2024 CCO 2.0 Value-Based Payment (VBP) Questionnaire

Introduction

As described in Exhibit H, Section 6, Paragraph b of the 2024 contract, each Coordinated Care Organization (CCO) is required to complete this VBP Questionnaire (previously VBP Pre-Interview Questionnaire).

Beginning in 2024, OHA will no longer be conducting VBP Interviews with CCOs. This document will be submitted as a standalone deliverable that will not precede an interview.

Your responses will help OHA better understand your CCO's value-based payment (VBP) activities for 2023-2024, including detailed information about VBP arrangements and HCP-LAN categories.

Instructions

A pre-filled version of this document containing previously submitted information will be sent to your CCO's designated VBP contacts via email. Please complete and return it as a Microsoft Word document, via the Contract Deliverables portal located at https://oha-cco.powerappsportals.us/, by **May 3, 2024**. (The submitter must have an OHA account to access the portal.)

- When responses from previous years are provided, please provide an update on previously submitted information. Previous responses are provided as a reference point to ensure continuity in reporting.
- Please be thorough in completing each section of this document. Incomplete submissions will be returned for revision.
- Please provide responses for all required questions. Questions #3, #4, #10, and #32 are optional.
- All the information provided in this document is subject to redaction prior to public posting. OHA will communicate the deadline for submitting redactions after reviewing your submission.

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

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Section 1: Annual VBP Targets

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

1) In 2024, CCOs are required to make 70% of payments to providers in contracts that include a HCP-LAN category 2C or higher VBP arrangement.

In 2022 and 2023, you were asked to describe the steps your CCO has taken to meet the annual VBP target requirement. Your response is displayed below:

Cascade Health Alliance has had greater than 60% of payments to providers that include an HCP-LAN category 2C or higher VBP arrangement for several years. This includes capitation contracts for both primary care and dental as well as shared risk contracts for primary care, dental, mental health, hospital, and specialists.

In 2024, Cascade Health Alliance should meet the 70% target. It is a continued focus to add VBP arrangements to contract relationships with providers. A factor that makes this difficult is due to our service area being a rural area of Oregon. Some of services are provided out of area with non-contracted providers which can be out of our control.

How confident are you in meeting the 2024 requirement?

☐ Very confident
☒ Somewhat confident
☐ Not at all confident
☐ Other: Enter description

Describe the steps your CCO has taken to meet the 2024 requirement since May 2023:

Cascade Health Alliance evaluates contracts for the possibility of adding VBP components and does so where feasible.

Please describe any challenges you have encountered:

Cascade Health Alliance would perform at a higher level if we are able to add a VBP component to our PBM contract for pharmacy benefits.

2) In 2024, CCOs are required to make 25% of payments to providers in arrangements classified as HCP-LAN category 3B or higher (i.e., downside risk arrangements).

In 2022 and 2023, you were asked to describe the steps your CCO has taken to meet the shared risk requirement. Your response is displayed below:

As noted above, Cascade Health Alliance has in place capitation contracts and shared risk contracts for a large part of its network and met this requirement in 2022 and 2023 and will do so in 2024 as well.

How confident are you in meeting the 2024 requirement?

☒ Very confident
☐ Somewhat confident
☐ Not at all confident
☐ Other: Enter description

Describe the steps your CCO has taken to meet the 2024 requirement since May 2023:

There were no additional steps needed. Cascade Health Alliance had already met this requirement in previous years.

Please describe any challenges you have encountered:

None

3) **Optional: Can you provide an example of a VBP arrangement that you consider successful? What about that arrangement is working well for your CCO and for providers?**

Click or tap here to enter text.

4) **Optional: In questions 1-2, you described challenges that you have encountered in meeting annual VBP targets. How have you responded to and addressed those challenges as a CCO?**

Click or tap here to enter text.

Section 2: Care Delivery Area VBP Requirements

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

5) **a. What is the current status of the new or enhanced VBP model your CCO is reporting for the hospital care delivery area requirement?** (mark one)

☒ The model is under contract and services are being delivered and paid through it.

☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: 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)?

This model is under contract with the local hospital and for 2024 includes four components—
1. Upside and downside risk sharing
2. Achieving an early elective delivery rate of less than or equal to target.
3. Reduction of the all patient, all cause readmission rate
4. Reporting on SDoH assessment completion rate

Click or tap here to enter text.

