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:

Karolyn Campbell, Ph.D. (she/her)
Transformation Technical Analyst, OHA Transformation Center
karolyn.campbell@oha.oregon.gov

Part I. Written VBP Pre-Interview Questions

Your responses will help the 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 via email.

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 a HCP-LAN category 2C or higher VBP arrangement. Describe the steps your CCO has taken to meet this requirement.**

In previous interviews and meetings with the OHA during 2022, Umpqua Health Alliance (UHA) showcased our CCO-wide VBP model (i.e. the Member Attribution Cost Summary [MACS] and Network Performance Report [NPR]). As a combination, these two reports feed into the financial performance of member attributed PCP clinics, [redacted]
All contracted providers with a withhold or risk-sharing opportunity are a part of this financial performance process. All dollars at-risk in a contract are subject to a cost performance threshold, as well as quality metric performance. Excluding additional quality incentives, UHA's percentage of value-based payments meeting 2C or above very easily exceeds the 60% requirement for 2023. UHA's model has 96% of its payments under a 2C or higher contract model.

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

As described in our response to number 1, MACS/NPR qualify all payments made to contracted providers with risk associated as 3B or higher (4A for capitated providers/4C for our contracted DCO), clearly exceeding the 20% threshold of providers in LAN category 3B or higher in 2023. UHA's model has 93% of its payments under a 3B or higher contract model.

3) **a. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>hospital</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)?

UHA elected to do a combo VBP in the realm of hospital and maternity care. Sole community hospital's delivery DRG payments are paid under a case rate agreement for maternity services which includes a quality incentive measure associated with it.

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

Model is implemented.

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)?

As noted above, UHA elected to do a combo VBP for maternity and hospital services. Our Sole community hospital's delivery DRG payments are paid under a case rate agreement for maternity services which includes a quality incentive measure associated with it.

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

Model is implemented.

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)?

UHA provides a PMPM payment with a withhold and quality component to incentivize PCPCH clinics to provide integrated behavioral health care to its members that require access to care for mild to moderate mental illness or substance use diagnoses. Additionally, UHA has further expanded our Behavioral Health VBP program in 2022 by increasing access to care through new behavioral health vendors with associated quality measures that meet LAN category 3B or higher.

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

Model is implemented.

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)?

While UHA has a standing VBP program associated with its Dental Care Organization (DCO), categorized as a 4A, UHA is researching a potential add-on in quality metrics to our existing contract or implementing a new program entirely.

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

UHA has ongoing operational meetings with its DCO partners and will use these meetings to discuss an enhancement to their current VBP arrangement. For UHA's CY2024 contract negotiations with its DCO (performed in 2023), UHA will discuss with the DCO the merits of including another metric as opposed to implementing a new program with a different vendor. This engagement will begin in Q2 of 2023, with an expected executed contract by the end of 2023.

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)?

On January 1, 2023, UHA implemented a new incentive payment centered around the children in DHS custody on the health plan. Providers are incentivized to render services that assist in meeting the Assessment for Children in DHS Custody measure. Incentives are paid on a per service methodology. There's an additional bonus payment provided to each provider who assists in successfully providing all required services for a child in DHS custody.

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

Model is implemented.

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.

N/A

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.

MAY 2021

Development:

Annually, through the Umpqua Health Alliance's (UHA) Budget Committee, comprised of representatives from the provider community, including the sole community hospital, the Community Mental Health Program (CMHP), local physician groups, and other community stakeholders, we review VBP programs and continue to expand VBP programs. Additionally, UHA regularly engages physician-led workgroups such as our UHA Board, Delivery System Advisory Council, Health Equity Committee, Quality Metrics Workgroup, and scheduled Provider Network events. Collaboration from these events and physician feedback has been instrumental in developing, modifying, and expanding VBPs. UHA also engages external actuaries to provide recommendations for certain VBPs to ensure fair and equitable settlements amongst the provider community.

