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:

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

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:

   PCS Community Solutions (PCS) achieved this 60% level for LAN category 2C in its CCO regions in 2021 or earlier, depending on the CCO.

   2024 answer: PCS achieved this 70% level for LAN category 2C in its CCO regions in 2023.

   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:

   The inclusion of pharmacy costs into VBP 2C arrangements was key to getting to the 2024 requirement.

   Please describe any challenges you have encountered:

   Click or tap here to enter text.

2) **In 2024, CCOs are required to make 25% of payments to providers in arrangements classified as HCP-LAN category <u>3B or higher</u> (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:

   PCS achieved this 20% level for LAN category 3B in its CCO regions in 2020.

2024 answer: PCS achieved this 25% level for LAN category 3B in its CCO regions in 2020.

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:

2024 answer: None needed.

Please describe any challenges you have encountered:

2024 answer: NA.

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?**

   Click or tap here to enter text.

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?**

   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 <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)?

PCS has incorporated models with upside and downside hospital risk, tied to certain quality metrics performance. These qualify for LAN category 3B.

2024 answer: PCS has incorporated models with upside and downside hospital risk, tied to certain quality metrics performance. These qualify for LAN category 3B.

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

2024 answer: NA

6) **a. What is the current status of the new or enhanced VBP model your CCO is reporting for the maternity 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)?

PCS has incorporated models with upside and downside risk for maternity providers, tied to certain maternity-based quality metrics performance. These qualify for LAN category 3B.

2024 answer:
PCS has incorporated models with upside and downside risk for maternity providers, tied to certain maternity-based quality metrics performance. These qualify for LAN category 3B.

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

2024 answer: NA

7) **a. What is the current status of the new or enhanced VBP model your CCO is reporting for the behavioral health 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)?

PCS has incorporated models with upside and downside behavioral health and behavioral health hospital risk, tied to certain quality metrics performance. These qualify for LAN category 3B.

2024 answer:
PCS has incorporated models with upside and downside behavioral health and behavioral health hospital risk, tied to certain quality metrics performance. These qualify for LAN category 3B.

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

2024 answer: NA

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

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

b. What attributes have you incorporated, or do you intend to incorporate, into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier)?

As shared in previous reporting, qualifying VBPs with each of PCS contracted Dental Care Organizations (DCOs) have been in effect for several years, across all CCO regions. When applicable, PCS updates DCO VBP arrangements to reflect changes with CCO quality incentive metrics. This last occurred in 2023 with the health equity/language access metric. PCS continues to collect data about and pursue the meeting of targets by DCOs concerning increasing the number of dental providers participating with VBP arrangements in LAN category 2C or higher to increase the percentage of total provider payments flowing through qualifying VBP provider contracts. PCS expects these efforts to result in a greater percentage of dollars flowing through qualifying VBP arrangements.

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

After convening internal stakeholders in 2023 and 2024 to determine next steps, PCS concluded adding oral health integration to the PCS PCPCH VBP Program would be aligned

with goals PCS currently has related to increasing VBPs, supporting oral health services in primary care and assisting clinics in tier advancing in PCPCH.

The PCPCH VBP Program is an optional program for PCPCHs who seek to go above and beyond to demonstrate access, quality, and accountability. PCS provides an enhanced PCPCH PMPM for participating clinics. Currently, 138 PCPCHs participate in the PCPCH VBP Program.

In 2025, clinics will be required to complete oral health screenings for their entire patient panel as part of the PCPCH VBP Program requirements. PCS will continue internal work in late 2024-2025 to determine next steps for preparing to add oral health interventions in the 2026 PCPCH VBP Program.

9) **a. What is the current status of the new or enhanced VBP model your CCO is reporting for the children's health 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)?

PCS has incorporated models with upside and downside pediatric provider risk, tied to certain quality metrics performance. These qualify for LAN category 3B.

2024 answer:
PCS has incorporated models with upside and downside pediatric provider risk, tied to certain quality metrics performance. These qualify for LAN category 3B.

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

2024 answer: NA

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?**

Click or tap here to enter text.

Section 3: PCPCH Program Investments

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

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

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

☒ Yes
☐ No

If no, please explain:

Click or tap here to enter text.

Section 4: Engaging with Providers on VBP

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

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

2021 response:

- PCS continues to annually convene with provider partners to educate on any new contracting requirements for the coming year (including those in the VBP Roadmap), negotiate the coming year's contract terms, and collaboratively determine quality metrics from the OHA's Aligned Measures Menu set (these metrics span the sectors of primary care, hospital, behavioral health, and oral health). In the second and third quarters of each year, the PCS contracting team for each CCO region meets to determine if there are any contract terms that need to be modified or added for the following year. The team proposes new terms, models, or metrics as appropriate and that adequately meet any OHA requirements for the upcoming year. We consult our regional VBP Roadmaps during this internal process. In the third and fourth quarters, we meet with provider partners to discuss the proposal of the internal contract team. Negotiations follow, often bi-weekly, until the agreement is finalized. Meanwhile, there is an additional quality team (as well as representation from our Analytics Department) and provider partners that meet to

determine what quality metrics to propose for inclusion in the agreement and the targets and weights of each metric.

- PCS continues to contract directly with our provider network and through independent practice associations (IPAs). We set arrangements with both upside and downside risk and aligned quality measures, consistent with the OHA guidance on the HCP-LAN classification for value-based payment (VBP) arrangements.
- PCS continues to offer optional PCPCH (Patient-Centered Primary Care Home) and Behavioral Health Integration (BHI) program participation to support non-billable services that have immense value for OHP members with physical and behavioral health needs. The programs are tied to state criteria and evidence-based standards. Regional meetings, which include both internal stakeholders and provider partners, occur throughout the contract cycle to evaluate and discuss progress on quality metrics and other contract terms.
- PCS collaborates with partners to develop and align VBPs with our 5-year VBP Roadmap in key care delivery areas.
- PCS monitors and evaluates VBP models through monthly contract-based reports (known as "risk reports") that it sends to the contracted entities. These reports include performance on the financial model and performance measures, including Quality Incentive Measures.
- In early 2021, PCS added additional accountable care organizations and IPA primary care populations to Insight, our member analytics platform. The platform, which filters by provider groups, allows for further monitoring of contract performance in various areas, including inpatient and emergency room service utilization, disease prevalence, performance on gap-in-care measures, potentially wasteful care, and a host of other measures that supplement contract monitoring. Our Population Health team works with our provider partners to review reported performance.
- PCS also engages with stakeholders in regional and partner-specific committees and reviews data such as quarterly cost of care and other trend reports.
- As part of the strategy to develop and evaluate VBP models, PCS maintains a VBP capabilities roadmap. As part of this roadmap work, PCS is assessing vendor VBP capabilities to scale further and expand its own VBP capabilities to meet VBP objectives. This project includes internal stakeholders such as Provider Network, IT, Analytics, Finance, and Actuarial.

2022 response:

- PCS continues to annually convene with provider partners to educate on any new contracting requirements for the coming year (including those in the VBP Roadmap), negotiate the coming year's contract terms, and collaboratively determine quality metrics from the OHA's Aligned Measures Menu set (these metrics span the sectors of primary care, hospital, behavioral health, and oral health). In the second and third quarters of each year, the PCS contracting team for each CCO region meets to determine if there are any contract terms that need to be modified or added for the following year. The team proposes new terms, models, or metrics as appropriate and that adequately meet any OHA requirements for the upcoming year. We consult our regional VBP Roadmaps during this internal process. In the third and fourth quarters, we meet with provider partners to discuss the proposal of the internal contract team. Negotiations follow, often bi-weekly, until the agreement is finalized. Meanwhile, there is an additional quality team (as well as representation from our Analytics Department) and provider partners that meet to

determine what quality metrics to propose for inclusion in the agreement and the targets and weights of each metric.