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

NA

6) 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)?

This model targets the local hospital and obstetric patients. It is focused on elective delivery rates and has a target rate of less than and or equal to 5%.

The target was changed for 2024 to less than 3%.

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

NA

7) 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)?

This model is contracted with our largest behavioral health clinics and includes—
1. Upside and downside risk sharing
2. Achievement of a benchmark or improvement from the prior year's performance based on members receiving a qualifying follow up behavioral health service within 30 days of an initial evaluation.
3. Achieving a targeted Assertive Community Treatment Score or Wraparound Fidelity Index.
4. Provision of services qualifying for the OHA Initiation and Engagement Measure

2024 changes include replacing #2 above with the SAMSA first contact and time to evaluation metric (I-EVAL) for one contract. All contracts include a component of medical/clinical risk adjustment which was also included in 2023.

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

The portion based on the OHA Initiation and Engagement Measure is currently being added to provider contracts.

All measures are under currently included in provider contracts.

8) 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)?

This model is with all our contracted primary care dental (PCD) providers and includes—
1. Capitated payment for PCD services
2. Upside and downside risk sharing

3. Performance Payment based on performance on OHA dental quality measures
4. Performance Payment based on percentage of members seen of the average assigned panel size during the year
5. Payment for the reporting of Health Information Technology information

For 2024, added payment for completing of the annual Social Determinates of Health Survey and completing the Healthy Aspects of Kindergarten Readiness survey.

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

The portion based on OHA Quality Metrics is currently being added to provider contracts.

The quality metrics was added in 2023 and all elements are contracted in 2024.

9) 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)?

This model is contracted with pediatric primary care providers (PCP) and includes—
1. Capitated payment for PCP services retrospectively adjusted based on acuity
2. Upside and downside risk sharing
3. Performance Payment based on performance on OHA PCP quality measures
4. Performance Payment based on percentage of members seen of the average assigned panel size during the year and aligned to the acuity of the member

No changes in 2024.

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

The portion based on OHA Quality Metrics currently being added to contracts.

The quality metrics was added to the contract in 2023 and continues in 2024.

10) <u>Optional</u>: In designing new or enhanced VBP models in additional care delivery areas, what have you found to be most challenging? What is working well?

Click or tap here to enter text.

Section 3: PCPCH Program Investments

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

11) OHA requires that PCPCH PMPM payments made by CCOs to clinics are independent of any other payments that a clinic might receive, including VBP payments tied to quality. In September 2023, OHA provided updated guidance on this in the VBP Technical Guide.

Are the infrastructure payments made to your PCPCH clinics separable from other payments made to those clinics?

☒ Yes
☐ No

If no, please explain:

Click or tap here to enter text.

Section 4: Engaging with Providers on VBP

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

12) In May 2022 and 2023, you reported the following information about how your CCO engages partners (including providers) in developing, monitoring or evaluating VBP models.

2021: Cascade Health Alliance (CHA) created an Alternative Payment Model (APM) Committee in November of 2015. Its members are made up of primary care providers, specialty providers, behavioral health providers, and community at-large members. The Committee met monthly until various alternative payment methods were decided upon and now functions as an ad hoc committee, meeting as needed. In September 2015, CHA applied for technical assistance from Oregon Health Authority via the Center for Evidence Based Policy at Oregon Health & Science University Center. As part of this initiative, the technical assistance enabled CHA to explore various health care payment learning & action network (LAN) payment models and enhance our journey and strategy around value-based payments.

Annually, CHA meets with its providers that have a value-based payment component as part of their contract to discuss any changes needed for the following year. Changes would include updating the quality measures included in the contract and/or the targets or measurements of success to ensure the appropriate outcomes. These changes are finalized through a contract amendment.

CHA monitors VBP's throughout the year, creating both dashboards and gap lists. These are shared with providers throughout the year.

2022: No changes

2023: CHA is adding more specific information describing the distribution of OHA quality pool funds to provider contracts in 2023.

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

2024: No changes

13) 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]:

Click or tap here to enter text.

14) Have you had any providers withdraw from VBP arrangements since May 2023?

