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:

To help achieve the VBP requirement of 60%, IHN-CCO has implemented contracts with our largest provider group, [redacted] our county mental health providers, multiple PCP Clinics, the regional NEMT provider, and all area dental care organizations (DCOs).

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:

To help ensure IHN achieves the VBP requirement of 70%, IHN is maintaining all contracts listed above as these provider contracts account for majority of the spend.

Please describe any challenges you have encountered:

Some provider groups we approached declined to participate due to reporting requirements for Quality Metrics, lack of staffing, and lack of understanding of VBP programs. One provider group (an FQHC) stated that they feared losing their additional federal funding if they moved to a capitation model.

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:

IHN-CCO has met the 20% 3B or higher requirement because all the contracts mentioned in number 1 qualify towards the requirement. Starting in 2021 [redacted] entered an upside/downside VBP which covered approximately 70% of the IHN population.

How confident are you in meeting the 2024 requirement?

☒ Very confident
☐ Somewhat confident
☐ Not at all confident
☐ Other: Click or tap here to enter text.

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

IHN-CCO has continued the shared risk agreement with [redacted] into 2024. Since this provider accounts for nearly 70% of the IHN-CCO population, and all costs for that population are at risk, it helps ensure the 25% requirement is met.

Please describe any challenges you have encountered:

For the [redacted] risk sharing agreement, all the members' costs are included. When it comes to submitting the data in the APAC PAF, we need to do manual work-around to ensure all the costs tied to this risk are indeed being counted and getting the LAN category credit.

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)?

2023: IHN-CCO is developing an episode payment VBP model for [redacted] Maternity episodes. This VBP will meet both the hospital and maternity care delivery area requirements. The report is still being developed and vetted. We are using the OHA Maternity Kick Payment logic to identify deliveries in any of the 5 [redacted] hospitals.

IHN-CCO will tie in quality measures focused on maternity care. Quality measures applicable include reduction in cesarean sections, increase in prenatal and post-partum care. The model will also drive behaviors in the facility and save costs by incentivizing reduction in c-sections.

2024:
IHN-CCO is still working through the complexities of the Maternity Episode VBP. IHN-CCO has however, already successfully met the hospital CDA requirement with another VBP program. IHN-CCO implemented a risk sharing agreement with [redacted] on all costs for members assigned to [redacted] PCPs, including inpatient care, outpatient hospital surgeries, maternity, and emergency room departments. [redacted] consists of 5 regional hospitals, 21 PCPCHs, and several specialty clinics.
This model incentivizes the holistic management of complex members by rewarding the VBP participant when these members are properly managed. [redacted] serves populations in rural communities (with RHCs) and has a team of traditional health workers.

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

2023: The claim data report needed for this model is still being built and vetted. We plan to implement this VBP soon and it will have an effective date on 1.1.2023.

2024: Model is under contract.

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)?

Click or tap here to enter text.

2023:
IHN-CCO is enhancing our Maternity Case Management Program (MCM) with each of county health providers. New this year is a Quality Metric Pay-for-Performance scorecard. The providers will focus on the Prenatal and Post-partum care measures.

2024:
IHN-CCO added maternity care centered measures to the [redacted] pay for performance scorecard. The providers will focus on the Prenatal and Post-partum care measures. [redacted] Care Opportunity teamwork with clinics for care coordination and close maternity care gaps.

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

2023:
See response to the hospital CDA status.

2024:
The MCM contracts are currently out for signatures from the County.
Maternity Care is also covered in the [redacted] VBP contract detailed in #5, hospital CDA status.

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)?

IHN-CCO has implemented a VBP contract with [redacted] Program to expand substance abuse services in Linn County. The [redacted] program is reaching rural areas with the addition of 3 addiction specialists. Community outreach will include middle and high schools. The VBP ties in quality measures focusing on Early Intervention, referral tracking and closure, and IET.

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)?