- PCS continues to contract directly with providers, clinics, facilities, and health systems, and through Independent Practice Associations (IPAs). We set arrangements with both upside and downside risk and aligned quality measures, consistent with the OHA guidance on the HCP-LAN classification for value-based payment (VBP) arrangements.
- PCS continues to offer optional PCPCH (Patient-Centered Primary Care Home) and Behavioral Health Integration (BHI) program participation to support non-billable services that have excellent value for OHP members with physical and behavioral health needs. The programs are tied to state criteria and evidence-based standards. Regional meetings, which include both internal stakeholders and provider partners, occur throughout the contract cycle to evaluate and discuss progress on quality metrics and other contract terms.
- PCS collaborates with partners to develop and align VBPs with our 5-year VBP Roadmap in key care delivery areas.
- PCS monitors and evaluates VBP models through monthly contract-based reports (known as “risk reports”) that it sends to the contracted entities. These reports include performance on the financial model and performance measures, including Quality Incentive Measures.
- Previously, PCS added additional accountable care organizations and IPA primary care populations to Insight, our member analytics platform. The platform, which filters by provider groups, allows for further monitoring of contract performance in various areas, including inpatient and emergency room service utilization, disease prevalence, performance on gap-in-care measures, potentially wasteful care, and a host of other measures that supplement contract monitoring. Our Population Health team works with our provider partners to review reported performance.
- PCS also engages with stakeholders in regional and partner-specific committees, and reviews data such as quarterly cost of care and other trend reports.
- As part of the strategy to develop and evaluate VBP models, PCS maintains a VBP capabilities roadmap. As part of this roadmap work, PCS is assessing vendor VBP capabilities to scale further and expand its own VBP capabilities to meet VBP objectives. This project includes internal stakeholders such as Provider Network, IT, Analytics, Finance, and Actuarial.

PCS continues to offer Patient-Centered Primary Care Home, and Behavioral Health Integration program participation to support non-billable services that have excellent value for CCO members with physical and behavioral health needs. In 2022 PCS updated this program to include [redacted] for participating providers/clinics that provide certified Traditional Health Worker services.

In the last year, PCS has begun two new engagements with key provider entities, with a focus on care provided to Medicaid members. PCS and WVP Health Authority have engaged in a series of Joint Operating Committees to review data and discuss cost management and quality improvements for the 45,000 CCO members assigned to WVP primary care providers in the Marion-Polk CCO. Within the Lane CCO, PCS has begun a leadership forum with PeaceHealth to review success metrics, including the 23,000 CCO members assigned to PeaceHealth primary care providers.

2023 response:

- PCS continues to convene annually with provider partners to educate on any new contracting requirements for the coming year (including those in the VBP Roadmap), negotiate the coming year's contract terms, and collaboratively determine quality metrics from the OHA's Aligned Measures Menu set (these metrics span the sectors of primary care, hospital, behavioral health, and oral health). In the second and third quarters of each year, the PCS contracting team for each CCO region meets to determine if there are any contract terms that need to be modified or added for the following year. The team proposes new terms, models, or metrics as appropriate and that adequately meet current OHA requirements. We consult our regional VBP Roadmaps during this internal process. In the third and fourth quarters, we meet with provider partners to discuss the internal contract team's proposals. Negotiations follow, often bi-weekly, until the respective agreement is finalized. Meanwhile, there is an additional quality team (as well as representation from our Analytics Department) that meets with provider partners to determine which quality metrics to include in the agreement, as well as to determine the target and weight of each metric.
- PCS continues to contract directly with providers, clinics, facilities, and health systems, and through Independent Practice Associations (IPAs). We set arrangements with both upside and downside risk and aligned quality measures, consistent with the OHA requirements on the HCP-LAN classification for value-based payment (VBP) arrangements.

  PCS continues to offer optional Patient-Centered Primary Care Home (PCPCH) and Behavioral Health Integration (BHI) program participation to support non-billable services that have excellent value for OHP members with physical and behavioral health needs. The programs are tied to state criteria and evidence-based standards. Regional meetings, which include both internal stakeholders and provider partners, occur throughout the contract cycle to evaluate and discuss progress on the quality metrics and other contract terms. In 2022 PCS updated this program to include [redacted] for participating providers/clinics that provide certified Traditional Health Worker services. In 2023, PCS increased its PCPCH base payments to providers, and clarified and simplified some of the program requirements as requested by providers.
- PCS collaborates with partners to develop and align VBPs with our 5-year VBP Roadmap in key care delivery areas.
- PCS monitors and evaluates VBP models through monthly contract-based reports (known as "risk reports") that it sends to the contracted entities. These reports include performance on the financial model and other measures, including Quality Incentive Measures.
- Previously, PCS added additional accountable care organizations and IPA primary care populations to Insight, our member analytics platform. The platform, which filters by provider groups, allows for further monitoring of contract performance in various areas, including inpatient and emergency room service utilization, disease prevalence, performance on gap-in-care measures, potentially wasteful care, and a host of other measures that supplement contract monitoring. Our Population Health team works with our provider partners to review reported performance.
- PCS also engages with stakeholders in regional and partner-specific committees, and reviews data such as quarterly cost of care and other trend reports.
- As part of the strategy to develop and evaluate VBP models, PCS maintains a VBP capabilities roadmap. As part of this roadmap work, PCS is assessing vendor VBP

capabilities to further scale and expand its own VBP capabilities to meet VBP objectives. This project includes internal stakeholder teams such as Provider Network, IT, Analytics, Finance, and Actuarial.

- In the last year, PCS has begun two new engagements with key provider entities, with a focus on care provided to Medicaid members. PCS and WVP Health Authority have engaged in a series of Joint Operating Committees to review data and discuss improvements in cost management and quality for the 44,000 CCO members assigned to WVP primary care providers in the Marion-Polk CCO. Within the Lane CCO, PCS has begun a leadership forum with PeaceHealth to review success metrics that include the 22,000 CCO members assigned to PeaceHealth primary care providers. PCS also engaged with three (3) provider entities who either resigned their affiliations with local IPAs or severed a relationship with another CCO payor and wished to establish a relationship with PCS. Those ensuing conversations and engagements led to the resumption of value-based arrangements with those providers (Praxis Medical Group/Pacific Medical Group, Mosaic Medical Group, and Salem Health Medical Group) and also the establishment of new PCPCH arrangements.

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

2024 response:

- PCS continues to convene annually with provider partners to educate on any new contracting requirements for the coming year (including those in the VBP Roadmap), negotiate the coming year's contract terms, and collaboratively determine quality metrics from the OHA's Aligned Measures Menu set (these metrics span the sectors of primary care, hospital, behavioral health, and oral health). In the second and third quarters of each year, the PCS contracting team for each CCO region meets to determine if there are any contract terms that need to be modified or added for the following year. The team proposes new terms, models, or metrics as appropriate and that adequately meet current OHA requirements. We consult our regional VBP Roadmaps during this internal process. In the third and fourth quarters, we meet with provider partners to discuss the internal contract team's proposals. Negotiations follow, often bi-weekly, until the respective agreement is finalized. Meanwhile, there is an additional quality team (as well as representation from our Analytics Department) that meets with provider partners to determine which quality metrics to include in the agreement, as well as to determine the target and weight of each metric.
- PCS continues to contract directly with providers, clinics, facilities, and health systems, and through Independent Practice Associations (IPAs). We set arrangements with both upside and downside risk and aligned quality measures, consistent with the OHA requirements on the HCP-LAN classification for value-based payment (VBP) arrangements.
  PCS continues to offer optional Patient-Centered Primary Care Home (PCPCH) and Behavioral Health Integration (BHI) program participation to support non-billable services that have immense value for OHP members with physical and behavioral health needs. The programs are tied to state criteria and evidence-based standards. Regional meetings, which include both internal stakeholders and provider partners, occur throughout the

contract cycle to evaluate and discuss progress on the quality metrics and other contract terms. PCS updated this program to include [redacted] for participating providers/clinics that provide certified Traditional Health Worker services. PCS increased its PCPCH base payments to providers and clarified and simplified some of the program requirements as requested by providers.

