024 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 an 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:

The CCO maintains agreements with provider entities that qualify at not only the LAN 2C category, with quality pay-for-performance, but at level 3B with both shared savings and downside risk. Our current projections show that we are on track to meet these requirements.

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:

We have maintained all existing 2023 agreements in both the 2C and 3B LAN categories, and our current projections show that we are on track to meet the 2024 requirements.

Please describe any challenges you have encountered:

We have been able to successfully maintain our relationships and value-based contracts with our provider partners our region.

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:

The CCO maintains agreements with provider entities that qualify at not only the 2C category, with quality pay-for-performance, but at level 3B with both shared savings and

downside risk. Our current projections show that we are on track to meet these requirements.

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:

We have maintained all existing 2023 agreements in both the 2C and 3B LAN categories and our current projections show that we are on track to meet the 2024 requirements.

Please describe any challenges you have encountered:

We have been able to successfully maintain our relationships and value-based contracts with our provider partners in our region.

3) **<u>Optional</u>: 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?**

We have developed and maintained a comprehensive total cost of care agreement with a key regional partner. The shared cost savings and quality measure performance has ensured financial support for us and the provider, improved quality outcomes for our members, and enabled enhanced collaboration between our provider partner and the CCO.

4) **<u>Optional</u>: 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?**

N/A

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 <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)?

This model includes hospitals, PCPs, and BH providers and focuses on quality measures related to members with chronic conditions and specific health needs.

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

N/A

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)?

Given the low number of births distributed across a wide geographic area, creating a maternity only measure with a meaningful denominator is challenging, so our intention is to create a proposal that combines maternity and early life supports.

This continues to be a challenge for us; we are continuing to work with key providers in other regions to find a way to incorporate CPCCO members into maternity focused quality measures to ensure we meet this requirement 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.

We are currently in contract negotiations with a provider as outlined above to ensure we have a maternity CDA in place for 2024.

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)?

2023: We launched a Pay for Performance (2C LAN) program focused on incentivizing the behavioral health specialty network providers for providing high quality care and services focused on the following key domains: outpatient mental health, outpatient SUD, withdrawal management, and SUD residential.

2024: Our Pay for Performance, Quality Improvement Incentive Program (QIIP) focuses on incentivizing the specialty behavioral health network providers for providing and improving high quality care and services focused on the following key domains: outpatient mental health, outpatient SUD, withdrawal management, and SUD residential. In 2024 we are redesigning this program to ensure increased alignment with regional priorities and current provider-stated clinical gaps and quality improvement efforts.

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

N/A

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)?

The dental benefit is partially delegated to our dental plan partner organizations. Contracts currently include performance-based metrics that must be met to reach full payment from the CCO. Some of our partners are fully integrated, staffed care delivery models. Some dental plan partners also utilize various VBP models with their contracted provider networks.

Others offer a blended model with various payment strategies and LAN categories for different providers or provider types. Approximately [redacted] of provider payments are LAN 4A or higher. We continue to work with our partners to grow and enhance VBP opportunities for dental providers. Additionally, we have added an oral health component to our primary care payment model that incentivizes referral pathways to a dental home and the use of fluoride varnish in primary care

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

N/A

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)?

One of our key APM programs is our Primary Care Payment Model (PCPM) Program. The PCPM program contains three tracks that are focused on clinical subspecialities within primary care, one of which is pediatric care. We incentivize the pediatric clinics in our region through this program track and have one CPCCO clinic currently participating in the pediatric track. This is a Pay for Performance (2C LAN) program, and the quality measure set for this track is focused on key pediatric preventive activities, like immunizations, well visits, and social emotional health. All other CPCCO clinics participate in the Family Medicine track, which while not focused specifically on pediatrics, does have quality measures that incorporate the pediatric patient population.

We have continued to maintain our PCPM Program as outlined above. Additionally, our total cost of care arrangement includes quality metrics specifically focused on pediatric and adolescent populations.

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

N/A

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?**

The maternity CDA continues to be very challenging for us, given the demographics of our region.