☐ Yes
☒ No

If yes, please describe:

Click or tap here to enter text.

Section 5: Health Equity & VBP

The following questions are to better understand your CCO's plan for ensuring that VBP arrangements do not have adverse effects on populations experiencing or at risk for health inequities.

15) In May 2022 and 2023, your CCO reported the following information about how you mitigate for the possible adverse effects VBPs may have on health outcomes for specific populations (including racial, ethnic and culturally-based communities, LGBTQIA2S+ people, people with disabilities, people with limited English proficiency, immigrants or refugees, members with complex health care needs, and populations at the intersections of these groups).

2021: CHA will use historical cost and quality performance information to set VBP targets. We plan to set the performance targets that trigger an incentive payment at either the CHA target or improvement from the contracted provider's prior year performance using the Minnesota method. This will decrease the likelihood that the VBP will adversely affect any of the specific populations listed above.

CHA has implemented risk adjustment VBP models that will calculate and report documented medical complexity for members assigned to PCPs and members treated by specialists. Providers that care for members with higher documented medical complexity have the potential to receive an increased share of VBPs. Medical complexity is a VBP balancing measure and will decrease the likelihood of VBP adversely affecting members with high medical complexity.

In the future, CHA plans to develop the capacity to measure and track social complexity for members and incorporate social complexity in our VBP methodology.

CHA also monitors the number of members that are "fired" from Providers taking capitation payments by tracking all PCP and Oral Health member assignment changes which includes changes initiated by both the provider and the member. Member-initiated requests are valuable to look for more subtle methods which providers may use to deselect members. CHA also tracks all patient grievances related to providers. Assignment changes and complaints are tracked and in the case of primary care and oral health providers, rates are calculated. Data feedback is reported to providers. If CHA identifies a provider in an outlier

status for assignment changes or grievances, CHA will pursue the following interventions as appropriate:

- Provider notification of outlier status
- Ongoing monitoring
- Request for Provider assessment of the root cause
- Request for Provider development of a Corrective Action Plan
- Eventual consideration of financial penalties, exclusion from VBP participation or possibly network participation

2022: CHA has added a complexity/burden of illness component of its VBP model for behavioral health providers.

2023: CHA has begun to collect member level data for EHR metrics, including REALD data. Analysis of performance on each metric related to REALD is performed quarterly and shared with providers. Phase one of the Health Equity Dashboards will be implemented and include REALD data as it relates to top chronic diseases for our population.

Please note any changes to this information since May 2023, including any new or modified activities.

CHA is in the process of implementing population health and health equity dashboards. CHA plans to use REALD data to not only monitor but actively improve health outcomes. CHA plans to set specific equity-focused performance targets for providers that directly address disparities in chronic disease management and prevention among underrepresented groups. CHA has not determined how this will be incororated into VBPs.

16) **Is your CCO employing medical/clinical risk adjustment in your VBP payment models?** [Note: OHA does not require CCOs to do so.]

☒ Yes
☐ No

If yes, how would you describe your approach?

There is an inherent disincentive in FFS methodologies for providers to serve medically/clinically and socially complex members. CHA seeks to reduce that disincentive and reward providers that care for complex members. Capitation payments to primary care clinics are adjusted for medical/clinical risk documented from ICD codes provided with encounter data. Fee for service payments to specialist providers are adjusted by medical/clinical risk of the members that they have cared for. Behavioral health provider payments are tied in part to improved documentation of medical/clinical risk.

How would you describe what is working well and/or what is challenging about this approach?

Providers serving members with greater medical/clinical risk receive a small increase in compensation. Providers have historically had no incentive to capture risk data and have not

prioritized capturing medical/clinical risk. Some providers are becoming more aware of the importance of this activity.

17) 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.]

CHA's 2024 VBPs with its contracted local hospital includes the collection of SDOH data on patients admitted to the facility for impatient and observation stays. CHA plans to change in 2025 to reporting of SDOH data for our members.

CHA is working to measure and track social complexity and anticipates integrating social complexity metrics into our VBP models. This will ensure that payments more accurately reflect the care needs of members with both medical and social complexities, particularly benefiting those in marginalized communities. Specifics of how CHA will do this are yet to be determined.