- PCS collaborates with partners to develop and align VBPs with our 5-year VBP Roadmap in key care delivery areas.
- PCS monitors and evaluates VBP models through monthly contract-based reports (known as "risk reports") that it sends to the contracted entities. These reports include performance on the financial model and other measures, including Quality Incentive Measures.
- Previously, PCS added additional accountable care organizations and IPA primary care populations to Insight, our member analytics platform. The platform, which filters by provider groups, allows for further monitoring of contract performance in various areas, including inpatient and emergency room service utilization, disease prevalence, performance on gap-in-care measures, potentially wasteful care, and a host of other measures that supplement contract monitoring. Our Population Health team works with our provider partners to review reported performance.
- PCS also engages with stakeholders in regional and partner-specific committees, and reviews data such as quarterly cost of care and other trend reports.
- As part of the strategy to develop and evaluate VBP models, PCS maintains a VBP capabilities roadmap. As part of this roadmap work, PCS is assessing vendor VBP capabilities to further scale and expand its own VBP capabilities to meet VBP objectives. This project includes internal stakeholder teams such as Provider Network, IT, Analytics, Finance, and Actuarial.
- In 2024 PCS has begun discussions with the few primary care entities, or their integrated hospital systems, which are either non-contracted, or contracted at VBP LAN category 1, with the goal of establishing or enhancing relationships which meet OHA requirements for 2024. Discussions are ongoing.

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:

Providence Hood River Medical Center withdrew from a VBP arrangement and is now Category 1.

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 response:
PCS does not believe any of the VBP instituted for 2021 have created any adverse effects on health equity nor for any specific population of members (racial, ethnic, LGBQT, disabled, limited language proficiency, immigrants, medical complexity, etc.).

PCS is mindful of creating contract language that does not impede or exacerbate issues of health equity. We list the following examples to illustrate our processes designed to mitigate adverse effects:

- PCS' Quality and Health Services teams negotiate performance measures that support health equity. Language currently exists in base provider agreements around health equity and Culturally and Linguistically Appropriate Services (CLAS) practices. PCS has updated this language for 2021 agreements. Some examples of measures that support health equity include Follow-Up after Emergency Department Visit for Mental Illness (2021), Assessments for Children in DHS Custody (2021), and the Language Access Measure (2021).
- PCS monitors VBP arrangements to evaluate health outcomes, utilization, cost, and appeals, with reporting regularly. We have expanded this monitoring to include

monitoring of language access needs of primary care groups by the creating a set of health equity dashboards. Additionally, we have added filtering to our Insight platform to include accountable care organizations and IPA-specific groups.

- When setting targets for contracted provider performance, PCS considers historical measure performance or benchmarks and adjusts to give the contracting entity an achievable and meaningful target. An example of this in the Central Oregon CCO, where we apply a higher benchmark to the Postpartum Care QIM to some providers, since the historical performance has been higher than the state benchmark. We continue to review our measure methodology in the VBP Roadmap workgroup to evaluate and improve our contracting measurement strategy to support health equity.
- In consideration of risk adjustment models for VBPs, PCS has been evaluating and considering various methods that could better match payment to risk. While we have done some preliminary research, the lack of commercially available models and the relative immaturity and incompleteness of the social complexity data continues to present significant challenges. We would encourage a workgroup or some level of partnership with OHA to work together to find an optimal solution.

  PCS uses the rate category as a proxy to align payment with risk for direct VBPs (i.e., capitation) and risk-sharing settlements with providers. We base our risk sharing settlements on a budget-based expense target relative to revenue, with the revenue varying by the member's rate category, and adjust to the mix of adults versus children, duals versus non-duals, etc. Rate category captures several areas of social complexity, including dual eligibility, disability, and foster care. It would be informative to understand how much additional gain will be leveraged by layering on additional risk adjustment relative to the current status, to evaluate additional strategies.

  Since September 2020, PCS has chartered a multi-year work plan and launched an internal workgroup dedicated to better understanding social determinants of health (SDOH) data and its relationship to healthcare outcomes. To date, we have:

    - Conducted a preliminary literature review and research on models and factors.
    - Loaded extensive publicly available data sets for relevant external data to analyze further and have started running some statistical tests. We have developed enhanced logic to identify individual level SDOH indicators.
    - Worked closely with projects like Connect Oregon (Unite Us) to ensure that we will be able to leverage patient-level SDOH screening and referral data from that platform. We expect to start receiving data files from Connect Oregon in July 2021.
    - Participated in a pilot with Alliance of Community Health Plans and Socially Determined to learn more about the landscape among other carriers and commercially available products.
- In spring 2021, PCS representatives attended the Evidence-Based Strategies for Advancing Health Equity webinar and had a technical assistance session with Dr. Marshall Chin specifically around VBP and Health Equity to help inform our strategy.

2022 response:
PCS does not believe any of the VBP instituted for 2021 have created any adverse effects on health equity nor for any specific population of members (racial, ethnic, LGBTQ, disabled, limited language proficiency, immigrants, medical complexity, etc.).

PCS is mindful of creating contract language that does not impede or exacerbate issues of health equity. We list the following examples to illustrate our processes designed to mitigate adverse effects:

- PCS' Quality and Health Services teams negotiate performance measures that support health equity. Language currently exists in base provider agreements around health equity and Culturally and Linguistically Appropriate Services (CLAS) practices. PCS has updated this language for 2021 agreements. Some examples of measures that support health equity include Follow-Up after Emergency Department Visit for Mental Illness (2021), Assessments for Children in DHS Custody (2021), and the Language Access Measure (2021).
- PCS monitors VBP arrangements to evaluate health outcomes, utilization, cost, and appeals, with reporting regularly. We have expanded this monitoring to include monitoring of language access needs of primary care groups by the creating a set of health equity dashboards. Additionally, we have added filtering to our Insight platform to include accountable care organizations and IPA-specific groups.
- When setting targets for contracted provider performance, PCS considers historical measure performance or benchmarks and adjusts provide the contracting entity with a target that is both achievable and meaningful. An example of this is the Central Oregon CCO, where we apply a higher benchmark to the Postpartum Care QIM to some providers, since the historical performance has been higher than the state benchmark. We continue to review our measure methodology in the VBP Roadmap workgroup to evaluate and improve our contracting measurement strategy to support health equity.
- In consideration of risk adjustment models for VBPs, PCS has been evaluating and considering various methods that could better match payment to risk. While we have done some preliminary research, the lack of commercially available models and the relative immaturity and incompleteness of the social complexity data continues to present significant challenges. We would encourage a workgroup or some level of partnership with OHA to find an optimal solution.
- PCS uses the rate category as a proxy to align payment with risk for direct VBPs (i.e., capitation) and risk-sharing settlements with providers. We base our risk sharing settlements on a budget-based expense target relative to revenue, with the revenue varying by the member's rate category, and adjust to the mix of adults versus children, duals versus non-duals, etc. Rate category captures several areas of social complexity, including dual eligibility, disability, and foster care. It would be informative to understand how much additional gain will be leveraged by layering on additional risk adjustment relative to the current status to evaluate additional strategies.
- Since September 2020, PCS has chartered a multi-year work plan and launched an internal workgroup dedicated to better understanding social determinants of health (SDOH) data and its relationship to healthcare outcomes. To date, we have:
    - Conducted a preliminary literature review and research on models and factors.