Monitoring:
UHA provides monthly and quarterly updates to participating providers to assist in quality measure achievements, with integration of additional quality metrics through our secure provider portal. For VBP arrangements linked to OHA's CCO Quality Metrics, UHA utilizes its secure provider portal for participating providers, which updates nightly to ensure our providers have the most up-to-date Quality Metrics information. This capability allows our providers to improve any clinical quality gaps to achieve optimal clinical outcomes for UHA's members.

Evaluating:
Beginning in 2021, UHA, through its collaboration and feedback with the provider network and external actuaries, implemented the Member Attribution Cost Summary (MACS) and Network Performance Report (NPR) under its VBP program. This program was created and refined throughout 2020 with participating provider feedback. The program has a four-year implementation timeline that begins with participating provider's risk withholds, dependent upon the success of the MACS/NPR year-end performance to achieve an MLR of 87%. The four-year implementation timeline uses an incremental approach of 25%, 50%, 75%, and ending at 100% risk to their withholding. All participating providers who have a withhold component are included under this new VBP. [redacted] such as:

[redacted]

[redacted]

[redacted]

The objective is to increase the quality of care due to increased communication and care coordination between PCP, specialists, and facilities regarding the managing of member care.

MAY 2022

In 2022, we continued to evolve and enhance our process in how we develop and monitor our VBPs. Our Quality Advisory Committee serves a significant role now in

identifying/developing new VBPs as well as tracking the performance of our existing VBPs. Additionally, our Executive Committee of the UHA Board provides governance and oversight to the process through monthly meetings and through the budget process. The Contracting work group specifically develops VBPs in provider agreements, and the Contract Adherence work group monitors deployment of the provider contract for consistency purposes. Evaluating: To continuously evaluate outcomes, UHA, in collaboration with its provider network and external actuaries, have agreed to move to the same risk stratification methodology as the OHA. [redacted]

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

Heading into 2023, UHA has begun a transformation of its workgroup/committee structure to facilitate clearer upstream information channeling for utilization and quality reporting. The intent behind this modification was to enhance UHA's quality strategy to make sure it encompasses attributes of UHA's quality program. This allows for more collaboration with community partners in relevant committees and quicker response times.

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]:

Behavioral health care utilizes a lot of specialty measures which require data elements related to timeliness/access, which claims data does not provide. Additionally, not every behavioral health provider has sophisticated systems to track data to support quality metrics.

For specialty care, unlike primary care, there are not global metrics that can be routinely utilized across all specialty types. Metrics must be individually created for each specialty type.

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

☐ Yes
☒ No

If yes, please describe:

N/A

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).

MAY 2021

UHA continues to review and assess our VBP arrangements to mitigate any adverse effects on health disparities or any adverse health-related outcomes. In addition, UHA has implemented a Behavioral Health Access and Health Equity Awareness Program as an enhancement to our PCPCH program effective January 1, 2021. The program is designed to supply financial support to Primary Care Providers who are actively working on developing and improving behavioral health access in primary care settings and increasing health equity Awareness. Recognizing that the funding mechanisms in Medicaid programs to support stand-alone behavioral health services are often not sustainable, this Behavioral Health Access and Health Equity Awareness Program, which was implemented as an enhanced payment methodology, and is designed to reduce financial barriers to ensure effective integration. Additionally, the program is developed to expand traditional health workers' usage and development while promoting a behavioral health workforce in the Douglas County area.

The Behavioral Health Access portion of the new program incentivizes 'PCP's to manage members with mild to moderate mental illness and/or substance use disorders within the

primary care setting to free up access within the CMHP for members with persistent and severe mental illness.

The Health Equity Awareness portion incentivizes 'PCP's to raise awareness and knowledge of concepts related to health equity including CLAS standards. Additionally, this program incentivizes the reporting of REAL+D and SDOH.

Specifics of the program include:

- Training for staff and providers on the use of CLAS Standards in the provision of services.
- Implementation of at least five CLAS Standards.
- Provision of cultural responsiveness and implicit bias training to staff and providers.
- Collected and supplied Race, Ethnicity, Language, and Disability (REAL+D) data consistent with OHA's OARs 943-070-0000 through 943-070-007 (Appendix B).
- Screen members for three (3) SDOH domains and use Z-codes for reporting [via claims]: Housing (Z59.0-1; Z59.8-9), Food Insecurity (Z59.4), and Income (Z56.0; Z59.6-9).