Section 6: Health Information Technology and VBP

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.

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

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

2021:

- **SQL Server and Quantum Choice Plexis:** CHA utilizes SQL Server and run regular queries to produce the population health management and VBP details we need to disseminate internally and with contracted providers and major clinics. This reporting includes all attributed provider gap lists and current progress status towards VBP agreements.
- **Tableau:** Utilized for visualization of Provider Dashboards.
- **Reliance eHealth Collaborative:** CHA has built full capabilities internally to produce OHA quality measure reporting for progress and gap list reporting. CHA also utilizes Reliance as a validation tool for quality measure performance tracking. CHA has also been working with Reliance since 2020 to populate all claims & EHR measure data as

well. This duplication between CHA and Reliance has enhanced the quality of this measure reporting

2022: None

2023: None

Please note any changes or updates to this information since May 2023:

In Q4 of 2023 CCC completed full implementation of Milliman's MedInsight population platform for analyzing, risk stratification, and reporting.

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

2021:

- **Milliman PRM Analytics:** Population Management tool to assist in risk stratification for leadership and CM assignment for intervention and care plans. This is a predictive model platform that ingests CHA claims monthly and applies patented algorithm logic models from PRM Analytics. Reports are generated through the user interface based on cohorts built within the tool.
- **Pareto Intelligence:** Currently, CHA utilizes provider scorecards to generate insights on providers' performance across multiple dimensions and inform the actions providers should take to improve clinical performance. This tool also generates suspected and captured chronic condition reporting for each attributed provider. Elements of these current scorecards/reports include the following:
  i. Captured clinical score vs. target clinical score.
  ii. Clinical recapture percentage.
  iii. Condition prevalence.
  iv. Members with captured conditions.
  v. Members with suspected conditions.
- **Collective Medical:** CM utilizes alert notifications, cohorts, flags, and reporting tools to assist in care coordination efforts, complex needs, and population health management.

2022: In 2021 CHA receives the Clinic Network Engagement Metrics report from Collective Medical that shows utilization metrics for the clinics in our network. This report is utilized to track adoption and target education for clinics not currently engaged in Collective Medical. In 2022 CHA is continuing to financially support the Collective Medical EDie Insights tool for the provider network.

2023: In 2023 CHA is in current development of a new population management tool upgrade and transition from Milliman's PRM Analytics to MedInsight platform. CHA anticipates full transition completed by Q4 2023. The new platform will include enhanced reporting capabilities with advanced query tools and assist in future VBP arrangement adjustments. The new platform provides additional industry leading groupers, methodologies, benchmarks and machine learning capabilities. With this implementation, CHA anticipates a deeper understanding of the member population and the providers services that impact their overall health.

Please note any changes or updates to this information since May 2023:

In Q4 of 2023 full implementation was completed of Milliman's MedInsight population health platform.

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

2021: CHA currently has a department (Business Intelligence) dedicated to support writing, running reports, maintain databases and network, and assisting staff with understanding data to include: (2) Data Analysts, (1) Database Administrator, (1) IT Systems Administrator, and (1) Director of Decision Support & Business Intelligence. These team members also support administration of platforms listed above related to reporting for VBP and Population Health Management. This department also utilizes Pareto Intelligence as a 3rd party consultant for producing additional data analysis reports regarding VBP arrangements and population health management.

2022: In 2021 CHA made some adjustments to the in-house staff regarding reporting and data analytics. The Director of Decision Support & Business Intelligence was promoted to Chief Operations Officer (COO), a Data Analyst was promoted to Business Intelligence Manager. Now reporting directly to Chief Financial Officer. There are still (2) Data Analyst and (1) Database Administrator. The IT Systems Administrator was moved to Operations department and reports directly to the COO.

2023: The current Business Intelligence department is made up of the Business Intelligence Manager, two Senior Data Analysts and one Data Analyst. This department continues to report directly to the CFO.

Please note any changes or updates to this information since May 2023:

In Q2 2024 the Business Intelligence department increased capacity with the addition of a new role of an Application Support Analyst.

