation of EOCCO's VBP agreements with primary care providers did not change other than the one-year modification to the performance-based incentive structure due to the pandemic and we do not believe this change impacts our LAN category placement for CY 2020.

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).

EOCCO has strategies in place for addressing health equity, which will help ensure that VBPs do not have adverse effects on any underserved population. These include strategies targeting both processes and outcomes.

Examples of process strategies include the following:

1) EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data;

2) Disparity populations are evaluated and monitored through subcommittees of the EOCCO Quality Improvement Committee which has oversight of the TQS;

3) EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis;

To measure outcomes, EOCCO has created a 'health equity index' to quantify disparities in utilization. This index is based on comparing the age-adjusted utilization levels of certain indicator services (such as PCP office visits) by population. Due to the low number of members in certain groups and the low utilization counts for certain services (e.g. back surgeries for non-English-speaking Asian members), the index is based on a basket of higher-volume services for which a sufficient volume of data exists to achieve credibility. Initial findings of the health equity index suggest that primary care VBPs might actually be correlated with a reduction in health inequity, perhaps due to the significant focus on member outreach across the entire EOCCO population to achieve quality measures – though more study is needed.

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

As mentioned above, the distribution of the quality distribution will differ compared to year one, however, the overall methodology does not change.

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?

EOCCO will be using a diagnosis-based risk adjustment tool to refine the total cost of care budget for at least one of our shared risk models. Risk adjustment is also part of the new methodology for PCPCH tier payments. Please see question 10 for additional details.

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

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.
b) Specific social factors used in risk adjustment methodology (for example, homelessness)
c) Data sources for social factors, including whether data is at the individual/patient or community/neighborhood level.

EOCCO is exploring options to incorporate social risk adjustment in risk sharing models. There are two parts to this effort: 1) collecting reliable sources of social risk data; and 2) using this data to build models with sufficient predictive power that they can be incorporated into provider agreements. In terms of data sources, EOCCO is exploring several options, including purchasing third-party data, building data connectors to bring in SDoH data from providers, and engaging/training providers on how to code SDoH data into claims.

In parallel, EOCCO has been using sample data to build and test predictive models. To date, this modeling has used community/neighborhood-level factors rather than individual factors – mainly because the sample data that is readily accessible has only that level of specificity. As we improve the completeness and reliability of other data sources, more individual factors will be used. For example, one of the clinics we are partnering with to supply SDoH survey data can provide individual factors such as housing, food, transportation, activity, isolation, stress, etc.

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

Prior to 2020 EOCCO provided per member per month (PMPM) payments to PCPCHs recognized by the State of Oregon for each member enrolled or assigned to the PCPCH. Our PMPM payments included a payment differential by PCPCH tier for tiers 3-5. Prior to 2020 EOCCO did not provide PCPCH PMPM payments for tier 1 and tier 2 practices as nearly all PCPCH certified providers in EOCCO's geography are certified as tiers 3-5.

To address the requirement to incent all PCPCH's regardless of tier we modified our 2020 agreements to include PCPCH PMPM payments for tier 1 and tier 2 practices while retaining PCPCH payments for tiers 3-5.

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

EOCCO revised its PCPCH payment structure in April 2020 to implement risk and in future years a quality component in addition to a tier-based payment component. This revision was not to comply with CCO 2.0 requirements, but an evolution of our existing PCPCH payment program that has been in place since 2013. Below is an overview of decision to modify our PCPCH PMPM program.

In 2017, the EOCCO Board of Directors authorized an assessment of PCPCH payment program to ensure the tier-based funds were helping to produce the results expected from highly functioning medical homes. Completed in 2018, the assessment revealed that the payments had allowed clinics to integrate additional services, albeit with varying degrees of success.

In addition, performance on CCO quality measures did not seem to correspond closely with the payments. Some clinics were much more

successful with meeting measures than others despite receiving the same amount of payments. As a result, the EOCCO Board subsequently appointed a PCPCH payment subcommittee to assess whether or not the PCPCH payment program should add a performance-based component. The Subcommittee began meeting in late 2018.

As part of its work the subcommittee recognized Senate Bill 934 (2017) and the work of the Primary Care Payment Reform Collaborative. Two of the EOCCO PCPCH subcommittee members served on the collaborative. The subcommittee determined that EOCCO should align its payment program to the extent possible with the statewide effort which was also consistent with that of the federal CPC+ program which calls for performance-based payments on priority measures and risk-adjusted payments based on panel risk scores.