IHN-CCO has enhanced the [redacted] contract to expand the delivery care model. This model utilizes an EPDH practicing at the top of their licensure as a Primary Care Dental Provider in a dental office to incorporate traditional dental care with tele-dentistry and the increased management of chronic conditions such as diabetes and hypertension.

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)?

2023:
IHN-CCO is currently in negotiations with [redacted]. The VBP model will focus prioritizing DHS behavioral clients for CANS and mental health assessments. The model will tie in quality measures such as the Assessments for Children in DHS Custody.

2024:
Contract has been in place since June 2023. There are 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.

N/A

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

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:
Currently IHN utilizes a cross functional team including Finance, Quality, and Contracting to strategize and develop VBPs. IHN is in quarterly meeting with key VBP Providers, where VBP performance and feedback is discussed to improve future VBP contracts.

2022:
IHN implemented a VBP roundtable which incorporates viewpoints from Finance, Quality, Product leads, Clinical Services, and VBP. This has led to better role definition in the creation and evaluation of VBPs. IHN continues to meet quarterly with VBP Providers to review performance and seek feedback on the effectiveness of the VBP model. In 2022 IHN funded a consultant to perform interviews with key PCPs under a VBP. This feedback will help IHN improve new and existing VBP arrangements.

2023:
IHN-CCO still utilizes the VBP Roundtable meetings as a platform for internal discussion. IHN-CCO has enhanced its quarterly VBP reporting for Provider Groups using the Arcadia Bindery platform. IHN-CCO currently sends [redacted] and [redacted] an Executive Summary and Performance Summary reports. Both are geared to show the group's effectiveness and utilization. Areas for improvement can be spotted and providers can make a targeted approach. We will add more Provider Groups to the list as soon as their EHR is connected to Arcadia.

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

2024:
A VBP Committee was established. The Committee meets quarterly and consists of the AVP-Finance, AVP-Network Strategy & Contracting, AVP-Clinical Services. All proposed VBP's are to be vetted by the VBP Committee. The goal of the VBP is to have more interactive, and meaningful VBPs, collaboration and post-VBP reviews to determine best practices.
Our Clinical Services Division has begun meeting with VBP providers on a monthly basis to review and discuss quality metric gap lists, trends, and areas for improvement. These meeting are a 'deep dive' compared to the quarterly VBP meetings held.

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:

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:
In our Health Equity plan we have focused efforts on education and awareness of bias and specifically institutional bias, creating a new lens to identify and reduce health disparities. We are working implement those evidence-based interventions that reduce health disparities by improving access to care and services. We are collecting social risk factor data to gain deeper insights into our member population. We are also engaging providers in project work to develop new approaches to address members with cooccurring mental health and substance use disorders, who may also be unhoused and or have complex health needs. Additionally, we are providing Trauma Informed Care training broadly across the provider network. We understand much more work is needed in this arena and believe our continued efforts to better understand our member population and share those insights with our provider network will continue to guide our efforts toward health equity.

2022:
IHN-CCO Quality Improvement Committee convened a value metrics workgroup to evaluate VBP arrangements through the lens of health equity. Additionally, IHN-CCO added the CCO Metric Meaningful Language Access to VBP contracts and provider scorecards as a focus measure. We are also exploring VBP with the Community Doula Program to better match services to members' cultural needs.

2023:
Since May 2022, the value metrics workgroup was combined with the provider network taskforce to incorporate provider voice in the review of value-based metrics. The quality and population health team are also working with the provider network to understand data needs as it relates to their gap lists. Our goal for 2023 is to begin an assessment of provider data capabilities and organize their gap lists based on their needs. For example, if they do not have the capability to establish data dashboards that show members race and ethnicity, we will support their needs by ensuring their gap lists have the member's racial and ethnic profile as well as aggregated data that shows potential disparities in care for that specific VB metric.