Both programs have a quality withhold component and qualify as a VBP LAN.

To date, 90% of our members are assigned to primary care providers who elected to participate under this new VBP program.

UHA began collecting data under the new programs and reporting its results during the monthly Quality Metrics Workgroup.

UHA plans to utilize this additional reporting and screening to review further our VBP arrangements and direct future investments and VBP programs.

MAY 2022

In the second half of 2021 UHA transitioned to reporting REAL+D dashboards through Tableau. This included a dashboard of PCPs participating in the Behavioral Health Access and Health Equity Awareness (BH/HE) program. The dashboard is shared monthly with the PCPs during the Quality Metrics Workgroup.

For example, as we investigated 2022, we recognized gaps in the quality and quantity of the REAL+D and SDOH data. Similarly, behavioral health access continued to be a problem within our provider network, as many providers do not have the time and resources to dedicate the level of care for some of our members with SPMI. As a result, UHA elected to modify one of its existing VBPs, by making the Behavioral Health Access and Health Equity Awareness Program available to all its primary care network. In prior years, this program was an “opt-in” contract in which UHA carefully selected a handful of PCPs to pilot the program. Once UHA recognized the potential of this program, it decided to use it as its 2022 Behavioral Health CDA by expanding it to all its primary care providers. PCPs are now automatically enrolled in this program in 2022, which will increase the number of providers participating in the program This expansion will help bring needed financial resources to the

PCP community to support members with SPMI, while also producing important data to understand the SDOH needs of its community.

This program is intended to:

- Increase access of behavioral health services within the medical model
- Provide support to the PCP in addressing patients' behavioral health needs
- Mitigate negative impacts on physical health
- Improve patient clinical outcomes and increase overall satisfaction with care through the integrated care model.
- Improve access to specialty behavioral health when patient care can be addressed with the PCP

UHA, like many other areas throughout Oregon, recognize that we have limited provider resources for the management of psychotropic medication, limited patient access to behavioral health providers due to being in a rural area and COVID, limited behavioral health referral network for providers for specialty care, ongoing challenges for patients and providers when attempting to navigate the behavioral health system, unfamiliarity with the limited overall community resources specifically for behavioral health issues for both providers and members, and continued breakdown of social systems as a result of behavioral health issues. By implementing this program, it opens further access to specialty behavioral health care where mild to moderate behavioral health needs can be referred to the PCP clinics for ongoing care.

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

Beginning in 2023, UHA removed the Health Equity Awareness payment to providers as UHA was not seeing enough adoption of the program to merit continuation. Additionally, the data UHA was receiving was not universally implement and untilzied. UHA is continuing the Behavioral Health Access program, however.

In the beginning of 2023, UHA staff underwent Diversity, Equity, and Inclusion training to expand our understanding of, and ability to interact with, people from differing cultures and backgrounds. This can and will be utilized to provide more emphasis on VBP research and implementation utilizing REAL+D and SOGI data, where applicable.

By the end of 2023, UHA is looking forward to OHA's release of the expanded REALD/SOGI codebook and related data files for our membership.

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.]

UHA currently utilizes CDPS+Rx risk adjustment [redacted]

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

MAY 2021

UHA utilizes the Umpqua Health Business Intelligence (UHBI) software platform for purposes of measuring and reporting VBPs along with measuring CCO Quality Metrics in real time for claims-based measures. UHA's provider portal on the UHBI platform allows participating providers secure, direct access to their CCO Quality Metrics performance as well as UHAs more recent VBP program; [redacted]

MAY 2022

UHBI platform has added more information to the Gap-reports, available for providers to download, in the Provider-Portal section; this information relates to REALD for UHA members identified in the Incentive measure gap-reports. The providers are now able to stratify the population by REALD. Also, a new report "Clinic Data Report" has been added which provides information to clinics pushing EMR data pertaining to eCQM incentive measures; this report helps the clinic and the CCO to ascertain if complete datasets related to eCQM are being shared.