    - Loaded extensive publicly available data sets for relevant external data to further analyze and have started running some statistical tests. We have developed enhanced logic to identify individual level SDOH indicators.
    - Worked closely with projects like Connect Oregon (Unite Us) to ensure that we will be able to leverage patient-level SDOH screening and referral data from that platform. We expect to start receiving data files from Connect Oregon in July 2021.
    - Participated in a pilot with Alliance of Community Health Plans and Socially Determined to learn more about the landscape among other carriers and commercially available products.
- In spring 2021, PCS representatives attended the Evidence-Based Strategies for Advancing Health Equity webinar and had a technical assistance session with Dr. Marshall Chin specifically around VBP and Health Equity to help inform our strategy.

2023 response:

PCS does not believe any of the previously instituted VBPs have created any adverse effects on health equity or for any specific population of members (racial, ethnic, LGBTQ, disabled, limited language proficiency, immigrants, medical complexity, etc.).

PCS is mindful of creating contract language that does not impede or exacerbate issues of health equity. We list the following examples to illustrate our processes designed to mitigate adverse effects:

- PCS' Quality and Health Services teams negotiate performance measures that support health equity. Language currently exists in base provider agreements around health equity and Culturally and Linguistically Appropriate Services (CLAS) practices. PCS has updated this language for prior agreements. Some examples of measures that support health equity include Follow-Up after Emergency Department Visit for Mental Illness, Assessments for Children in DHS Custody, and the Language Access Measure.
- PCS monitors VBP arrangements to evaluate health outcomes, utilization, cost, and grievances and appeals, with reporting on a regular basis. We have expanded this oversight to include monitoring of language access needs of primary care groups by the creating a set of health equity dashboards. Additionally, we have added filtering to our Insight platform to include accountable care organizations and IPA-specific groups.
- When setting targets for contracted provider performance, PCS considers historical measure performance or benchmarks, and adjusts provide the contracting entity with a target that is both achievable and meaningful. An example of this is the Central Oregon CCO, where we apply a higher benchmark to the Postpartum Care QIM to some providers, since the historical performance has been higher than the state benchmark. We continue to review our measure methodology in the VBP Roadmap workgroup to evaluate and improve our contracting measurement strategy to support health equity.
- In consideration of risk adjustment models for VBPs, PCS has been evaluating and considering various methods that could better match payment to risk. While we have done some preliminary research, the lack of commercially available models and the relative immaturity and incompleteness of the social complexity data continues to

present significant challenges. We encourage a workgroup or some level of partnership with OHA to find an optimal solution.

PCS uses the rate category as a proxy to align payment with risk for direct VBPs (i.e., capitation) and risk-sharing settlements with providers. We base our risk-sharing settlements on a budget-based expense target relative to revenue, with the revenue varying by the member's rate category, and adjust to the mix of adults versus children, duals versus non-duals, etc. Rate category captures several areas of social complexity, including dual eligibility, disability, and foster care. PCS would find it informative to understand how much additional gain would be leveraged by layering on additional risk adjustment relative to the current status, to evaluate additional strategies.

Over the past few years PCS has chartered a multi-year work plan and launched an internal workgroup dedicated to better understanding social determinants of health (SDOH) data and its relationship to healthcare outcomes. To date, we have:

- Conducted a preliminary literature review and research on models and factors.
- Loaded extensive publicly available data sets to further analyze and have started running some statistical tests. We have developed enhanced logic to identify individual-level SDOH indicators.
- Worked closely with projects like Connect Oregon (Unite Us) to ensure that we will be able to leverage patient-level SDOH screening and referral data from that platform. We receive data files from Connect Oregon in support of that work.
- Participated in a pilot with both the Alliance of Community Health Plans and Socially Determined to learn more about the landscape among other carriers and commercially available products.

Previously, PCS representatives attended the Evidence-Based Strategies for Advancing Health Equity webinar and had a technical assistance session with Dr. Marshall Chin specifically around VBP and Health Equity to help inform our strategy. Ongoing work and education continue.

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

Our strategies to mitigate potential adverse effects VBPs may have on health inequities or any adverse health-related outcomes for any specific population remain consistent with what is listed above from prior years.

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?

Click or tap here to enter text.

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

2024 answer: It is challenging to know the best path and contemplate how to explain it to providers who will be impacted**.**

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.]

2024 answer: Yes, however this is exploratory as PCS assesses the best path.

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**

Cognizant TriZetto Facets – Core Administration platform with developing VBP capabilities.

[redacted] – Population Health and Care Coordination platform with advanced integration capabilities to support real-time data exchange.

Data Storage Tools – Microsoft SQL Server and Microsoft SQL Server Analysis Services, Microsoft Azure Data Lake, SAS OLAP Cube
Data Modeling Tools – Informatica, Edifecs, Microsoft SQL Server Integration Services, Alteryx Designer and Scheduler, Tableau Prep

Analytics Models – Cotiviti-certified HEDIS software, SQL-built Quality Incentive Measures (mirroring OHA specifications), PCS-developed identification algorithm with risk stratification (v1), Cotiviti DxCG Risk Models, Milliman Health Waste Calculator, Milliman HCG Grouper and Benchmarking, Optum Symmetry Episode Treatment Grouper and Procedure Episode Grouper

Advanced Analytics Processes – SAS, R integration into Tableau, R integration into Microsoft SQL

Server Management Studio, Alteryx Designer

Analytic Languages – SAS, SQL, R, C#.NET, Python

Reliance eHealth Collaborative (Analytics) – The Reliance platform provides data to support performance management and quality reporting of CCO metrics. The Reliance platform also supports clinical workflows to minimize duplication and care quality.

Collective Medical – The Collective platform provides a critical and near real-time collaboration between the CCO and provider partners supporting population health and VBP performance.

Proprietary PCS Tools developed by PCS Analytics:

Member Insight Provider Insight (MiPi) – A comprehensive suite of analytic tools, reports and data visualizations used to support population health and VBPs.

Care Program Identification Algorithm (CPIA) – A categorization algorithm that identifies best fit population health programs for PCS members.

PCS Provider Portal – Supports the delivery of data, analytics, and member assignment data to providers.

PCS standard population health data feeds – PCS has developed a standard set of data feeds with specifications that are provided to providers upon request. These files are typically ingested into a provider's EHR or Population Health Management System. These standard files are accepted by a number of popular vendors like; Lightbeam, Arcadia, Epic, Deerwalk, Springbuk, and numerous others.

PCS' tool set is consistent with the previous response from 2021 except for Collective Medical which we accidentally omitted in prior years.

2023:

PCS' tool set is consistent with the previous response from 2022 except for a Databricks implementation currently in process for 2023.

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

2024:
PCS's tool set is consistent with the previous response from 2023 with the exception of Collective Medical, which has been purchased by, and is now known as, PointClickCare. The Databricks implementation has completed its initial phase but no other major updates or changes here.

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

We have included this information in the responses for Section a., above.

2023: PCS' tool set is consistent with the previous response from 2021 and 2022.

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

2024: PCS' tool set is consistent with the previous response from prior years.

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.