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

In addition to above, the Quality and Health Outcomes team is looking at metric performance by available REALD data. The intent is to see how our various member categories by race, ethnicity, and language fare when they are broken down and not all pooled together to help us better identify where disparities my lie, and work with our provider network in addressing them.

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?

For Primary Care capitation arrangements, IHN-CCO uses the CDPS suggested Risk Scores out of Arcadia. Capitation rates are based on the members risk and condition complexities.
The [redacted] risk sharing agreement is risk adjusted.

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

The risk-based capitation model was well received by the Provider Groups. Each month they receive a detailed report to support the capitation payment and it includes the member's risk score. The capitation rates are adjusted based on the level of health condition and complexity. The providers appreciate this level of detail to monitor their panels. .

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.]

Not yet, but IHN is exploring ways we can leverage SDOH data in some type of social risk adjustment when it comes to VBPs.

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:

IHN-CCO utilizes multiple data sources to support our VBP programs. IHN-CCO has robust claims reporting through SQL queries, crystal reporting, and the HPXR/Empower data warehouse. We also use supplemental data, stored in our data warehouse, from the Provider to evaluate performance and compare to reimbursement expectations. IHN-CCO is going live with Arcadia as the primary VBP platform in 2021. This tool will

enable near real time reporting on quality and cost performance, utilization trends, and other performance measures.

2022:
IHN-CCO established provider learning collaboratives in late 2021 to support the collection and integration of data for provider performance reports to improve CCO Metric performance. IHN-CCO's population health system, Arcadia has been configured to integrate provider and other data to support metrics performance.

2023:
IHN continues to implement Arcadia for CCO quality measures by combining claims and EHR clinical data.

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

Arcadia is now live, and we have. Our largest clinic system [redacted] is live with metric data in Arcadia. Four of our other clinic systems are in line for data validation to enable them to go live.

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

2021:
Currently VBP Scorecards and gap lists are generated monthly and financial reports are generated quarterly. Monthly scorecards are focused on Quality measure tracking to achieve performance goals and achievement of the Quality Pool. Capitated providers receive financial reporting that tracks assumed costs and encounters. This allows IHN-CCO to compare expected service levels to what has been reimbursed. IHN meets regularly with the providers to review the mentioned reports. These meetings are productive in driving towards expected performance level.

2022:
IHN-CCO consistently engages community partners and providers to address data challenges related to health equity and VBP arrangements. While this data is difficult to obtain and is based on voluntary reporting, IHN-CCO has made efforts to align system data collection and reporting across multiple operational components (e.g., utilization management, care coordination, language access, and REALD).

2023:
See response below.

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

IHN continues to leverage Arcadia for the bulk of our analytics. We do share data with some provider clinics related to utilization. IHN internally reviews trends for ED utilization, Readmissions, IP/OP utilization, Rx costs, and other key cost drivers and shares with key Providers to influence long term rate of growth targets and network management. For 2024, we are looking to expand on that and incorporate more SDOH data and possible utilization effects based on that (correlation)

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:

To support the VBP program IHN-CCO cross coordinates across several functions:

- Finance – The VBP Analyst, Finance Dept, and Finance Director are responsible for VBP scorecard and report publishing. The department develops the reports based on contracts, financial goals, and aligned incentives. Finance also develops VBP payment models, strategy, and provides analysis of VBP objectives.
- Network Strategy – The VBP Coordinator, Provider Relations Team, and Director of Network Strategy distribute and coordinate VBP scorecards and contracts. The team matches the best VBP model for the Providers services, cost profile, and operational capabilities. This team is key in education and evaluation of VBPs.
- Quality – The Quality Analysts and Director of Population Health are key in identifying and developing the quality metrics used in VBP contracts. The department looks at the health priorities of IHN and establishes metrics and targets that will improve Health Outcomes of our IHN members.
- Information Technology – The IT supports the above departments with the data warehouses, data feeds, and reporting solutions required to maintain VBP processes.