In 2020, UHA engaged with Arcadia Analytics to implement a case management and population health platform for the CCO. We have been using the platform for the past eleven months to be ready for phase two of the platform to begin the work of quality and population health use. 2022 adds an HIT bonus program where UHA encourages providers to connect their EHR to the system and use the platform for their population health analytics. This work, while slow, is coming along and expect to be able to see community results and will be able to capture SDOH, REAL + D and SOGI when that is defined. This data will assist in creating further developed VBPs.

UHA has been very active in rolling out Collective Medical for use in all the practices including dental and behavioral health. This tool is instrumental in capturing and being able to manage high utilizers of the ED and unplanned inpatient stays where discharge planning is critical for the success of the members. The capture of this data assists in VBP metrics where we are working to reduce the overuse of ED.

While still in the implementation period, UHA is spearheading the deployment of Connect Oregon (CIE) in Douglas County. First participants will join the platform by the end of May 2022, and UHA hopes to use some of the data to inform decision making on expanded VBPs towards population health. Our most significant achievements from our 2021 HIT Roadmap submission has been our ongoing collaboration and engagement with our community partners by identifying the CIE in Douglas County. We spent most of 2021 engaging our partners and have implemented Connect Oregon in 2022. We will use future data from Connect Oregon to inform our VBP arrangements with our providers and CBO partners.

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

There have been no changes in UHA's HIT tools except what was reported in previous years. The implementation of Connect Oregon was very successful. UHA has seen a significant utilization across Douglas is consistently one of the higher utilized county[OBJ] [OBJ]

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

MAY 2021

In December 2020 UHA implemented their new population health platform, Arcadia. This population health management platform provides additional HIT tools to better manage population health such as development of provider specific reports delivered through Arcadia's Bindery functionality.

Arcadia is currently used primarily as a Case Management tool that works to identify members that are high risk, prioritized population such as SPMI, programs that we manage such as Hepatitis C, and Health Risk Assessments. However, phase two will be visible to provider groups to assist in closing of gaps, risk assessment, and will enable us to assist providers to optimize financial outcomes in both value-based care and fee-for-service payment models while empowering opportunities to deliver quality care. This tool will assist in:

- Aggregating disparate data from across the care continuum- from I, to unstructured note and health claims – into one common data asset that facilitates value-based care
- Enabling comprehensive views of target populations by generating longitudinal views of individual patients and customizable patient cohorts, across multiple contracts
- Engaging patients with optimized resources by automating workflows around care management
- Meeting health equity goals by identifying patients most likely to benefit from interventions
- Seamlessly surface actionable insights to providers at the point of care to act on quality and risk gaps
- Reconciling contract performance against plan-generated reporting

MAY 2022

In mid-2021 UHA added Tableau a data visualization software to its HIT analytics toolbox. Tableau has been widely accepted throughout the organization, as well as providing real-time reporting from its wide range of data sources. The Tableau reports range from appeals and grievances dashboards that include REAL+D member stratification, to total cost avoidance. Recently UHA was recognized by the Criminal Justice Commission and the OHSU Technical Assistance Outreach teams for its robust Tableau reporting for its work under a statewide grant.

Tableau data sources currently include Medical/Dental/BH data from our third-party claims administrator, Rx data from the UHBI database, care coordination data from Arcadia. It also includes reference data from government agencies (OHA/CMS) that includes a wide range of information from member demographics such as REAL+D to physician federal register relative value units. Doing so allows UHA to coalesce multiple data sources into a single location for the purposes of developing Tableau dashboards for internal and external parties

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

UHA continues to expand on the number of reports generated in Tableau for real-time access to data for internal/external parties. Currently working to develop a comprehensive dashboard which tracks non-CCO incentive metrics.

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.