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:

N/A

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:
Columbia Pacific CCO (CPCCO) actively collaborates with stakeholders and providers in the development, monitoring, and evaluation of VBP models across our physical health, behavioral health, and oral health networks. Providers are engaged at the beginning of the process to help identify quality measures through a shared, iterative process. Multiple data points are reviewed jointly, and key performance indicators are chosen. Once those areas are identified, targets for improvement are collaboratively agreed upon. A regular review process is then set up for the providers and CPCCO staff to review how the provider is performing. During these meetings, performance is reviewed, areas of improvement are

discussed, and technical assistance offered if needed to support the provider. Regular reports are provided on the VBP performance; however, 2021 reporting has been placed on hold due to the impact of COVID-19. The CPCCO Board was kept abreast of adaptations to the VBP made in response to COVID.

The CPCCO Board of Directors has knowledge of the VBP models and monitors CPCCO's Risk Shares via their Finance Committee and quality metric attainment via their Network & Quality Committee. Each of our three County Collaborative Risk Share groups also has a committee comprised of participating provider groups that meets regularly to monitor their performance throughout the year. CPCCO's leadership team meets with each of our clinic leadership teams on a quarterly basis to review individual performance on our Primary Care Payment Model and with our Community Mental Health Providers leadership teams to gather feedback on our behavioral health VBPs. In addition, CPCCO's Clinical Advisory Panel is comprised of a cross section of providers within the CPCCO network, and reviews performance indicators at both a clinic and CCO level. Committee recommendations based upon their expertise guide CPCCO improvement activities.

CPCCO is also working with a third-party evaluator on formal evaluation of the Primary Care VBP programs (Primary Care Payment Model [PCPM]). Preliminary results will be available at the end of 2021 and will be shared with network partners and used as a basis for program refinement.

2022:
The information above is still accurate. However, the timeline for the PCPM evaluation was pushed back slightly due to the COVID-19 PHE and inability to meaningfully engage participating providers in the qualitative portion of the study.
CPCCO also remains active in the above collaboratives except for the CPC+ state payer group due to sunset of the program.

The CCO is also in collaborative risk arrangements in each of its three counties. The partners include hospitals, primary care, and community mental health partners. The CCO shares performance data related to their total cost of care with each set of county partners every other month and quality metric performance data quarterly. For our more advanced partners, the CCO provides a claims data feed that enables their internal population segmentation tool to include cost analysis.

This TCOC model is intended to further the goals of the quadruple aim. Specifically, we hope to:

- Build shared ownership and accountability among partners in keeping Medicaid costs within the 3.4% cost curve.
- Foster collaboration on supporting the county's local Medicaid population through shared investment into quality improvement initiatives and/or local social health investments

2023: No changes

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

2024: The information above is still accurate with one exception, the PCPM evaluation was completed, and learnings were shared to Columbia Pacific and broader audiences by Providence Center for Outcomes Research and Education.

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]:

As outlined above, meeting the Maternity CDA requirement continues to be challenging, and providers are still generally risk averse, but we meet all other LAN and CDA requirements.

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

☐ Yes
☒ No

If yes, please describe:

N/A

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:

The activities described in the last report are still in place. Since September of 2020, CPCCO has completed our retrospective chart reviews and anonymous baseline assessment of our primary care clinics' ability to provide interpretation services to our members. The results were shared with each clinic individually and improvement initiatives have been discussed in our Quality Improvement Workgroup and clinic individual coaching sessions that are offered as part of our technical assistance. CPCCO also received the first equity narratives as part of our Primary Care Payment Model and incorporated the scores into clinic payment adjustments and quality improvement initiatives.

CPCCO also launched our Justice, Equity, Diversity, and Inclusion (JEDI) workgroup infrastructure. This effort includes nine workgroups focused on integrating equity into CPCCO's internal and external work. Our VBP contracts fall under the purview of the Resource Allocation and Contracting Practices workgroup that is responsible for auditing and monitoring how our VBPs are being used to further equity within our region.

CPCCO has also partnered with CareOregon on development of a Data Equity Guide which will inform analytic activities, including VBP performance measures, moving forward. The guide includes practical recommendations for integrating equity into data analysis and data visualization.