2022:

IHN-CCO has established a population health taskforce and value metrics workgroup to improve surveillance and reporting for state and federal metrics and to measure the impact VBPs have on health equity.

2023:

The quality and population health management team are making strategic changes in staffing, roles and responsibilities, and how the team partners with the network strategy, finance, and data analytics teams. The quality improvement program manager has been a standing position within health plans and focuses on state and federal projects. The responsibilities of this position are expanding to be an additional support for the provider network with VBP contracts when it comes to data analytics and metric specification. The provider network taskforce (which inherited the value metrics workgroup -see question 12) will be used to help the quality and population health team, network strategy, finance, and data analytics teams reduce silos and ensure full collaboration for support equitable and high quality VBP outcomes.

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

The staffing model and process has been consistent through 2023 and 2024. A dedicated Analytics platform manager was filled in 2024 to administer the complexities of the Quality and Analytics tools.

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:

IHN-CCO's goal is to centralize and simplify VBP arrangements to maximize our HIT capabilities. This means reducing the number of custom metrics to reduce development workloads. With Arcadia we will utilize their set of OHA, NCQA, and HEDIS measures wherever possible. We will also limit the number of metrics in scorecards so that Providers can focus on the key drivers of performance. In 2020 we reduced the number of measures per scorecard and the number of custom measures to ease HIT workloads.

Payment models will also be standardized based on service type and size. Only Providers over a certain attribution size would be allowed to deviate from a standard VBP contract. This will simplify configuration and HIT requirements for each VBP contract administered. It will also ease education of the VBP payment structures. In 2020 we shifted from [redacted] capitation model, which was costly to administer, to a rate of growth target model. This continued into 2021 with simplified County, PCPCH, and THW models.

Long term IHN-CCO will develop standardized PCP VBP models that incorporate Risk Scores, SDOH, and Rate of Growth targets. This work will require Arcadia risk modeling to achieve. Episode payments are also on the horizon, pending contracting HIT solutions. Beyond that VBPs models will require HIT that allows us to disconnect the underlying VBP payment structure from FFS to either a Value/Outcome payment structure and/or market-based pricing.

IHN-CCO is also moving away from "custom" metrics to more standardized metrics via Arcadia.

2022:

a. IHN-CCO has ensured that utilized technology platforms can support CCO metrics and the efficient delivery of care across the continuum. The Arcadia population health management system is currently being upgraded, with a phased approach to data integration and reporting capabilities that will allow IHN-CCO to scale to numerous data sources and provider types. Additionally, IHN-CCO is upgrading its Facets NetworX module to enhance and scale VBP modeling and payment arrangements using pricing and bundling capabilities.

b. IHN-CCO is providing education and technical assistance to community-based providers, i.e., doulas. IHN-CCO is evaluating barriers and exploring ways to reduce implementation costs and subsidizing providers to adopt and use technologies for care coordination, referral management and outcome tracking.

c. IHN-CCO is leveraging the HIT Strategy Committee and existing committee structures with providers to address Health Information Exchange (HIE) strategy. IHN-CCO is evaluating HIE platforms based on functionality and configurability that will allow integration and exchange of data. IHN-CCO is augmenting provider contracts to incorporate any changes necessary to encourage providers to integrate with the implemented HIE.

2023:
See response below.

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.

IHN contracted with Arcadia to enable us the capability to scale our VBP arrangements with clinics. Administratively, a platform manager position was created to facilitate internal and external utilization of the system.

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

The quality and health outcomes team connect with different community-based organizations throughout the year to understand their services and resource/capacity building needs. This occurs among community behavioral health entities, substance use treatment partners, mental health partners in the community, such as [redacted] and [redacted], as well as County Public Health agencies home visiting nurses. Currently IHN is completing a VBP with our county maternity care management programs to leverage all the good work happening in the counties around maternal care.