MAY 2021

UHA has doubled its programming and analytics workforce by bringing the programming department in-house, as well as new staffing hires to deepen its technical expertise that allows for SQL database reporting for all claims data, including pharmacy and dental as well as all membership files. UHAs investment in workforce and training of its analytics team allows UHA to maintain and excel at reporting and increasing their VBPs and population management into the future.

MAY 2022

UHA has committed to investing in its analytics team through education and training to strengthen the report writing capabilities through SQL. UHA expanded its staffing model with two new analytics team members, a business analyst and software developer, were hired to support the developers and decision support teams. These skill sets enhance the ability query and analyze the data for high level decision maker or identify areas to improve, including the development of VBPs.

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

UHA expanded our data analytics team by adding a VBP analyst to develop, track, and monitor our VBP program. All of the analytics team members attend additional training to further develop their analytics and reporting skills, which will assist in developing metrics dashboards for outside entities to review on a regular basis.

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.

MAY 2021

UHA's HIT analytics software, Umpqua Health Business Intelligence (UHBI), through its secure provider portal, allows providers to review their status on all claims based CCO quality metrics at any time throughout the year. UHA continues to expand transparency to providers for better care coordination and improve health outcomes through its HIT analytics software UHBI.

MAY 2022

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

As part of our HIT Roadmap and CCO 2.0 application Umpqua Health dedicated and identified significant HIT tools and resources that it will be deploying over the five-year period. Such resources include expanding and enhancing our internal analytics team, adding to our internal software development team, procuring a new population of health platform; Arcadia, deploying a CIE with Connect Oregon, greater utilization of Collective Medical throughout the community, and enhancing our HIT bonus program so all our provider community is participating in data exchange.

b. spread VBP to different care settings, and

We successfully deployed a Hospital and Maternity Care combined VBP using our HIT analytics software UHBI that went into effect January 1, 2022. We plan to further develop and utilize our software and solution to expand to Dental and Children's Healthcare VBPs in 2022 for deployment in 2023.

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

UHA feels confident that we have the right tools to perform VBP reporting, however most of our focus will be on making our reports more meaningful by leveraging our technology using Tableau and phase two of our population health platform, Arcadia where it will:

- Aggregate disparate data from across the care continuum – frIEHR, to unstructured note and health claims – into one common data asset that facilitates value-based care
- Enable comprehensive views of target populations by generating longitudinal views of individual patients and customizable patient cohorts, across multiple contracts
- Engage patients with optimized resources by automating workflows around care management
- Meet health equity goals by identifying patients most likely to benefit from interventions
- Seamlessly surface actionable insights to providers at the point of care to act on quality and risk gaps
- Reconcile contract performance against plan-generated reporting

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.

UHA believes we have exceeded the VBP requirements through calendar year 2023 and are working on the final CDA (Dental care).

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

UHA wrapped up and rolled out a Children's CDA VBP to incentivize providers for providing care to UHA assigned DHS children. UHA will look to expand on the final CDA (Dental) by the end of the year.

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:

UHA has continued to integrate non-claims based data into its reporting process, utilizing the case management data from Foundry (Arcadia's raw data warehouse) to expand on the total analysis of member care, such as tracking members who are homeless through Z codes and HRA responses, increasing efficiency in HRS tracking to related member cases, etc.

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.

UHAs HIT analytics software, Umpqua Health Business Intelligence (UHBI), through its secure provider portal, allows providers to review their status on all claims based CCO quality metrics at any time throughout the year. UHA continues to expand transparency to providers for better care coordination and improve health outcomes through its HIT analytics software UHBI.

UHA also provides metrics updates at the request of providers and are currently developing a more comprehensive performance dashboard in Tableau for non-CCO Metrics related contract incentive payments in CY2023 for real-time performance tracking.

Briefly summarize updates to the section above:

UHA continues to work with its community partners to ensure that providers are aware of the data that is readily available on the UHBI platform and has begun to build a consolidated performance metrics dashboard for ease of access to non-CCO incentive metrics.