2022:

Since May of 2021 Columbia Pacific CCO has partnered with CareOregon to develop and implement staff training on Equity in Data Analysis. This training is intended for all staff members who research and prepare or consumes data and is reviewed by staff who develop information around our Value Based Payment programs.

This course offers concrete suggestions to think differently about how our CCO prepares and views data, specifically as it relates to demographic characteristics like race/ethnicity, sex assigned at birth, language and more. This course is a starting point in learning about the intersection of equity, diversity, & inclusion (EDI) and data.

Training Outcomes:

- Learn the definition of Data Equity and why it is important
- Discover options for changing the way we view or interact with data
- Locate resources for continued learning
- Understand why there is a need for continued learning

2023: The activities outlined in 2021 and 2022 remain an area of focus. In addition, we are beginning to explore ways to bring non-claims data into VBP work, such as EHR or patient-reported outcomes data. This work is in the early stages in 2023 and will include discussion on data ethics and how we should or not should be using different types of data for risk adjustment models or quality measurement associated with VBPs.

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

2024: No significant changes to the information above.

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?

CCO uses the CDPS+Rx risk score model to adjust targets for providers in trend-based and MLR-based shared savings models.

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

The use of CDPS+Rx aligns financial incentives for providers in VBP payment models and fosters collaboration with the CCO. Additionally, it mitigates risk for providers during periods of significant population changes.

One challenge is that providers tend to be less familiar with the CDPS+Rx model than another model such as the CMS-HCC model. This requires ongoing education to make sure they understand the nuances of the model. Another challenge is that CDPS+Rx does not factor in non-medical/clinical factors such as social determinants of health and cultural differences.

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.]

CCO is considering incorporating risk adjustment for social factors in future iterations of VBP models, but there are no concrete plans at this time.

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:
We use industry standard tools, processes, and practices for managing data and for assessing performance. Our tool set includes comprehensive EDW and Data Marts as data repositories. Our data repositories are primarily SQL Server Enterprise running on robust infrastructure. We use SSIS as our tool of choice for moving data between systems and databases. We use third party software platforms, such as Cotiviti, as well as internally programmed applications to assist with clinical quality measure calculation.

2022:

The information above remains accurate in 2022.

CareOregon has built an Enterprise Data Warehouse (EDW) for analytics. The warehouse is built using the Kimball Dimensional Model, converting raw data into star schemas for efficient and accurate ingestion and storage, and subsequently modeled into flatter analytical tables for analyst consumption.

2023: The information shared above remains accurate in 2023.

CareOregon will also begin implementing Epic Payer Platform with the goal of establishing bi-directional data exchange with key health systems and FQHCs to streamline data sharing processes and quality improvement measure development, monitoring, and reporting.

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

2024:
CPCCO in partnership with CareOregon will financially support our Federally Qualified Health Centers (FQs) who elect to participate with us in the EPIC Payer Platform (EPP)

data exchanges, to adopt EPIC's Value Based Performance Management (VBPM) and NCQA Certified HEDIS Measures analytics tools. These tools are designed to enhance each FQ's ability to manage and monitor their performance and the health of their populations associated with our value-based payment contracts and make optimal use of the data exchanges enabled through EPP.

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

2021: We use a variety of industry-leading tools to drive analytics. VBP data is ingested into our EDW, whereas Tableau is used for generating and distributing robust, meaningful, and easy-to-understand analysis dashboards and scorecards. Our Tableau infrastructure delivers these dashboards within our CCO and to our clinic partners. These dashboards are refreshed between weekly and quarterly depending on business needs.

We use SQL Server Reporting Services to deliver transactional and detailed reports to users on a regular basis. Frequency of these reports varies from real-time to quarterly depending on business needs.

Excel is used as a reporting tool where it is appropriate. CPCCO uses SAS auto jobs and other tools to generate these files on a regular basis. Frequency of refresh for these files varies from weekly to quarterly depending on business needs.

Tools such as R, SAS, SPSS, and Python are used for statistical and predictive modeling to answer advanced analytics questions such as identifying populations at risk of adverse health related events.