The subcommittee concluded that the program's fairness could be improved by accounting for a clinic's quality measure performance and panel risk but not to the extent of significant adverse effect on clinics with low risk panels. Furthermore, the subcommittee felt the performance-based and risk-based components should be phased in over a period of 3 years to ensure that the desired outcomes were being achieved.

Based on extensive modeling of impacts, the subcommittee anticipated recommending that the degree of the performance-based payment component should not exceed 15%, the degree of the risk-adjustment component should not exceed 40 – 60% of the total payments, and no clinic should experience a reduction greater than 10%. Details for year one are outlined as follows:

Year 1, beginning April 2020:

- **Payment composition is as follows**
  - **70% based on Tier Level**
  - **0% based on past performance (due to Covid-19 the past performance component will not be implemented until 2022)**
  - **25% based on the risk profile of the clinic's panel**

EOCCO will annually evaluate the impacts of this change to ensure that the desired outcome are being met.

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

N/A

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.

EOCCO will build upon its current VBP structure and work with its Quality Measure subcommittee, CAP, its contracted provider partners and the EOCCO board to implement the new and expanded care delivery area VBPs for 2022 and beyond.

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?

EOCCO's has worked with its Behavioral Health partner to discuss modifications to the contractual arrangements with their network of Behavioral health providers, many of whom are under a capitated payment arrangement today. The discussions have included incorporating quality measures from the HPQM aligned measure set into the payment arrangements. These changes will result in moving the agreements into VBP LAN category 2C and higher. Additional discussions with our Behavioral health partner will occur in CY 2020/2021 to ensure implementation by CY 2022.

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?

Today, EOCCO has a shared savings model with hospitals, primary care and specialty providers that includes an incentive for primary care practices that meet performance targets on a subset of CCO quality measures. EOCCO's plan is to modify its existing shared savings model to incorporate a maternity metric from the HPQM aligned measure set into our existing VBP model. Primary care and OBGYN providers will be eligible for an incentive for meeting performance targets on the selected maternity metric.

EOCCO discussed VBP modifications to incorporate the new care delivery area for maternity care and the associated metric at risk with its quality

measure subcommittee of the board in July 2019 and the EOCCO board in November 2019 where initial approval was received.

The EOCCO CAP, quality measure subcommittee and board will reevaluate this decision prior to implementation in 2022.

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?

Today, EOCCO has a shared savings model with hospitals, primary care and specialty providers. EOCCO's plan is to modify its existing shared savings model to incorporate hospital quality metrics from the HPQM aligned measure set into our existing VBP model. Hospitals will be at risk for meeting performance targets on the selected hospital metrics.

EOCCO discussed VBP modifications to incorporate the new care delivery area for hospital care and the associated hospital metrics at risk with its quality measure subcommittee of the board in July 2019 and the EOCCO board in November 2019 where initial approval was received.

The EOCCO CAP, quality measure subcommittee and board will reevaluate these decisions prior to implementation in 2022.

Additionally, in order to ensure our shared savings model meets the CMS guidelines for meaningful risk we will be increasing the provider withhold at risk no later than CY 2022.

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

☐ Yes (please respond to a–c)

☒ 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.

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.

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).

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.

EOCCO has a number of VBPs already in place today with primary care, hospital and specialty providers. These VBPs primarily fall into LAN Categories 2C and 4A and represent a significant portion of the dollars paid by EOCCO. As a result, EOCCO expects to exceed the requirement to achieve the 20% target for VBPs in calendar year 2020.

As discussed above our goal is to modify existing VBPs to ensure they fall into LAN categories 2C and higher focusing on maternity care, hospital care and behavioral health for implementation in 2022.

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.

The approaches will be similar to what we had originally intended in 2020 for implementation in 2021, but we will be delaying the implementation for planned VBP modifications to 2022 due to COVID-19.

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?

Primarily to ensure that our planned and existing VBPs will meet CCO 2.0 VBP requirements.

Additionally, as EOCCO moves further toward achieving the 70% VBP target we may need assistance from OHA on handling out of area/out of State providers. For example, due to our rural service area and geography all tertiary hospital and most high-level specialty care is provided out of area/out of State. There has been reluctance by our contracted out-of-state providers to participate in EOCCO's Value Based Payment models which could impact our ability to ultimately achieve a 70% VBP target. EOCCO may need assistance from OHA to work through some of these unique geographical challenges to meet its ultimate VBP goals.

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

We have not identified any additional support at this time.

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?

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

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