20) 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. **How you will spread VBP to different care settings**
c. **Plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract**

2021: Pareto Intelligence: Along with risk adjustment performance data, CHA currently utilizes provider scorecards to generate insights on providers' performance across multiple dimensions and inform the actions providers should take to improve clinical performance. CHA plans to expand the report to include additional insights and

combine quality metric gaps by Q1 2022. This tool also generates suspected and captured chronic condition reporting for each attributed provider. By Q4 2024 CHA plans to integrate these Provider Scorecards and chronic condition reports within a Provider Portal for real-time access for attributed providers. Elements of these current scorecards/reports include the following:

- Captured clinical score vs. target clinical score.
- Clinical recapture percentage.
- Condition prevalence.
- Members with captured conditions.
- Members with suspected conditions.

Tableau & SQL Server: In 2020 CHA successfully implemented an in-house solution for creating Oral and Medical Health reporting dashboards (described above) with quality metric and VBP results to attributed providers.

CHA's current VBP agreements include some OHA quality measures and other alternative local community focused incentives. By 2023 CHA intends to expand these local community focused incentives VBP to include local needs within the Klamath Falls community related to SDOH/HE

2022:

a. No changes expected
b. No changes expected
c. No changes expected

2023: In 2023 CHA is in current development of a new population management analytics tool upgrade and transition from Milliman's PRM Analytics to MedInsight platform. CHA anticipates full transition completed by Q4 2023. The new platform will include enhanced reporting capabilities with advanced query tools and assist in future VBP arrangement adjustments. The new platform provides additional industry leading groupers, methodologies, benchmarks, and machine learning capabilities. With this implementation, CHA anticipates a deeper understanding of the member population and the providers services that impact their overall health.

Please note any changes or updates for each section since May 2023.

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

Utilizing multiple platforms and data validation from Business Intelligence department provides expansive data options for monitoring provider progress in multiple facets, even outside current VBP arrangements. This allows leadership to monitor provider encounters and trends for potential future arrangements.

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

CHA has incorporated Specialty, Dental, Behavioral Health, Primary Care, and Hospitals in the VBP today.

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:

Plans would be managed by an Operations Project Manager and documented in HIT Roadmap.

21) 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 2022 and 2023. If the field below is blank, please provide updates on specific milestones from your 2021 HIT Roadmap submission.

2021: Pareto Intelligence: Along with risk adjustment performance data, CHA currently utilizes provider scorecards to generate insights on providers' performance across multiple dimensions and inform the actions providers should take to improve clinical performance. CHA plans to expand the report to include additional insights and combine quality metric gaps by Q1 2022. This tool also generates suspected and captured chronic condition reporting for each attributed provider. By Q4 2024 CHA plans to integrate these Provider Scorecards and chronic condition reports within a Provider Portal for real-time access for attributed providers. Elements of these current scorecards/reports include the following:

- Captured clinical score vs. target clinical score.
- Clinical recapture percentage.
- Condition prevalence.
- Members with captured conditions.
- Members with suspected conditions.

Tableau & SQL Server: In 2020 CHA successfully implemented an in-house solution for creating Oral and Medical Health reporting dashboards (described above) with quality metric and VBP results to attributed providers.

CHA's current VBP agreements include some OHA quality measures and other alternative local community focused incentives. By 2023 CHA intends to expand these local community focused incentives VBP to include local needs within the Klamath Falls community related to SDOH/HE

2022: **Tableau & SQL Server**: In 2020 CHA successfully implemented an in-house solution for creating Oral and Medical Health reporting dashboards with quality metric and VBP results to attributed providers. By Q4 2024 CHA plans to integrate Provider Risk Scorecards and chronic condition reports within a Provider Portal for real-time access for attributed

providers. In 2022 CHA expanded the reporting to include additional insights and combined quality metric gap opportunities.

In 2021, CHA continued to use Pareto Intelligence, Tableau, and SQL Server to administer VBP arrangements and reporting.

In early 2021, Tableau dashboards with VBP metrics and quality metrics were finalized and shared with attributed providers.

Working in partnership with Pareto Intelligence, the combined report for risk adjustment related chronic conditions and quality metric gaps was developed as expected by Q1 2022.