Tools such as the Johns Hopkins ACG are used for risk assessments and stratification of population, and other third-party tools are used to distribute reports. We use our care Coordination platform to provide up-to-date information on care coordination activities.

2022: The information previously reported remains accurate in 2022.

CareOregon utilizes an Enterprise Data Warehouse (EDW), along with the Cotiviti measurement and reporting software to integrate and aggregate Value Based Payment data. Data is calculated using these systems through SQL queries and direct analysis.

This data forms the basis for many reports that are delivered automatically and manually through SQL Server Reporting Services (SSRS) and other tools.

While we recognize that specific questions regarding HIT in OHA reporting deliverables are not duplicated verbatim, there is up-to-date information around our capabilities and strategies related to HIT for purposes of VBP administration, spread, and population health management in our 2022 HIT roadmap and ISCAT Tool. Both were recently submitted to the OHA.

2023: The information previously reported remains accurate in 2023. In addition, CareOregon is collaborating with our actuarial consultant, [redacted], to build and implement improved data tools and reports to our network partners who are in risk arrangements with the CCO.

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

No significant changes to the information above.

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:
We have robust data and reporting teams. In collaboration with CareOregon, we have 30 permanent data and analytics staff members who manage our HIT and databases, assure data quality, develop reports, conduct statistical analyses, develop predictive models, and perform other data/analytics functions across the enterprise. We can also subcontract to outside vendors if additional specialized skills are needed. Our team includes software developers, data architects, database administrators, business analysts and healthcare analysts; these skill sets cover the entire spectrum of activities and skills needed to deliver high quality analytics.

In addition, we have dedicated quality improvement and technical assistance staff to offer support for data/report translation and implementation activities both internally and externally. Our quality improvement staff are skilled in explaining data to internal staff and external provider partners on the level that meets the need. Our staff have dedicated time over the past year to honing data visualization skills in order to better communicate complex analyses to wider audiences. Our quality improvement team has also directly helped clinics run reports, especially as related to disaggregated data reports.

Our Innovation Specialist team offers technical assistance directly to providers and can help with report reading and translation, as necessary. This team also assists providers with using data in meaningful ways for quality improvement purposes. Lastly, our Panel Coordinators, working full-time directly in the provider's offices, are also available to assist clinic staff in understanding data and reports.

2022:
While we have experienced some staffing turnover, our approach and roadmap for analytics has remained largely unchanged.

2023: While we have experienced some staffing turnover, our approach and roadmap for analytics remains the same as described in 2022 and 2021.

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

No significant changes to the information above.

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:

CPCCO is committed to further enhancing analytics capabilities to better model, negotiate, administer, and monitor value-based payments by stronger integration of data between financial systems, contracting systems, clinical systems, and claims systems. Integration will allow us to better track the percentage of VBP payments in relation to claims payments and ensure provider expectations are being met. While data integration is the overarching strategy, Individual steps include:

1. **Ensure payment systems are capable of administering non-FFS based arrangements**

We continue to leverage the Provider Incentive Payment System (PIPS), a tool which streamlines the administration of PMPM payments. The tool facilitates a programmatic structure to manage attributed member-based payments made according to different quality performance levels, and population risk tiers. The system is integrated with our claims system, taking advantage of existing provider EFT payment pathways. This infrastructure has added significant efficiency to the process of evaluating and ultimately making PMPM payments to providers. In 2021, we plan to continue to migrate other PMPM based payment programs into PIPS to leverage the workflow and reporting capabilities. This will include all our current and future Primary Care capitation contracts.

2. **Ensure metrics calculation and analytics tools are capable of generating robust reports**

The CCO's HIT infrastructure, which is powered by CPCCO's analytics platform and resources, will play a key role in monitoring both CCO performance and accountability of its partners. Our analytics platform is the result of considerable investments to ensure that validated and reliable metrics are available. Data and measures will be regularly shared with partners to identify opportunities and drive performance. See section 6.a.1 for additional detail.