PCS has staff who write and run reports and who help other staff understand the data. Our staff include Data Scientists, Healthcare Data Analysts, Value Based Payment Data Analysts, Business Intelligence report developers, Facets business support developers, Data Integration developers, Data Architects, Risk Adjustment Analysts, Actuaries, and Actuarial Analysts. For 2021, PCS has 17 FTE from these groups allocated to Medicaid. Most staff are in-house employees, although we do engage contracted staff as well. Staff also make reporting capabilities available to providers and staff in the company via self-service methods using tools like SSRS, Tableau, Microsoft Analysis Services, Power BI, and SSRS report builder. As we grow our capabilities and systems, we will be adding additional specialty system administration resources to support core VBP Systems.

The staffing model for 2021 is consistent with the previous year.

In 2023, PCS added two additional staff to support these activities. The staffing model has remained consistent with 2021.

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

2024: PCS' staffing model is consistent with the previous response from prior years.

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**
Plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Summary: One of the high-value use cases of HIE to CCOs and Health Plans is in the ability to improve the ability to gather and aggregate clinical data required to support performance metrics centrally. Performance on OHA QIMs is one of the foundational constructs of our CCO VBP contracts.

Today, much of this data collection is done via custom data feeds from each provider's EHR or through manual/human access to electronic charts stored in the EHR. Ideally, these data would be aggregated and received by the CCO/Health Plan via a consolidated data feed for their members. During the prior contract period, PCS established the viability of utilizing direct data feeds and is in discussion with Reliance and Diameter Health about file formats required to support these quality programs with supplemental data feeds replacing more manual information capture methods. As discussed in HIE Strategies we believe the NCQA DAV program sends a strong signal about the viability of this specific use-case to support VBP across Medicaid, Medicare, and Commercially insured lives.
Reference: https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/data-aggregator-validation/

Activities	Milestones and/or Contract Year
Implement Diameter Health tool or identify alternative strategy to integrate clinical data obtained through HIE in databases used for performance measurement and feedback.	2022 (Completed)
Integrate Reliance HIE clinical data as a supplemental source of encounter data in applicable measures such as electronic clinical quality metrics (eCQMs), Quality Incentive Metrics (QIM), HEDIS, and other measures from Aligned Measure Menu.	2022 (Completed)
Expand integration of clinical data as a source to calculate additional measures from existing sets in use, such as eCQM, QIM, HEDIS, and Aligned Measure Menu, consistent with the requirements set forth in the OHA VBP Roadmap.	2023-2024

VBP Strategy 7 – Acquire and implement modules, tools, and platforms to improve the scalability and performance of value-based payment arrangements.

Summary:

One of the greatest challenges in administering meaningful VBP is the immaturity of the VBP platforms market. We have been researching and exploring scalable solutions to meet the many requirements of administering mature VBP, to date, no clear comprehensive solution has been identified leading us to develop proprietary systems and processes to support arrangements. Starting in 2019, a PCS strategic initiative was created to construct a Roadmap of systems and processes to improve our ability to successfully support advanced VBP in alignment with the LAN framework.

The initial focus of this initiative was to identify and implement a more advanced and capable population health management system to support care and utilization management. One of the primary requirements for this new system was its ability to integrate with internal and external systems with a focus on real-time clinical data.

The focus of the 2021 strategic initiative is on developing a scalable VBP Administration Roadmap that is likely to be comprised of multiple components from existing and new

vendors. We also anticipate that PCS will continue to build some proprietary solutions to address current needs. The VBP Administration Roadmap is anticipated to continue iteratively over the contract period as the market matures to meet the requirements of CCOs.

Activities	Milestones and/or Contract Year
Identify and select next gen Population Health Management/Care Management system.	2020 (completed)
Implement new Care Management platform [redacted]	2021 (Q4) - 2023
Identify prioritized requirements for VBP Administration Initiative.	2021 (Q2)
Identify and select VBP components for implementation in 2022 plan year.	2021 (Q3)
Implement or build selected solutions.	2022
Continue to re-assess and acquire or build components in alignment with VBP Administration Roadmap initiative.	2022-2024 (ongoing)

2023:
Our strategies to support these goals remain consistent with what is listed above from prior years.

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.

PCS had intended to pursue a formal project in 2023 to assess and document viability of using FHIR-based technology to support provider-reported electronic clinical quality measure (eCQM) metrics such as Patient Health Questionnaire 9 (PHQ9) scores and HEDIS electronic clinical data systems (ECDS) for quality measurement and quality reporting. After further evaluation and consideration, we transitioned our strategy away from the PHQ9 measure specifically, and toward HEDIS ECDS broadly, with a focus on measures including breast cancer screening (BCS-E), colorectal cancer screening (COL-E) and so on.)

PCS has previously reported on scalability challenges with our existing care management platform and worked throughout 2023 toward a 2024 implementation of a replacement solution [redacted]. The first wave of a Phase 1 release of this new platform is expected in 2024. The first wave of Phase 1 will support Utilization Management, Pharmacy (including electronic prior authorizations for Pharmacy), and Grievances and Appeals functionality and is expected to launch mid-year. 2024 Health IT Roadmap Guidance, Evaluation Criteria & Report Template - Page 30 The second wave of Phase 1 supporting Care Management, Disease Management and Quality is expected to launch later. A backlog of additional

enhancements and features will follow in Phase 2 with a release date yet to be determined. Because the data resources we currently receive from PCC are not in a format that can easily integrate into [redacted] we will need to evaluate an HIE data infrastructure we can use to integrate these feeds, including identifying actions to continue and expand on supporting population health in real time. This infrastructure enhancement will be considered for inclusion in the Phase 2 efforts noted above. As with today's tools, even after this change we would expect to retain processes with smaller hospital systems where daily census is obtained via phone or fax.)

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

Our strategies and activities to support these goals remain consistent with what is listed above from prior years.

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:

Our strategies to support these goals remain consistent with what is listed above from prior years.

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 response:

Activities that have been canceled or modified have strikethroughs.

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Activities	Milestones and/or Contract Year
Pilot Diameter Health in partnership with Reliance to cleanse, codify, and "enrich" clinical data from Reliance to integrate into the quality measure platform.	2020 (complete)

Validate results of Diameter-calculated metrics against both provider and Reliance-calculated metrics.	2020-2021
Identify standard specification(s) from Reliance for data feeds in supporting CCO quality programs.	2021
~~Implement Diameter Health tool or~~ identify alternative strategy to integrate clinical data obtained through HIE in databases used for performance measurement and feedback.	2022 (complete)
Integrate Reliance HIE clinical data as a supplemental source of encounter data in applicable measures such as eCQM, Quality Incentive Metrics (QIM), HEDIS, and other measures from Aligned Measure Menu.	2022 (complete)
Expand integration of clinical data as a source to calculate additional measures from existing sets in use, such as eCQM, QIM, HEDIS, and Aligned Measure Menu, consistent with the requirements set forth in the OHA VBP Roadmap.	2023–2024

VBP Strategy 7 – Acquire and implement modules, tools, and platforms to improve the scalability and performance of value-based payment arrangements.

Activities	**Milestones and/or Contract Year**
Identify and select next gen Population Health Management/Care Management system.	2020 (Complete)
Implement new Care Management platform ████.	2021 (Q4) – 2023
Identify prioritized requirements for VBP Administration Initiative.	2021 (Q2) (complete)
Identify and select VBP components for implementation in 2022 plan year.	2021 (Q3) (complete)
Implement or build selected solutions.	2022
Continue to re-assess and acquire or build components in alignment with VBP Administration Roadmap initiative	2022-2024 (ongoing)

2022 response:

Listed below are the VBP initiative milestones back to Year One. Activities that PCS has added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethroughs. Any dates that have changed will have a strikethrough on the previous date and will have the revised date next to it.