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:

HIT capabilities are reviewed by IHN on a regular basis. Any needed enhancements are reviewed and presented to the project governance committee for approval and prioritization of resources.

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:
See response to question [16] above.

2022:
IHN-CCO continued to implement VBP and expand use of technology, incorporating risk, SDOH and rate of growth into VBPs.

2023:
IHN-CCO will continue to implement Arcadia with all contracted sites throughout 2023 where sites can access their CCO measure scorecards, dashboards, and gap lists in real time. In the next phase for 2023, we are expanding EHR integration to our FQHCs

Briefly summarize updates to the section above:

IHN has now built connectors to 7 clinic systems, which covers approximately 80% of our membership. One clinic [redacted] is live, working on data validation for the remaining clinics, with go live dates between 4th quarter 2024-2nd quarter 2025.

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

2021:
IHN-CCO made great strides in 2020 by implementing Arcadia data feeds and development. We also developed or expanded VBP scorecard tracking and performance monitoring. Utilizing data, we were able to shift major contracts ([redacted]) to new VBP models in 2021 that will simplify payments while aligning long term financial and quality goals. IHN-CCO rolled out PCPCH tier-based payment capability in 2020 and expanded it in 2021.

2022:
The PDM team has created a PCPCH-tier report to validate incentive payments. Additionally, we published first ever executive level cost and utilization standard reporting.

2023:
While there have been challenges, we have been able to integrate a majority of CCO metrics that are part of VBP contracts with EHR data with [redacted] being the pilot clinics

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

[redacted] is now live with metrics, and in addition, IHN implemented the ASSESS module, which will enable connected clinics to upload verification documentation to become numerator

compliant, which optimizes that verification process. ASSESS will be available to all clinics once data validation is completed.

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

2021:
Getting to a higher level of HIT coordination with our Providers has been a challenge. In some cases that means getting quality data from providers at lower HIT sophistication levels, or complex data from higher level HIT partners. Then IHN-CCO is challenged with reporting back the data in a meaningful way that Providers can ingest and develop actions around.

Past VBPs have been very customized around the Provider's HIT capabilities. Going forward we will have standard data requirements under Arcadia so that we can quickly onboard Providers to a VBP model and report back to them in a consistent well-established method.

2022:
IHN-CCO continues to work through barriers and challenges associated with certain provider types i.e., THW with limited access to technologies required for data collection. Additionally, collecting SDOH screening data. Additionally, smaller provider practices with limited technology and staffing to support metrics reporting proved to be a challenge. IHN-CCO continues to provide technical assistance and training.

2023:
There have been numerous roadblocks to providing accurate scorecards, dashboards, and gap lists in Arcadia. These include missing and/or incomplete data from sources (EHR); variations in mapping to individual measure builds causing some data inaccuracies in Arcadia; long timelines in data delivery, and validation/reprocessing efforts.

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

The biggest barrier to our timelines continues to be resources. Data validation is a huge lift, and an even bigger one for a new site that just got a connector build. The work required to connect a clinic to a bidirectional platform has definitely impacted the length of time in going live with additional clinic systems.

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:
IHN-CCO provided 100% of Providers on a VBP contract either monthly or quarterly scorecards on metric performance. In addition, capitated providers receive financial reports detailing payment history and encounter data.

In 2020 these performance measures were created manually and delivered via SFTP. The strategy 2021 going forward is to automatically deliver robust reporting via Arcadia and provide on-demand performance via Arcadia's web user interface.

VBP Providers receive a monthly attribution and gap list of the members being counted towards their Quality measures. This information is accurate at the Clinic level but may vary at the PCP level due to reassignments within the Provider's office.