Our platform is capable of attributing members to particular clinics (PCPCH assignment) and can also track members as they move from one delivery network to another. It also manages attributions for dental relationships. Maintenance of provider attribution information has required considerable effort and will be an area of continuous improvement to ensure that performance is tracked accurately in an increasingly risk-bearing environment for physical, dental, and behavioral health.

CPCCO continues to partner with [redacted] our consulting actuaries, to provide regular reporting packets to our Total Cost of Care VBP partners. We plan to continue this partnership with plans to enhance reporting and bring pieces of the work in house. All of this will enhance our flexibility and nimbleness in meeting the needs of our provider partners.

3. **Explore additional enhancements and technologies.**
While the PIPS tool remains a key to our VBP programs and oversight, we are continuing to evaluate the market for tools to enhance our capabilities. We are evaluating a potential RFP process in Q2 2021 to identify additional tools and opportunities.

During 2020 we explored integration options, feasibility of integration of these systems, and developed concrete roadmaps based on findings. In the coming years, we expect to implement identified roadmap items and make them fully operational in Years 4 and 5. Additionally, our capability to more nimbly calculate and report on metrics in new care delivery areas will be enhanced as we continue to expand our EDW. Given that we have not yet developed the payment models for future years, we cannot articulate specific data-related milestones as we do not yet know the performance metrics or other parameters associated with those models.

In the latter half of 2020 we implemented a business glossary (data dictionary) in order to support continued data fluency across the organization. We are also migrating our EDW from on-premises MSSQL infrastructure to Snowflake (hosted on Microsoft's cloud platform – Azure) in support of the increasingly large datasets which we have cultivated.

2022:

a. The information above remains accurate in 2022. CareOregon has built an Enterprise Data Warehouse (EDW) for analytics. The warehouse is built using the Kimball Dimensional Model, converting raw data into star schemas for efficient and accurate ingestion and storage, and subsequently modeled into flatter analytical tables for analyst consumption. This infrastructure is scalable into the future as VBP arrangements grow and evolve.

b. The information above remains accurate in 2023.
We are also specifically engaging more with our behavioral health care provider community to develop meaningful arrangements, including acquisition of data for performance measurement.

c. The current HIT used by Columbia Pacific CCO and CareOregon administers value-based payment arrangements as set forth in the contract.

CareOregon systems continue to enhance the collection and automation of data processing as much as possible to ensure efficiency, timeliness, and accuracy. Data developed through electronic health record / electronic clinical quality measures must meet Oregon Health Authority specifications.

2023: The information above remains accurate and there no significant changes to report.

We have successfully launched a P4P (2C LAN) VBP with our specialty BH network. In 2023, we have begun mapping out a VBP model for our hospital system. We anticipate this will be a 2C LAN model with upside risk to start and will evolve in complexity year over year.

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.

Technical assistance will continue to be provided to clinics around optimization of their EHRs however, opportunities will be developed on an as needed basis in consultation with primary care clinic partners. This technical assistance is designed to enhance each provider's ability to manage and monitor their performance and the health of their populations associated with our value-based payment contracts.

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

The CCP remains committed to further enhancing analytics capabilities to better model, negotiate, administer, and monitor value-based payments by stronger integration of data between financial systems, contracting systems, clinical systems, and claims systems.

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:

Through our team of Innovation Specialists, the CCO provides technical assistance / practice coaching to our provider network partners to support various clinic and system transformation goals. This includes identifying opportunities to use their EHRs more meaningfully to improve workflows, support Quality Metric documentation, and support Value Based Payment performance. Additionally, they help clinic partners modify their operations and EHRs to support telehealth visits.

21) You reported the following information about your specific activities and milestones 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:

Activities	Milestones and/or Contract Year
Hospital VBPs – establish standard report sets for VBPs implemented with hospital partners	2021
Develop and implement a Behavioral Health VBP model, including development of performance management infrastructure	2021
Develop and implement a Maternity VBP model, including development of performance management infrastructure	2021
Develop and implement a Children's Health VBP model, including development of performance management infrastructure	2022
Develop and implement an Oral Health VBP model, including development of performance management infrastructure	2022
Conduct semi-annual reviews of existing reporting and performance management infrastructure. Identify opportunities to further develop and update HIT to streamline program administration	2021 - 2024

2022:
While each of these milestones remain accurate for development of each model addressed, robust implementation of each has been slightly delayed. We are currently reviewing the status of each care area and reassessing specific milestones associated with each to develop a workplan for the next two years.