18) You provided the following information about successes or accomplishments related to using HIT to administer VBP arrangement:

MAY 2021

In 2020, UHA spent a considerable amount of time developing reports to support providers' VBP. Through a multidimensional workgroup, UHA was able to develop a report that provides clarity on the 'whole' member cost of care. Partnering with external actuaries and incorporating their recommendations to avoid unfairly penalizing or rewarding providers who have an overall relative prevalence of higher costs or lower cost members. After the reports were developed, UHA brought them to a large provider stakeholder group to review and provide feedback. The feedback was immensely important as it further allowed UHA to craft a report that providers could speak to, and say they had a role in its development.

Through the work of UHAs programming department, UHA is prepared to roll-out, on its UHBI secure provider portal, the Member Attribution Cost Summary (MACS) report as mentioned in 6.a above during the first quarter 2021. The provider portal of the MACS report allows providers to compare their performance to other clinics at a summary level. Clinics also have availability to drill down to their specific attributed members:

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This HIT Platform allows providers to not only monitor to achieve their VBPs but also allows providers to develop care coordination for members through better understanding of the members' overall healthcare.

MAY 2022

The MACS/NPR reports are reviewed at monthly provider facing meetings. UHA continues to encourage providers to access their MACS/NPR reports through the secure provider portal. UHA's Quality Department works with all PCP clinics to provide training on how to access OHA Incentive Metrics related data reports and, as part of this training UHA shares the User-Manuals which provide step-by-step guidance for navigating the UHBI Platform. All updates to the UHBI Platform are highlighted by banners within the system each time the user logs in.

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

To align risk stratification of members to the same methodology as used by OHA for purposes of rate setting, UHA engaged Milliman in late 2021 to move from Milliman Mara Concurrent risk stratification to CDPS+Rx. [redacted]

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

Having more complete race and ethnicity data from the eligibility files. Another challenge is rolling out VBPs to new CDAs in which they typically do not have a strong HIT infrastructure such as behavioral health and dental providers.

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

UHA has concerns for gathering REAL+D and SOGI data for members who decline to provide a response in those related fields when performing assessments. Creates a large data limitation in REAL+D/SOGI analytics exercises. UHA is considering launching a pilot program that could potentially get this information through select pharmacies in the local area through relevant assessments.

In regards to the VBPs for required CDAs, UHA decided to implement a simple approach related to increasing utilization for specific areas of care, such as our program for the children's health VBP.

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.

MAY 2021

UHAs provider portal, through their Umpqua Health Business Intelligence (UHBI) software platform, allows providers to securely access their CCO Quality Metrics, based on claims data, at their convenience. UHA has also expanded this program to allow Primary Care Providers secure access their performance of the Member Attribution Cost Summary (MACS) with the goal of collaborating amongst the provider network to achieve the triple aim. [redacted]

UHA socializes VBP reports and other health plan related reports with its provider network through its monthly Quality Metrics Workgroup and Delivery System Advisory Committee meetings. UHA will be socializing VBP reports through quarterly Provider Network meetings in 2021, this includes the MACS and NPR reports as discussed above. Based on provider feedback we have expanded our report library shared at these meetings.

Each week, UHAs Customer Care team securely distributes member attribution reports to each of its PCP network providers. This allows providers to identify new members and provides opportunities for direct outreach and care coordination. Beginning in March 2021, from information on the member attribution reports providers will be able to log onto UHAs HIT secure provider portal–UHBI - [redacted]

MAY 2022

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

We have successfully embedded our MACS/NPR report into our UHBI secure provider portal which allows providers to receive a static report monthly. This report allows them to see their performance measures and will provide significant insight on their VBP performance. In addition, UHA has deployed Arcadia as their Case Management and population of health solution which allows the organization to ingest significant amounts of clinical documentation from our provider community. We have successfully onboarded and digested clinical data from three provider practices thus far and will be using that information to help determine future VBP's as well as communicate those VBP's and the performance of those VBP's in the Arcadia desktop solution.

b. Providers receive accurate and consistent information on patient attributon.

UHA continues to securely distribute member attribution reports to each of its PCP network providers weekly.