2023: In 2023 CHA is in current development of a new population management analytics tool upgrade and transition from Milliman's PRM Analytics to MedInsight platform. ~~CHA anticipates full transition completed by Q4 2023.~~ In Q4 of 2023 full implementation was completed of Milliman's MedInsight population health platform. The new platform will include enhanced reporting capabilities with advanced query tools and assist in future VBP arrangement adjustments. The new platform provides additional industry leading groupers, methodologies, benchmarks and machine learning capabilities. With this implementation, CHA anticipates a deeper understanding of the member population and the providers services that impact their overall health.

Briefly summarize updates to the section above:

Updated the plan to implement to now implemented.

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

2021: Pareto Intelligence: CHA utilized this tool in 2020 to produce Specialist Risk Adjustment reporting with attribution logic based on services provided to a member in that year. By Q4 2024 CHA plans to integrate these reports with a Provider Portal for real-time access.

Tableau & SQL Server: In 2020 CHA successfully implemented an in-house solution for creating Oral and Medical Health reporting dashboards in 2020 (described above) with quality metric and VBP results to attributed providers.

In 2020 CHA conducted a Quality Metrics monthly meeting with Primary Care Physicians (PCP) to discuss the overall performance along with barriers or concerns, shared successes, and best practices. CHA was able to utilize in-house capabilities for generating the Quality Metrics Dashboard visualization and gap lists. CHA was also successful in conducting a BH Metrics monthly meeting facilitated by the CHA CM & BH Director.

2022: N/A

2022: No changes

Please note any changes or updates to these successes and accomplishments since May of 2023.

Utilizing multiple platforms and data validation from Business Intelligence department provides expansive data options for monitoring provider progress in multiple facets, even outside current VBP arrangements. This allows leadership to monitor provider encounters and trends for potential future arrangements.

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

2021: COVID-19 related activities and extra work/guidelines/safety procedures for providers and clinics.
2022: N/A
2023: N/A

Please note any changes or updates to these challenges since May of 2023.

N/A

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

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

2021: **Tableau:** CHA has created a specific visualization, Oral and Physical Health Metrics Dashboards monthly that includes VBP in the contracted provider agreements. By Q4 2023 CHA plans to utilize Tableau Server to provide web-based real-time access for Quality Measure and VBP agreements progress and results across all provider types. In 2020 CHA disseminated this information via secure emails with attributed providers.

Pareto Intelligence: Along with risk adjustment performance data, Pareto produces attributed Provider Scorecards described above and updated monthly and disseminated by Compliance and Provider Network Management department on a regular basis (min. Quarterly) via secure email. CHA also utilizes this tool in 2020 to produce Specialist Risk Adjustment reporting with attribution logic based on services provided to a member in that year. These results are disseminated on an annual basis since members are not assigned to a Specialist.

The above reporting includes monthly actionable services gap lists sent by secure email that includes updated member attribution and current eligibility for each provider. Specialist attribution is based on annual progress reports of attribution logic for members who received services by the Specialist provider in that year.

2022:

a. Change in responsibility for disseminating reports from Compliance to Risk Adjustment.
   In 2022 CHA expanded the reporting from Pareto to include additional insights and combined quality metric gap opportunities.
b. Not included in previous submission, oral health and physical health providers are sent updated full member rosters weekly with change reports sent daily.
c. No changes

2023: Not included in the previous submissions, however, behavioral health providers are also sent VBP metrics performance information monthly.

Please note any changes or updates to your strategies since May of 2023.

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

Yes, shared at least quarterly.

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

Yes, updated and reported monthly

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

Delivery via secure email, and some providers are set up with a sFTP for sharing data reports.

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

25) You previously reported the following information about how your CCO <u>uses</u> data for population management to identify specific patients requiring

intervention, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes.

2021: SQL Server and Quantum Choice Plexis: CHA has an internal Data Analyst team that utilizes SQL Server and run regular queries to produce the Population Health Management details we need to disseminate internally and with contracted providers and major clinics. This reporting includes all attributed provider gap lists. Additional Population Health Management reporting is available to identify specific members in need of intervention based on historical data and services available within submitted claims in Plexis.

Milliman PRM Analytics: Population Health Management tool to assist in risk stratification for leadership and CM assignment for intervention and care plans. This is a predictive model platform that ingests CHA claims monthly and applies patented algorithm logic models from PRM Analytics. Reports are generated through the user interface based on cohorts and specific data points built within the tool.