2023: Some of the milestones have been delayed. Providers are expressing concern in moving towards value-based in this region due to the challenges they face with capacity and staffing. We are actively collaborating with providers to find a model that will work for them.

Briefly summarize updates to the section above:

2024: No significant changes to the information above.

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

2021: CPCCO currently has implemented VBP arrangements with a number of providers and is committed to increasing VBP over the next five years. Our arrangements incentivize and hold partners accountable for performance on Oregon's CCO incentive metrics as well as other measures of clinical quality. While the measures for these arrangements are currently aligned with OHA priorities, future governance decisions and VBP needs could expand these measures of accountability to include engagement with high-priority populations, elimination of health disparities, or other measures related to quickly emerging VBP arrangements.

To that end, we are well poised to operationalize these evolving arrangements through our software platform, PIPS, which supports PMPM VBP administration. This VBP tool, a leading third-party software, currently allows us to administer payments, adjust performance-based payments, and integrate VBP and claims data. This functionality is critical to our ability to report on payment arrangements by LAN category, as required.

We use this software to manage payments for our PCPM, CPC+ and IBH programs. The evolution of work in this area may seem intuitive, however, administration of non-claims-based payments in a health system that was built on an FFS system has required a significant amount of operational overhaul. Moving from manually processing checks to integrating this work into our claims processing system, including records of performance has greatly improved efficiency and allows us to administer and record performance and associated payment in one location. In 2020, we expanded use of this tool to include capitation payments and other PMPM contract models.

Another critical tool supporting VBP expansion is the financial model developed by Wakely, an actuarial consulting service, which provides the architecture that supports our Total Cost of Care (TCOC) and Medical Loss Ratio (MLR) risk agreements. This financial model calculates the total cost of care for a primary care partner's assigned membership, along with detailed cost data analytics allowing the provider to identify trends, and areas of opportunity to better manage resources. In 2020, Wakely further developed modules within this model that aid in the process of risk recapture and managing the health of a population. The risk recapture/population health module allows the provider to search for members previously diagnosed with high-risk conditions, without a recent claim showing that diagnosis. This tool can be used to proactively outreach to members with chronic conditions to ensure they are receiving preventive care.

2022: Columbia Pacific CCO aligned with CareOregon continue progress in partnership with our provider network in the development of arrangements which incentivize and hold providers accountable for performance on measures of clinical quality.

2023: Yakima Valley has successfully integrated their attributed patients' claims data provided by Wakely and CareOregon into their Epic Payer platform.

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

No significant changes to the information above.

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

2021:
All of the systems that house data needed to administer VBP arrangements, including those supported by the OHA, contain different file formats, fields, and provider identification information. Therefore, generating the information to respond to OHA's payment arrangement reporting is difficult. We combine both claims payment data, along with other types of payments made in relation to a VBP (e.g., PCP risk agreement includes both the FFS claims data, and settlement payments made when the agreement year ends with a surplus). It can be challenging when combining data from the general ledger, with claims data to match up those payments with the right provider contracts, and so associating with the correct LAN category.

2022: Our provider network continues to be challenged by the impact of COVID 19 and its effect on operations and workforce availability.

2023: The same challenges continue to exist in this region in 2023.

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

No significant changes to the information above.

24) You previously reported the following information about your strategies, activities and milestones 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:
Strategy 1: Provide timely and accurate performance data
The CCO regularly shares data, at least quarterly, with its providers. We are currently expanding this capability to ensure that data provided to clinics is specific to VBP arrangements in which they participate. Our existing analytics infrastructure and software tools allow us to deliver Oregon's CCO incentive metrics and select HEDIS–NCQA measures to providers on a regular basis. Enhancements will continue to expand our ability to deliver additional measures, as appropriate based on VBP arrangement participation, to providers on a regular and automated basis. Providers will be able to

view a broad menu of measures, as well as those applicable only to their payment arrangements. Scorecards include both aggregate (clinic-level) and member-level information, making data more actionable for intervention. See section 6.a.1 for additional detail.