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Activities	Milestones and/or Contract Year
Pilot Diameter Health in partnership with Reliance to cleanse, codify, and "enrich" clinical data from Reliance to integrate into the quality measure platform.	2020 (complete)
Validate results of Diameter-calculated metrics against both provider and Reliance-calculated metrics.	2020-2021 (complete)
Identify standard specification(s) from Reliance for data feeds in supporting CCO quality programs.	2021 (complete)
~~Determine if the Diameter tool will transform and standardize clinical data to use alongside claims information for quality measure calculation.~~ -	~~2022~~
~~Implement Diameter Health tool or identify alternative strategy to integrate clinical data obtained through HIE in databases used for performance measurement and feedback.~~	~~2022~~
Integrate Reliance HIE clinical data as a supplemental source of encounter data in applicable measures such as eCQM, Quality Incentive Metrics (QIMs), HEDIS, and other measures from Aligned Measure Menu.	2022 -2023
Expand integration of clinical data as a source to calculate additional measures from existing sets in use, such as eCQM, QIM, HEDIS, and Aligned Measure Menu, consistent with the requirements set forth the in the OHA VBP Roadmap.	2023–2024

VBP Strategy 7 – Acquire and implement modules, tools, and platforms to improve the scalability and performance of value-based payment arrangements.

Activities	Milestones and/or Contract Year
Identify and select next gen Population Health Management/Care Management system.	2020 (complete)
Implement new Care Management platform [redacted].	~~2021 (Q4)~~ 2023
Identify prioritized requirements for VBP Administration Initiative.	2021 (Q2) (complete)
Identify and select VBP components for implementation in 2022 plan year.	2021 (Q3) (complete)

Implement or build selected solutions.	2022
Continue to re-assess and acquire or build components in alignment with VBP Administration Roadmap initiative.	2022-2024 (ongoing)
Integrate Reliance data into new Care Management platform ████.	2024-2025

2023 Response

Listed below are the VBP initiative milestones back to Year One. PCS has added activities since 2021's roadmap are identified with "NEW" at the initiative's beginning. Activities that have been canceled or modified have strikethroughs. Any dates that have changed will have a strikethrough on the previous date and will have the revised date next to it.

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Activities	Milestones and/or Contract Year
Pilot Diameter Health in partnership with Reliance to cleanse, codify, and "enrich" clinical data from Reliance to integrate into the quality measure platform.	2020 (complete)
Validate results of Diameter-calculated metrics against both provider and Reliance-calculated metrics.	2020-2021 (complete)
Identify standard specification(s) from Reliance for data feeds in supporting CCO quality programs.	2021 (complete)
~~Determine if the Diameter tool will transform and standardize clinical data to use alongside claims information for quality measure calculation.~~ -	~~2022~~
~~Implement Diameter Health tool or identify alternative strategy to integrate clinical data obtained through HIE in databases used for performance measurement and feedback.~~	~~2022~~
Integrate Reliance HIE clinical data as a supplemental source of encounter data in applicable measures such as eCQM, Quality Incentive Metrics (QIMs), HEDIS, and other measures from Aligned Measure Menu.	2022 (complete)
NEW Explore viability of provider reported eCQM metrics such as PHQ9 scores and ECDS	**2023**

Expand integration of clinical data as a source to calculate additional measures from existing sets in use, such as eCQM, QIM, HEDIS, and Aligned Measure Menu, consistent with the requirements set forth in the OHA VBP Roadmap.	2023–2024
NEW Pilot digital Chart Retrieval from our HIE partners.	**2023–2024**
NEW Explore HIE data to support SDoH screening and gap closure information	**2023-2025**

VBP Strategy 7 – Acquire and implement modules, tools, and platforms to improve the scalability and performance of value-based payment arrangements.

Activities	**Milestones and/or Contract Year**
Identify and select next gen Population Health Management/Care Management system.	2020 (complete)
Implement new Care Management platform .	~~2021 (Q4)~~ **2024**
Identify prioritized requirements for VBP Administration Initiative.	2021 (Q2) (complete)
Identify and select VBP components for implementation in 2022 plan year.	2021 (Q3) (complete)
~~Implement or~~ build selected solutions.	2022-2023 (complete)
Continue to re-assess and acquire or build components in alignment with VBP Administration Roadmap initiative.	2022-2024 (ongoing)
Integrate Reliance data into new Care Management platform .	2024-2025

The plan continues to progress with very few changes. A recent activity was added to VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements.

Explore viability of provider reported eCQM metrics such as PHQ9 scores and ECDS: PCS explored its desire to use inbound interoperability and/or health information exchange data feeds to capture data from providers that PCS can then use to report on provider-reported measures such as Patient Health Questionnaire-9 (PHQ9) depression screening scores and HEDIS electronic clinical data systems (ECDS) performance reporting. There is an increasing need, particularly in behavioral health, to support alternative methods for gathering data to support these claim-based measures. As a result of this exploration, PCS intends to pursue a formal project in 2023 to assess and document viability of using FHIR-based technology to support provider-reported eCQM metrics such as PHQ9 scores and ECDS for quality measurement and reporting. We expect this project to lay the groundwork for support of more value-focused FHIR-based interoperability objectives for provider-reported measures.

Medical Management Platform Implementation has been extended out to 2024: In 2020, PCS selected a new core medical management/population health solution that will allow for the real-time integration of HIE, CIE, and other HIT data. We expected to launch Phase 1 of the new platform in 2022, but the project was delayed. The first wave of Phase 1, which supports Utilization Management, Pharmacy, and Grievances and Appeals, is expected to launch soon. We will begin the second wave of Phase 1, which supports Care Management, Disease Management and Quality, soon thereafter. HIE/CMT integration will follow in Phase 2.

2024 Response: Listed below are the VBP initiative milestones back to Year One. PCS has added activities since 2021's roadmap are identified with "NEW" at the initiative's beginning. Activities that have been canceled or modified have strikethroughs. Any dates that have changed will have a strikethrough on the previous date and will have the revised date next to it.

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Activities	**Milestones and/or Contract Year**
Pilot Diameter Health in partnership with Reliance to cleanse, codify, and "enrich" clinical data from Reliance to integrate into the quality measure platform.	2020 (complete)
Validate results of Diameter-calculated metrics against both provider and Reliance-calculated metrics.	2020-2021 (complete)
Identify standard specification(s) from Reliance for data feeds in supporting CCO quality programs.	2021 (complete)
~~Determine if the Diameter tool will transform and standardize clinical data to use alongside claims information for quality measure calculation.~~ -	~~2022~~
~~Implement Diameter Health tool or identify alternative strategy to integrate clinical data obtained through HIE in databases used for performance measurement and feedback.~~	~~2022~~
Integrate Reliance HIE clinical data as a supplemental source of encounter data in applicable measures such as eCQM, Quality Incentive Metrics (QIMs), HEDIS, and other measures from Aligned Measure Menu.	2022 (complete)
NEW Explore viability of provider reported eCQM metrics such as PHQ9 scores and ECDS	**2023**

Expand integration of clinical data as a source to calculate additional measures from existing sets in use, such as eCQM, QIM, HEDIS, and Aligned Measure Menu, consistent with the requirements set forth the in the OHA VBP Roadmap.	2023-2024
NEW Pilot digital Chart Retrieval from our HIE partners.	**2023-2024**
NEW Explore HIE data to support SDoH screening and gap closure information	**2023-2025**

VBP Strategy 7 – Acquire and implement modules, tools, and platforms to improve the scalability and performance of value-based payment arrangements.