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

UHBI, Arcadia, Collective Medical and Tableau

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.

In the second half of 2022, UHA enhanced the community metrics scorecard to calculate the percent of attainment for overall CCO Metrics performance for each individual participating clinic. Through our secure provider portal, clinics can access their CCO Quality Metrics scores at any time to view their total percent of attainment as it pertains to their VBP contract requirements to achieve a minimum percent threshold of met status.

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

Process remains unchanged

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

Data sources remain unchanged

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.

MAY 2021

UHA incorporates Milliman MARA concurrent risk scores at the member level, on a monthly basis into its business intelligence platform UHBI to provide member level risk stratification reports for various cohorts or categories of need to identify for case management with the purpose of improving outcomes. UHA also uses the state MEPP fka Prometheus database for purposes of targeted area of potentially avoidable costs (PACs).

MAY 2022

Beginning January 2022, UHA will transition from Milliman Mara Concurrent risk stratification to the same methodology used by OHA, [redacted]

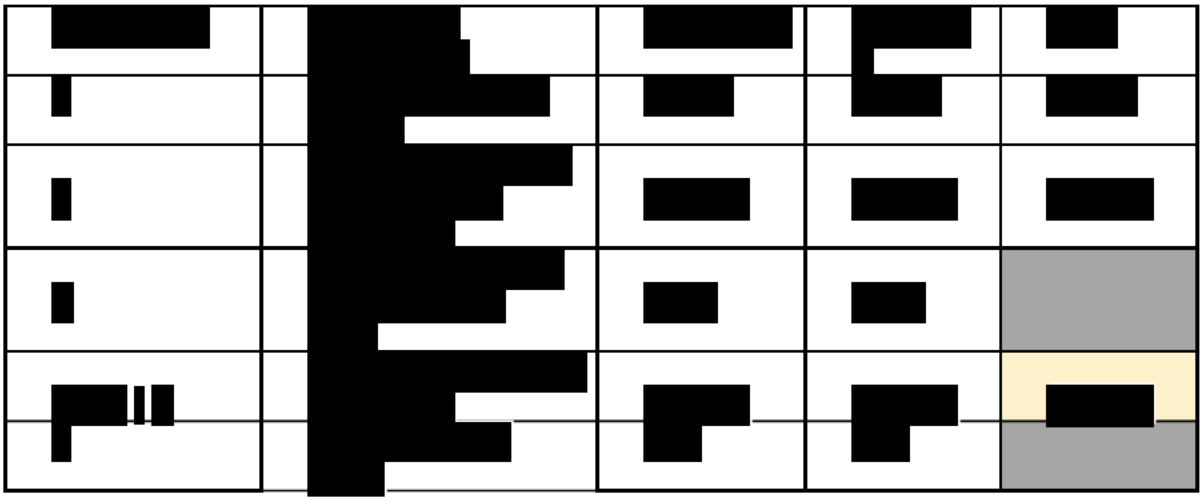
Please note any changes or updates to this information since May 2022.