The CCO is also in collaborative risk arrangements in each of its three counties. The partners include hospitals, primary care, and community mental health partners. The CCO shares performance data related to their total cost of care with each set of county partners every other month and quality metric performance data quarterly. For our more advanced partners, the CCO provides a claims data feed that enables their internal population segmentation tool to include cost analysis.

Moving forward, providers will have access to a more comprehensive array of reports through our FIDO web portal (the front end for our EDW). We are currently piloting access to a limited group of users, with full implementation planned by the end of 2021.

Strategy 2: Ensure providers have access to accurate and consistent patient attribution data

Our reporting platform includes data on patient assignment and utilization. For purposes of VBP arrangements, we calculate performance based on the providers assigned member population. In instances where members are inappropriately assigned, we have staff that work to quickly reconcile and reassign as appropriate and coordinate these activities with providers. We also employ auto-assignment for new members, and auto-reassignment for existing membership. New members are assigned to a PCP based on their address, history of OHP eligibility and PCP assignment, assignment of eligible family members, etc. Current members are automatically reassigned to a new PCP if their actual utilization patterns indicate they see a different PCP. Information on patient assignment is available both through our data reporting platform as well as our provider portal. Transparency of this information allows for productive conversations around population health management expectations under our VBP arrangements.

2022: The information listed above remains accurate in 2023.

CareOregon uses Tableau and a Tableau server to maintain an externally available quality dashboard for network clinics. The dashboard includes information on member attribution, member characteristics, aggregate performance on measures included in VBPs and member level gaps in care. This dashboard is available to any provider involved in a primary care VBP with CareOregon.

Providers participating in risk-share agreements also received detailed cost, utilization, and risk files compiled by a third-party.

2023: The information listed above remains accurate in 2023.

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.

No significant changes to the information above.

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

No significant changes to the information above.

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

No significant changes to the information above.

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:
Strategy 3: Implement a multi-prong approach to facilitate population management in service to population health and quality improvement These approaches include:

Member level data as a tool for population management:

1. We can generate member level data and lists to identify gaps in care are provided to our clinic partners, so our network can outreach and provide clinical services to close the gaps. We are working to integrate physical health data and oral health data in order to provide a member-centered population management list. Contracted providers within our network have regular/real-time access to data and patient-lists through our data portal (FIDO). CPCCO also has executed LOA with all three county public health agencies to share county-level member lists related to vaccines,

including COVID-19, as an opportunity to close gaps in care more broadly than within contracted clinics.

2. Risk stratification (member level and population level) reports are currently being enhanced to include several markers of risk, including health care condition recapture data. These reports are the foundation for discussion of clinical quality improvement best practices held at our network-wide learning collaboratives and one-on-one technical assistance meetings.
3. Population Health explorer: We have developed a dashboard called population health explorer that allows us to look at member level data from a variety of lenses in order to develop care plans, gaps in care.
4. We have developed a COVID-19 dashboard, both in general and one focusing on vaccines. We used an equity-data approach to categorize populations can pull member lists and share with our network or public health department for direct outreach.
5. Collective for population management: We have many providers using Collective to outreach to unengaged members seeking care through the Emergency Department, as well as using our Medecision care coordination platform to coordinate services for members with complex chronic health problems or psychosocial issues. The team is also working to identify a member caseload for each CPCCO panel coordinator based on risk criteria and will be responsible for ensuring that each member has meaningful contact, gaps in care addressed, and are engaged with their primary care provider.

Support to use data for action:
In addition to external provider reporting, the CCO has internal staff that directly support identification and coordination of members in need of services. We have a team of panel coordination staff who are out stationed in our network and act directly as a part of the clinic care team. This team uses the reports previously described, as well as data obtained directly through chart review to prepare providers for member office visits. They currently focus primarily on needed services identified by a gap in a CCO incentive, CMS Star measure or lack of engagement with their primary care provider. With onset of COVID and COVID-19 vaccines, these staff also are helping with outreach to members to ensure they have necessary services and will be outreaching related to access to COVID-19 vaccine.

