2021 CCO 2.0 VBP Interview Questionnaire and Guide

Introduction

Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, will be scheduled in June 2021. Please schedule here if your team hasn't already done so.

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.

Please complete **Section I** of this document and return it as a Microsoft Word document to OHA.VBP@dhsoha.state.or.us by **Friday, May 28, 2021**. 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.

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

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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.

EOCCO has an internal VBP workgroup that creates VBPs and 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 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)

☐ 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 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.

In accordance with rules issued and guidance released by OHA, EOCCO expanded the availability and provision of telehealth to members. The availability of telehealth created additional access points for members to seek care during the pandemic. Providers can bill telehealth eligible codes, and these are counted as claims under the VBP contracts already in place.

EOCCO accepts telehealth claims for most incentive measures in accordance with OHA rules, but this does not impact the overall VBP model for quality performance.

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

Due to the impact of COVID-19, EOCCO has taken a more comprehensive approach to measuring quality. This includes evaluating performance on metrics by demographic data elements, telehealth services, and access to services by

region. Since the pandemic had a large effect on EOCCO's incentive measure performance, EOCCO has made some changes to its 2021 VBP model to encourage providers to focus on measures that were impacted more severely by the pandemic. This additional VBP formula has been implemented in 2021 and will include a supplementary payment to providers based on performance on the challenge pool measures.

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.

EOCCO has strategies in place for addressing health equity, which 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) 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 uses 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 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.

EOCCO provides clinics with monthly quality reports and member rosters that include demographic and language data. EOCCO is currently working on collecting more comprehensive REALD data through Arcadia Analytics, our population health management tool, as well as the Accountable Health Communities (AHC) grant project.

The EOCCO Quality Improvement Team stratifies incentive measures by race, ethnicity, language, disability, and other demographic data to identify disparities in care or health outcomes. The team will then implement targeted interventions to address the identified disparities.

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

Through the Health Equity Plan and TQS focus areas including language access and reporting, member education and accessibility, culturally and linguistically appropriate services and CLAS as an organizational framework, EOCCO has made some changes to its processes. As noted above, EOCCO is working on collecting more comprehensive REALD data to better evaluate and identify disparities. EOCCO will then stratify incentive measures, particularly those included in the VBP formulas, by race, ethnicity, language, and disability data. Interventions will be implemented to address identified disparities in collaboration with EOCCO's provider network.

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

Yes, 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.

In June 2021, EOCCO will implement risk adjustment as part of the new methodology for PCPCH tier payments. Practices will receive higher capitation rates for members with a higher health risk score, as calculated by the Optum Symmetry risk score calculator. Quartile 1 represents members with the lowest health risk, and quartile 4 represents members with the highest health risk.

In October 2022, EOCCO plans to implement quality based PCPCH capitation payment rates to include a component based on a clinic's performance meeting or exceeding the 2021 CY CCO incentive measures, with higher-performing clinics receiving a higher capitation rate. In each subsequent year, each clinic's capitation rates will be updated on October 1st based on the prior calendar year performance on the CCO incentive measures.

These two enhancements were not to comply with CCO 2.0 requirements, but an evolution of our existing PCPCH payment program that has been in place since 2013. EOCCO will annually evaluate the impacts of this change to ensure that the desired outcomes are being met.

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 the process 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.

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

In April 2021, EOCCO increased each tier amount to comply with CCO 2.0 requirements and to continue to provide meaningful support to clinics who deliver patient-centered care.

In June 2021, EOCCO will implement risk adjustment as part of the new methodology for PCPCH tier payments. Practices will receive higher capitation rates for members with a higher health risk score, as calculated by the Optum Symmetry risk score calculator. Quartile 1 represents members with the lowest health risk, and quartile 4 represents members with the highest health risk. EOCCO intended to implement this change in 2020, but due to the COVID pandemic, this was delayed until June 2021.

All these enhancements were approved by EOCCO's board of directors which includes partners and representatives from EOCCO's community.

10) Please describe your CCO's model for 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.

EOCCO's PCPCH model and incentive program is designed to recognize the importance of patient centered care and provide meaningful PMPM payments to clinics with assigned membership. EOCCO's PMPM payments include a payment differential based on the PCPCH tier level. Although tiers 1-2 also receive a monthly PMPM, tiers 3-5 receive a higher PMPM to encourage and incentivize clinics to increase their tier status. Since September 2020, EOCCO has increased each tier payment.

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? 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).

EOCCO has implemented a work group 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 further risk sharing and adding quality measures from the HPQMC aligned measure set into the payment arrangements. These changes will result in moving the agreements into VBP LAN category 2C and higher.

The Behavioral Health CDA will be implemented by CY 2022 to ensure alignment with OHA's VBP requirements.