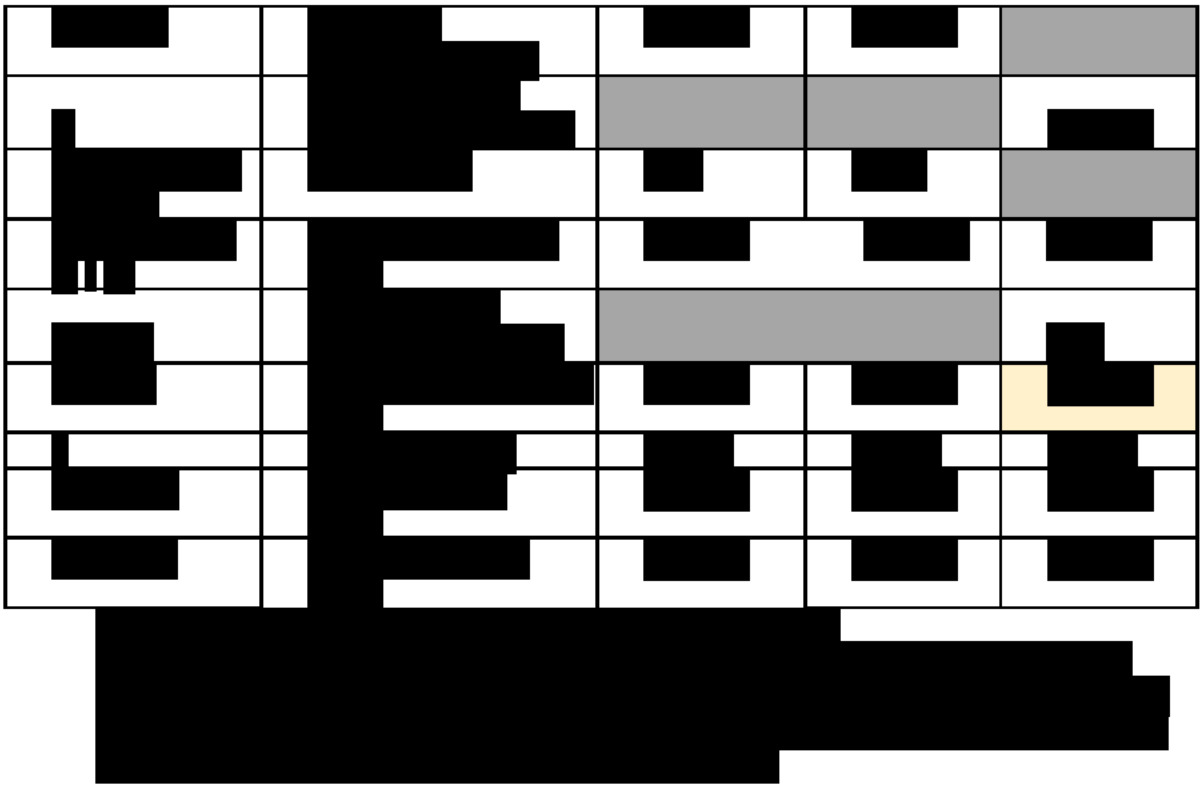
[redacted]

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.

MAY 2021

[redacted]





MAY 2022

[redacted]

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

[redacted]

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

Estimated percentage	Reporting method
10%	Excel or other static reports
45%	Online interactive dashboard that providers can configure to view performance reporting for different CCO populations, time periods, etc.
45%	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)?

CCO Incentive Metrics that are utilized in VBPs are tracked through our business intelligence platform, UHBI. There, UHA's contracted provider panel can review both the plan's current performance for the selected year, as well as monitor their own specific quality performance, in real time. For other contract metrics, data is supplied in meetings with the contracted entities, as well as upon request.

For Hospital/Maternity, both the hospital (Mercy Medical Center) and UHA track the number of DRG deliveries by type throughout the year and monitor the cesarean rate.

For Oral Health, the DCO tracks the metrics utilizing their own analyst, comparing their data with UHA's, monthly.

For the children's health care measure, providers have access to real time data through UHBI and the related DHS measure to see current performance. Additionally, contracted providers receive notifications and gap lists from UHA to provide them ample time to schedule and address members within the required time frame.

For behavioral health care, some contracts have quality measures that the entity is required to report on to UHA, as they are access measures related to data that isn't entirely based in claims. Data is reviewed quarterly, and auditable through compliance reviews.

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

MAY 2021

[redacted]

MAY 2022

[redacted]

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

[redacted]

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

UHA does not foresee any challenges to achieve our goals as related to VBPs.

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

No changes.

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?

None as of yet.

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

UHA believes that, short of implementing the dental VBP expansion in 2024, we are ahead of the established timeline.

<u>Optional</u>
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?

- UHA has a query concerning the 4C LAN model.
- Additionally, UHA has a query concerning the ability to penalize PCPCHs for closing panels (e.g. reduction in PCPCH PMPM payment?).

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

APAC Question: An entity type list would be extremely helpful, whether it's by taxonomy type or NPI/Tax ID. How are other CCOs doing this?

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.