Accessmobile: In 2020 CHA completed multiple campaigns for targeted cohort text messaging for Population Health Management efforts that included: Health-Related Goals, Improving Health Literacy, Flu-Shot Education, Breast Cancer Screening, Colorectal Cancer Screening, Medical Supply Delivery, Breathing Issues, Child/Adolescent Immunizations, Telehealth, Available Benefits, PPE Distribution, Stress, Community Information Exchange, SDOH/HE Surveys, and Behavioral Health Needs

2022: Accessmobile is now InOn Health.
In 2022, we are working on a pilot project with Pareto Intelligence and an additional analytics vendor to deploy predictive data models to measure/identify social risk across member populations.
Not included in previous submission:
Collective Medical: Collective Medical is utilized daily by CHA CM department to monitor cohorts built in Collective Medical, and service utilization by members with open cases to coordinate care, ensure member needs are being met, and reduce unnecessary use of services.
Reliance: Reliance eHealth is used by CHA to integrate the disparate information from multiple EHRs used within our service area. CHA pulls data from Reliance to validate and supplement EHR metric reporting. CHA's Business Intelligence department uses Reliance to help supplement member demographic information in reports sent to providers and partners, as well as reports used internally.

2023: In 2023 CHA is in current development of a new population management analytics tool upgrade and transition from Milliman's PRM Analytics to MedInsight platform. CHA anticipates full transition completed by Q4 2023. The new platform will include enhanced reporting capabilities with advanced query tools and assist in future VBP arrangement adjustments. The new platform provides additional industry leading groupers, methodologies, benchmarks and machine learning capabilities. With this implementation,

CHA anticipates a deeper understanding of the member population and the providers services that impact their overall health.

Please note any changes or updates to this information since May 2023.

In Q4 of 2023 full implementation was completed of Milliman's MedInsight population health platform.

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

2021: Pareto Intelligence: Attributed Provider Scorecards described above are updated monthly and disseminated by Compliance and Provider Network Management department on a regular basis (min. Quarterly) via secure email. There are occasions prior to the current COVID pandemic when Provider Network Management department would meet in-person to discuss current progress with an attributed provider and discuss intervention needs and how CHA can assist when necessary. During these times of provider intervention CHA may produce additional reports for Population Health Management to enhance the identification necessary interventions for those members in need of services.

Provider Network Management department conducts dissemination and collaboration at least quarterly for Physical and Oral Health Dashboards (described above), with attribution identification within gap lists for targeted provider intervention to assist in improving outcomes. CHA is currently researching technology solutions for enhancing sharing data related to VBP arrangements and Population Health Management. CHA plans to have a new HIT solution in place by Q4 2023. This solution will give providers a single web-based location with the most current data available produced by CHA and/or other data resources

2022: In 2022, we are working on a pilot project with Pareto Intelligence and an additional analytics vendor to deploy predictive data models to measure/identify social risk across member populations.

2023: No changes

Please note any changes or updates to this information since May 2023.

In Q4 of 2023 full implementation was completed of Milliman's MedInsight population health platform.

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

Estimated percentage	Reporting method

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

How does 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)?

No difference between provider types

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

2021:
Tableau: In 2020 CHA successfully created new Physical and Oral Health Dashboards and disseminated to attributed providers at least quarterly.

Pareto Intelligence: in 2020 CHA successfully created new Provider Risk Adjustment Scorecards for the provider and clinic level with all attributed members to include details on suspected and captured chronic conditions and other risk related details. CHA also successfully created Behavioral Health scorecards and chronic conditions reporting for the (2) major clinics with VBP arrangements for members seen in the last year

2022: No new changes

2023: No new changes

Please note any changes or updates to this information since May 2023.

In Q4 of 2023 full implementation was completed of Milliman's MedInsight population health platform.

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

2021: N/A
2022: N/A
2023: N/A

Please note any changes or updates to this information since May 2023.

N/A

Section 7: Technical Assistance

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

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

Incorporating health equity into VBPs.

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

More complete, validated, and updated HE data.

32) <u>Optional</u>: Do you have any suggestions for improving the collection of this information in subsequent years? If so, what changes would you recommend?

Suggest OHA incorporating into HIT Roadmap activities.