Future strategies are in development with Arcadia to ingest PCP attribution from the Provider's EHR and/or reassign based on claims-based algorithms (i.e., most frequent PCP utilized)

2022:
a. IHN-CCO is working collaboratively with provider practices to streamline PCP assignment and using technology through Arcadia for more accurate PCP attribution.
b. IHN-CCO continues to improve patient attribution and has created streamlined process for managing ongoing changes (PCP changes i.e., providers leaving or joining practice, new members, redeterminations etc.).
c. Arcadia, Clinical CareAdvance (CCA), Collective Medical, Provider Connect, Unite Us.

2023:

See response below.

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.

VBP providers receive at minimum quarterly updates on their progress. They are provided with gap lists and scorecard monthly. Starting in 2024 many VBP providers are choosing to meet with the quality and health outcomes team on a monthly basis (outside of the quarterly check-ins) to review progress, address barriers, and engage in performance.

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

While still not perfect, leveraging Arcadia will significantly improve the accuracy and consistency on patient attribution. A recent completed project on a different line of business solidified the accuracy of the Arcadia data for PCP attribution A project is underway to utilize the EHR data within Arcadia to do the same for IHN.

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

Arcadia and our internal data warehouse are used to generate reporting to providers.

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:
IHN-CCO regularly assesses its population integrating multiple types and sources of data. Medical, pharmacy, behavioral, and oral health claims data are integrated and combined with available member characteristics such as ethnicity, language, race, and disabilities, and social and economic factors such as food insecurity, housing instability and lack of transportation that can impact a member's overall health. Criteria are used to monitor, screen, and risk stratify the population and to identify and segment individual members into cohorts with similar care needs. IHN-CCO identifies members with special health care needs and screens for care coordination needs and Intensive Care Coordination services. The first level of stratification uses claims and demographic data, and the second level of risk stratification is based on the health risk and clinical assessment, and other screenings completed with the member.

The risk level segments members with similar complexity and care needs into four levels:

- Low risk (I) – stable medical conditions, able to obtain medical services and access providers without barriers;
- Rising risk (II) – stable medical conditions that require monitoring to ensure medical services are obtained and any barriers addressed;
- High risk (III) – unstabilized condition(s) or recently diagnosed new condition i.e., chronic kidney disease, coronary artery disease, chronic obstructive pulmonary disease, depression, diabetes and issues obtaining medications or adhering to treatments, or barriers accessing providers; and

- Complex (IV) – new health catastrophic event or condition or diagnosis with significant resource needs i.e., motor vehicle accident, traumatic brain injury, spinal cord injury, amputations, difficulty adjusting to new serious diagnosis and not well connected with PCP or specialist, i.e., Lupus, HIV, Multiple Sclerosis, active cancer with chemotherapy and complications, unplanned hospital admission, difficulty performing activities of daily living.

The process of risk stratification is ongoing throughout the member's eligibility. Risk levels may be adjusted based on a change in the member's status identified through clinical review, event notification, screening, and/or referrals.

2022:
We have expanded risk identification and stratification through Arcadia. The Arcadia Analytics Risk module allow for more efficient risk modeling for VBP and the ability to share real-time risk indicators and data with providers.

2023:
Current efforts to implement MAO004 and MOR reports into Arcadia for HCC recapture. IHN-CCO is working closely with [redacted] to ensure provider workflows and their Epic build is built to ensure HCC's are captured more consistently and accurately. These tools include adding HCC information to the Storyboard; soft stopping providers before closing encounters to address HCCs yearly; and dashboards to track HCC capture rates.

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

We have now enhanced our risk stratification modeling to aid in population health activities, care coordination and VBP. SHP IHN's calculation process for risk stratification begins by querying various sources of data to identify and flag relevant factors for each member. The process includes data integration of multiple sources and analysis to ensure that each member's unique needs and conditions are accurately identified and addressed. This approach allows for a nuanced and thorough risk assessment, enabling SHP IHN to categorize members into four distinct risk strata and prioritize members for care coordination interventions.
The individualized considerations for risk stratification classifications include but are not limited to:

- Utilization and cost patterns, particularly utilization of the emergency department, inpatient admits
- Social determinants of health at a personal and community level
- Chronic conditions and medical history
- Medical fragility and/or complexity of conditions,
- Untreated mental health diagnoses and/or substance dependency
- Receipt of appropriate preventative care (physical, behavioral, and dental)
- Patient-reported concerns
- Cognitive impairment or decline

- Additional factors that may adversely impact a member's health

The data querying of relevant risk factors is followed by a weighted scoring system that accounts for the relative importance of each risk factor. The result is a composite Risk Score for each member, derived from the relative contribution of each factor to the overall risk profile. Member-level risk scores are then used to categorize members into one of the four discrete Risk Strata and match members to care coordination programs and population health efforts.

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:
Results of screenings, assessments and risk level are shared with the member's PCP and used to develop the shared plan of care. Member care gap lists are provided monthly.

2022:
Expanded data sharing through Arcadia as stated above.

2023:
The quality and population health management team are establishing a population assessment that follows NCQA's Population Health Management Model. The data are shared through the Quality Management Council and other provider related committees.

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

In addition to population health assessment data, the quality and health outcomes team are sharing Emergency Department utilization with VBP provider groups to understand members on their panel with high ED utilization. The data are segmented by general ED utilization, High ED utilizers (>3 encounters in the quarter), diabetes related ED visits, Mental and Behavioral Health related ED visits

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

Estimated percentage	Reporting method
63%	Excel or other static reports
32%	Online interactive dashboard that providers can configure to view performance reporting for different CCO populations, time periods, etc.
5%	Shared bidirectional platform (example: Arcadia) that integrates electronic health record data from providers with CCO administrative data.
[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)?

The bulk of our interactive dashboard and bi-directional VBP performance sharing is with physical health. Note that 68% of members are assigned to a Provider group that has a Bi-Directional platform. We do have behavioral health, dental/oral care, pediatrics and now maternal, but currently it is via excel dashboards augmented with monthly deep dive and information sharing meetings with providers that engage with us when we have reached out. The number of non-physical providers skews the reporting percentages, with fewer VBP funds at risk with the Excel based providers but with a higher number of these providers.

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

2021:

- IHN-CCO has implemented Arcadia Analytics platform and is testing the output of new risk stratification models that provide deeper insights into the member population.
- Despite initial project delays due to the Covid-19 pandemic, IHN-CCO was able to engage providers in focused project work on three initiatives. The initiatives are focused on identifying and reducing potentially avoidable costs while at the same time, improving member experience and health outcomes. Subsequent data analysis identified three conditions with opportunity – diabetes with co-occurring substance use disorder and/or mental illness, high risk pregnancy, and hypertension.
- Due to Covid-19, 2020 was only a Reporting year. In April, a final reconciliation will be conducted, and we will be able to see how the provider groups preformed for 2020.

2022:

IHN-CCO has supported providers in achieving metrics through project work, such as the CCO Metric HbA1c Poor Control >9% and Initiation, High-risk pregnancy and Postpartum Care, and Initiation and Engagement in Substance Use Treatment.

2023:

See response below.

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

For the first time in a few years, IHN met the IET measure for 2023. We heavily leveraged data sharing and communication to make this a reality and success.

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

2021:

- Covid-19 response presented challenges for the provider network and IHN-CCO staff;

- Our current processes are manual and some of the VBP Provider Groups do not have EHR systems.
- Consistent data for analysis; and
- Competing priorities.

2022:
IHN-CCO and its provider network continued to face challenges with staffing and resource constraints associated with the COVID-19 pandemic.

2023:
Please see response below.

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

Leveraging HIT data requires time commitments on the Provider and CCO side to understand the data, analyze it, and implement actions to improve goals. This continues to be a challenge with multiple competing priorities faces by clinics.

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?

No TA is required at this time.

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

DCOs have performed historically performed well on Metrics. There are likely best practices to be learned from them that could be applied to PCPs.

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?

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