Activities	Milestones and/or Contract Year
Identify and select next gen Population Health Management/Care Management system.	2020 (complete)
Implement new Care Management platform [redacted]	~~2021 (Q4)~~ **2023-2025**
Identify prioritized requirements for VBP Administration Initiative.	2021 (Q2) (complete)
Identify and select VBP components for implementation in 2022 plan year.	2021 (Q3) (complete)
~~Implement or~~ build selected solutions.	2022-2023 (complete)
Continue to re-assess and acquire or build components in alignment with VBP Administration Roadmap initiative.	2022-2024 (ongoing)
Integrate Reliance data into new Care Management platform [redacted].	2024-2025
[redacted]	2024-2025

Briefly summarize updates to the section above:

The plan continues to progress with a few changes.

PCS had intended to pursue a formal project in 2023 to assess and document viability of using FHIR-based technology to support provider-reported electronic clinical quality measure (eCQM) metrics such as Patient Health Questionnaire 9 (PHQ9) scores and HEDIS electronic clinical data systems (ECDS) for quality measurement and quality reporting. After further evaluation and consideration, we transitioned our strategy away from the PHQ9 measure specifically, and toward HEDIS ECDS broadly, with a focus on measures including breast cancer screening (BCS-E), colorectal cancer screening (COL-E) and so on.)

PCS has previously reported on scalability challenges with our existing care management platform and worked throughout 2023 toward a 2024 implementation of a replacement

solution ██████████████. The first wave of a Phase 1 release of this new platform is expected in 2024. The first wave of Phase 1 will support Utilization Management, Pharmacy (including electronic prior authorizations for Pharmacy), and Grievances and Appeals functionality and is expected to launch mid-year. 2024 Health IT Roadmap Guidance, Evaluation Criteria & Report Template - Page 30 The second wave of Phase 1 supporting Care Management, Disease Management and Quality is expected to launch later. A backlog of additional enhancements and features will follow in Phase 2 with a release date yet to be determined. Because the data resources we currently receive from PCC are not in a format that can easily integrate into ██████, we will need to evaluate an HIE data infrastructure we can use to integrate these feeds, including identifying actions to continue and expand on supporting population health in real time. This infrastructure enhancement will be considered for inclusion in the Phase 2 efforts noted above. As with today's tools, even after this change we would expect to retain processes with smaller hospital systems where daily census is obtained via phone or fax.)

In late 2023 PCS began an initiative which has continued into 2024 to explore the implementation of Epic Payer Platform which seeks to improve the flow of information between the CCO and Providers who utilize Epic as their primary EHR. This platform significantly improves the efficiency of exchange of information for several key use cases; medical record retrieval, facilitation of prior authorization, real-time exchange of gap in care data and clinical data exchange to support clinical programs.

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

2021 response:

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Summary: In 2020, PCS determined that receiving and processing raw HL7 clinical data into its Edifecs Clinical Data Warehouse was not viable. This is primarily because of the data inconsistencies and the mapping management required to support these feeds. In Q4 of 2020, PCS discontinued the implementation of the Edifecs Clinical Data Warehouse and began pursuing a more direct file feed approach to establish a clean data feed for support of specific uses or quality programs. This platform was also discontinued by our vendor in favor of more modern FHIR-based approaches. PCS believes a partner like Diameter Health will be key in helping to ensure high quality and consistent data feeds from HIE partners such as Reliance.

Activities	Milestones and/or Contract Year
Pilot Diameter Health, in partnership with Reliance to cleanse, codify, and "enrich" clinical data from Reliance to integrate into the quality measure platform.	2020 (complete)
Validate results of Diameter-calculated metrics against both provider and Reliance-calculated metrics.	2020-2021 (complete)

Identify standard specification(s) from Reliance for data feeds in supporting CCO quality programs.	2021 (in progress)

2022 response:

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

In 2021, PCS, in partnership with Reliance and their vendor IMAT Solutions, continued exploring how to leverage contributed HIE data directly into quality programs as supplemental data. After researching the National Committee for Quality Assurance Data Aggregator Validation program (often referred to as the NCQA DAV program), Reliance has applied to be part of the summer 2022 certification cohort.

The focus of this work is in support of HEDIS for Medicare and Commercial business lines and establishes a certified process for payers to receive supplemental data from their provider partners. This creates a high-value use case, enabling administrative simplification for both providers and payers.

Our goal with this strategy is to create a strong incentive for payers and providers to join a centralized HIE like Reliance and dramatically increase the coverage of HIEs working to receive this certification. In our experience, most providers who service CCO members also have a strong panel of Medicare and/or Commercial members. We are hopeful this program will also establish an accepted standard for supplemental data in support of the various CCO quality metrics that rely on clinical data as a component for measurement.

As we wait for Reliance to go through the NCQA DAV certification process, we expanded our current EMR data model to include additional diagnosis codes and SNOMED codes fed from Reliance data and added this information to our clinical data warehouse, and then loaded this data from the data warehouse into HEDIS. Phase two of this effort will continue to enrich available data in 2022 for use in our HEDIS and QIM quality programs.

Also, PCS decided not to move forward with Diameter Health after the evaluation work was completed, impacting the related 2022-2024 roadmap deliverables. The focus has instead moved to work with Reliance outlined above to put in place the data infrastructure to support Strategy 7. In 2022, PCS will make further adjustments to the roadmap through 2024 based on this.

VBP Strategy 7 – Acquire and implement modules, tools, and platforms to improve the scalability and performance of value-based payment arrangements.

In 2021, PCS begin the implementation of a new population health management platform. That work is still in progress in phases in 2022/2023. Also, in 2021, PCS completed the VBP system solution activities outlined in the roadmap and has commenced implementing the phase 1 solution for 2022.

2023:
VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements.

PCS successfully implemented a pilot project in 2022 to load clinical and lab data from Reliance HIE as a supplemental data source to use in HEDIS measurement year 2021 with a goal to integrate the data more broadly for use in quality incentive measures. As part of the next phase of the project, the provider identifier NPI fields will need to be remediated to make the data more usable as a supplemental data source. The pilot was for Medicare, including dual eligible members that is expanding to Medicaid in 2023.

VBP Strategy 7 – Acquire and implement modules, tools, and platforms to improve the scalability and performance of value-based payment arrangements.

In 2022, PCS began the process to build out a new reporting system for provider VBP shared risk and quality metric incentive arrangements. As of April 2023, PCS completed a major milestone of this build and used the first reports to estimate the financial liabilities for these arrangements for the 2023 contract year. The build process is on track to produce the first provider reports in the new system in June 2023. In addition, the 2022 contact period will be reconciled in the new system in summer 2023. Starting in 2023, PCS began working with its claims and capitation processing system vendor to implement new functionality in that platform to scale prospective payment and capitation arrangements better. PCS also has a strategy to expand administration of retrospective and prospective bundled payments and plans to implement a module of the existing claims-processing platform to administer this type of value-based payment. The current plan is to implement this module in 2024 for use in 2025 VBP arrangements.

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

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements.

Since early 2021, PCS – in partnership with Reliance and their vendor IMAT Solutions – has been exploring how to leverage contributed HIE data directly into quality programs as a supplemental data source (SDS). Healthcare Effectiveness Data and Information Set (HEDIS) chart retrieval and abstraction work is time consuming and often requires access that providers would prefer not to give. Using an SDS offers an option for addressing gap closures in an automated fashion without human intervention. However, direct SDS feeds require considerable time from IT staff at both the provider and payer/CCO. Reliance solves this problem by acting as a data aggregator, pulling data from providers, and sending data to payers in a way each is already accustomed to. Our initial intent with this strategy was that it would create a strong incentive for payers and providers to join a centralized HIE like Reliance and dramatically increase the coverage of HIEs. In our experience, most providers who serve CCO members also have a strong panel of Medicare and/or Commercial members. We have been hopeful this program would also establish an accepted standard for supplemental data in support of the various CCO Quality metrics that rely on clinical data as a component for measurement. This incentive is proving out to some degree.