Population Level Data- though not used for direct patient outreach, this level of data does greatly contribute to overall improved health outcomes.
CareOregon and CPCCO use sophisticated methods to pull and analyze claims data based on different populations, incorporating pharmacy data, NEMT data, Geo mapping, as well an ensuring data is disaggregated based on REAL-D. This data is utilized to develop broader population health strategies and initiatives to help improve health outcomes for our membership. These strategies are developed in a data-informed way, in partnership with our CACs and CAP, and informed by our regional health improvement plan.

- **Population level data available to the network:** We make data inclusive of clinical quality measure performance and health system utilization available to providers continuously through an online platform. We also present this data to help inform strategy development on a larger systems level, informed by our network. We have developed multiple other population level data dashboards focusing of different populations and elements of care (SUD, specialty access, opioid prescribing). These are not available for external use, but we do share the data individually with clinics, and with our regional clinical advisory panel. We also use this data for strategy development.
- **Population level data for strategy development:** The same dashboards described in #3 above are used for population level strategy development. We also have developed a tool entitled "population health explorer," that allows both a member view (as described above) and a population view to identify population-level gaps and opportunities. As noted above, we have a COVID-19 dashboard that can also be used for planning, tracking, and continual improvement at a population level.
- **Predictive modeling:** On a quarterly basis, we also use the Johns Hopkins ACG model to generate risk scores for our population. We stratify our population using advanced clustering and machine learning to identify populations which may benefit from interventions. Our regional care teams use information from these tools to guide their work in the Medecision care coordination platform. This data also helps to inform targeted population-level strategies, as noted above.

Equity data approach: Our Quality Improvement Team is in the process of developing a training curriculum on how to use data to support equity work. This training covers best practices on centering equity in analyses and when making data-driven decisions. We are currently seeking feedback from key stakeholders, with a focus on partners of color and organizations that serve communities that have been marginalized. By improving both the quality of our data and shifting our culture around how we use data, we hope to build better strategies to support our members.

2022: The information listed above remains accurate in 2022-2023.

2023: This information listed above remains accurate in 2023.

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

No significant changes to the information above.

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:
Contracted providers within our network have regular/real-time access to data and patient-lists through our data portal (FIDO). (See Question 18)

As indicated, we also can share data from dashboards that are not yet externally facing with individual organizations, in a more manual manner, or through an interactive meeting

2022:
The information listed above remains accurate in 2022.

2023:
The information listed above remains accurate in 2023.

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

No significant changes to the information above.

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

Estimated percentage	Reporting method
70	Excel or other static reports
30	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)?

N/A

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

2021: Progress, including accomplishments and successes, are all described in the specific sections above.

2022: Progress, including accomplishments and successes, are all described in the specific sections above.

2023: Progress, including accomplishments and successes, have been described in detail in the specific sections above. A highlight would be successfully maintaining our VBP contract reporting, APM PCPM reporting, and launching a new BH QIIP program while still navigating resource and capacities constraints internally and in the network.

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

No significant changes to the information above.

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

2021:
Technology available to CCOs has not quite caught up with the increasing VBP reporting demands, particularly as categorized by the LAN. While the aim of the reporting requirements is directionally correct, fulfilling them remains equally or more challenging than implementation of the VBP arrangements themselves.

2022: Our area continues to experience the challenges caused by the COVID 19 pandemic in operations and workforce availability.

2023: Provider capacity remains stretched due to the impact of the pandemic on the workforce and the continued shortages the network is experiencing. This has impacted engagement in VBP programs and the ability to adopt new HIT tools.

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

No significant changes to the information above.

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?

Despite the official end of the COVID crisis, providers generally remain hesitant to take on additional downside risk. Something that would help would be making the meaningful risk definition more palatable to providers.

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

No additional information to add.

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?

No additional information to add.