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? 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).

EOCCO currently 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 HPQMC 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. This will increase the current shared savings model to LAN category 3B since there will be downside risk associated with the quality metric.

EOCCO has implemented an internal focus workgroup that will finalize the design and VBP modifications to incorporate the new care delivery area for maternity care and the associated metric(s) at risk. EOCCO discussed and received approval for the initial VBP modifications to incorporate the new care delivery area for maternity care and the associated maternity care metrics at risk with its Quality Measure Subcommittee of the Board in July 2019 and the EOCCO Board of Directors in November 2019. However, the focus workgroup will update each stakeholder and receive final approval in Q3 CY 2021 to ensure timely implementation by CY 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? 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).

EOCCO currently 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 HPQMC aligned measure set into our existing VBP model. Hospitals will be at risk for meeting performance targets on the selected hospital metrics. This will increase the current shared saving LAN category to 3B since there will be downside risk associated with the quality metrics.

EOCCO has implemented an internal focus workgroup that will finalize the design and VBP modifications to incorporate the new care delivery area for hospital care and the associated metric(s) at risk. EOCCO discussed and received approval for the initial 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 of Directors in November 2019. However, the focus workgroup will update each stakeholder and receive final approval in Q3 CY 2021 to ensure timely implementation by CY 2022.

In Q3 2020, two hospital partners participated in a Hospital Prepayment Model. In this model, EOCCO provides a monthly prepayment PMPM based on the category of aid in the designated county. During a reconciliation period, EOCCO reconciles the monthly prepayments to fee for service. The primary intent of this model is to transition to partial hospital capitation and/or episode-based payments (maternity case rate); successful implementation will resort in a LAN category of 3B or 4A due to the risk and combination of quality metrics as part of the hospital CDA.

Additionally, to ensure our shared savings model meets the meaningful risk requirements, EOCCO will be increasing the provider withhold at risk no later than CY 2022.

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.

EOCCO has several VBPs already in place today with primary care, hospital, and specialty providers. These VBPs primarily fall into LAN Categories 2C, 3A, 4A and represent a significant portion of the dollars paid by EOCCO. As a result, EOCCO expects to exceed the requirement to achieve the 35% target for VBPs with LAN 2C or higher in calendar year 2021.

EOCCO has two internal workgroups that are focusing on enhancing the current VBPs in place and exploring other possible models to address VBP requirements over the next two-year period to ensure that:

- **At least 50% of payments fall within LAN category 2C or higher in 2022 and there is a clear transition to 60% of payments falling within LAN 2C or higher in 2023.**
- **At least 20% of CCO payments to providers fall within LAN category 3B in 2023.**

As mentioned in question 13, EOCCO (along with stakeholder support) is working on identifying partial capitation options for hospitals and identifying a potential maternity case rate to the existing models in place. This effort is also being tracked and monitored by EOCCO's VBP workgroup.

Also, starting in 2022, EOCCO will participate in additional workgroups focused on the Children's Health Care and Oral Health Care CDA design to ensure implementation by CY 2023.

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.

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.

EOCCO is currently working on enhancing current VBP models in place to build onto the success and knowledge of the models already in place:

LAN Category	Payment Model Characteristics	Implementation Year
2A	PCPCH foundational payments to support primary centered care	Ongoing
4A	Capitation for Non- Residential Substance Abuse • Incorporate quality into the existing capitation model. This is for Community Mental Health Programs (CMHPs).	2022-2023
4A	Capitation for ACT/SE • Incorporate quality into the existing capitation model. This is for CMHPs and ACT/SE Services	2022-2023
4A	Capitation for Non-In-patient Mental Health • Incorporate quality into the existing capitation model. This is for CMHPs.	2022-2023
2C	Add Incentives for quality measures to fee-for-service contracts for Mental Health Inpatient and SUD Residential. This is for contracted facilities for MH Inpatient and SUD Residential.	2022-2023
3B or 4A	Partial Capitation for Hospitals: • The primary intent of this model is to transition to partial hospital capitation and/or episode-base payments (maternity case rate)	2022
3B	Increase meaningful risk and include quality metrics: • Modify shared savings model (includes hospitals, specialists) to increase meaningful risk and quality metrics	2022

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 overall approach to designing and implementing VBP has not changed since 2020. EOCCO continues to collaborate and explore options to create innovative VBP models that local providers and stakeholders will adopt and support.

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?

Primarily to ensure that our planned and existing VBPs will meet CCO 2.0 VBP requirements through 2023.

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.

17) 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.

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?

19) 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.
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, 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

Questions topics will include your CCO's VBP activities and milestones in 2021, 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, particularly in the areas of behavioral health, maternity, and hospital care.

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 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.