The on-going trajectory of this work from inception through 2023 has included: Expanding our data model to include additional diagnosis and SNOMED codes fed from Reliance data. Adding this information to our clinical data warehouse. Loading this data from the data warehouse into our HEDIS program as standard supplemental data. Identifying and implementing areas of improvement with Reliance to member matching, provider matching and provider/NPI parsing. Implementing automated monthly member data feeds between Reliance and PCS. While the results initially considered compliant and approved as supplemental data by our auditors were limited, it has proven the model as a proof of concept for the work. Through multiple iterations of Reliance and PCS sharing test files and validation feedback over the last two years, we have continued to see a significant year-over-year improvement in the quality and quantity of supplemental data being returned.

VBP Strategy 7 – Acquire and implement modules, tools, and platforms to improve the scalability and performance of value-based payment arrangements.

In 2022, PCS began the process to build a new reporting system for provider VBP shared risk and quality metric incentive arrangements. As of April 2023, PCS completed a major milestone of this build and used the first reports to estimate the financial liabilities for these arrangements for the 2023 contract year. The build process produced the first provider reports in the new system in June 2023. In addition, the 2022 contact period was reconciled in the new system in summer 2023. Starting in 2023, PCS worked with its claims and capitation processing system vendor to implement new functionality in that platform to scale prospective payment and capitation arrangements better. PCS has put on hold its strategy to expand administration of retrospective and prospective bundled payments and does not plan to implement a module of the existing claims-processing platform to administer this type of value-based payment currently due to the focus around the existing community risk model.

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

2021 response:
Vendor technology immaturity is a major driver. PCS has done several reviews of technology vendors supporting VBP administration over the years, including in 2020. Each time, we have determined that the solutions are too narrow in scope to truly address the broad set of capabilities required including the following:

1) Integration with other PCS systems (Claims Processing, Financial, Billing, etc.) – Integration with other systems for tracking total cost of care is critical for hybrid payment models. This feature is necessary to ensure VBP processes are working with, rather than against, our systems supporting the classic fee-for-service claims-processing model.
2) Support of multiple payment models (PMPM, Bundled Services, Pay for Performance, shared savings, etc.) – Our experience is that most solutions only address one or two of these varied models, at most. This capability is necessary to address VBP approaches as we understand them today.
3) Flexible addition of novel payment models – Without the ability to add new types of models to a system, we are forced to manually track payment models outside of

any system we purchase. This capability is critically necessary to support the future of VBPs.

Without these basic feature sets, too much manual administration becomes necessary outside of the VBP platform, thereby making the platform unusable.

2022 response:
In 2021, PCS completed an evaluation of VBP-administration vendors and a process improvement project examining the existing infrastructure. This resulted in a 2022 Analytics/IT project charter to improve the existing internal reporting process for pay-for-performance and budget-based financial arrangements. The focus of the 2022 project is integration of non-standard data sources and moving all calculations into a data-access layer.

2023: Data integration supporting provider-reported measures continues to be a challenge, particularly for behavioral health care. PCS has a project in 2023 to pilot the viability of ECDS metrics such as PHQ9 scores. As mentioned above, PCS explored its desire to use inbound interoperability and/or health information exchange data feeds to capture data from providers that PCS can then use to report on provider-reported measures such as Patient Health Questionnaire-9 (PHQ9) depression screening scores and HEDIS electronic clinical data systems (ECDS) performance reporting. There is an increasing need, particularly in behavioral health, to support alternative methods for gathering data to support these claim-based measures. As a result of this exploration, PCS intends to pursue a formal project in 2023 to assess and document viability of using FHIR-based technology to support provider-reported eCQM metrics such as PHQ9 scores and ECDS for quality measurement and quality reporting. We expect this project to lay the groundwork for support of more value-focused FHIR-based interoperability objectives for provider-reported measures.

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

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

PCS had intended to pursue a formal project in 2023 to assess and document viability of using FHIR-based technology to support provider-reported electronic clinical quality measure (eCQM) metrics such as Patient Health Questionnaire 9 (PHQ9) scores and HEDIS electronic clinical data systems (ECDS) for quality measurement and quality reporting. After further evaluation and consideration, we transitioned our strategy away from the PHQ9 measure specifically, and toward HEDIS ECDS broadly, with a focus on measures including breast cancer screening (BCS-E), colorectal cancer screening (COL-E) and so on.

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 response:

VBP Strategy 2 - Implement and develop measures for VBP arrangements that focus on provider efficiency and potentially wasteful care

Summary: In 2020, PCS developed visualizations as part of its Provider Insight platform that demonstrated provider performance with Milliman Health Waste Calculator measures. We piloted a set of provider-facing reports with a group of provider partners and got their feedback around improvements. In 2021 and beyond, we intend to develop patient-level reports and broadly distribute the aggregate and patient-level reports to our provider partners to give them the appropriate level of information to act on these identified areas of potential waste. Milliman has its own roadmap to expand the list of measures and will continue to adopt its software updates and new measures annually.

Activities	Milestones and/or Contract Year
Develop and deliver phase 1 reports for use in 2021 VBP contracts.	2021
Develop later phase reports for use in 2022-2025 VBP contracts, including member level detail.	2022-2024

VBP Strategy 3 - Implement and/or develop a comprehensive list of measures that align with state efforts to standardize measures in VBP arrangements to share with provider partners in VBP arrangements

Summary: In 2020, PCS developed and implemented a limited set of four of the Aligned Measures Menu set. PCS sent these to its provider partners via the existing gap care reports and Excel Member Insight. In 2021, we intend to implement a broader set of the Aligned Measures Menu in preparation for 2022 contracting. Our efforts initially focused on HEDIS measures, since currently we include our Medicaid population in our existing HEDIS measure calculation software and have results for the entire set of administrative measures. The work we intend to do in 2021 and beyond is to integrate that data into our enterprise data warehouse and provider reporting suite to expand the set of measures and create common measure options for our provider partners who also serve our Medicare and Commercial lines of business.

Activities	Milestones and/or Contract Year
Continue development to align measures in our value-based arrangements with the OHA Aligned Measures Menu as measures are added or changed.	2021-2024
Evaluate software to support measure calculation measures and changes to specifications.	2022-2024
Continue to annually evaluate changes to measure sets and incorporate changes.	2021-2024

VBP Strategy 4 - Provider attribution supports accurate payment incentives for primary care and specialist physical health providers

Summary: In addition to longstanding reports that are regularly provided to providers regarding member assignment, we have expanded our focus to support specialist attribution. As listed in the 2020 progress section below work has taken place to implement Optum Episode Treatment Groups (ETG) and Procedure Episode Group (PEG) which contains a method for attributing responsible providers to a condition or procedure-based episode of care. We started piloting reports of this attribution with our provider partners in early 2021, moving forward we will be sharing member-level reports in addition to the summary-based reports we have created to inform providers on the cost and utilization of those attributed episodes. This will give specialists a better understanding of how the uses of services vary for their attributed members. In addition, our plan is to complete the improvements to 2021 Primary Care Physician (PCP) attribution and utilize that to inform member PCP assignment changes where the attributed PCP does not match what has been assigned.

Activities	Milestones and/or Contract Year
Specialist Attribution - Develop attribution capability to inform specialists about their performance related to peers.	2021-2022
PCP Attribution - Compare claims-based PCP attribution to PCP assignment to identify changes in PCP assignment.	2021-2024 (Ongoing)
Specialist Attribution - Develop and distribution standard reports based on specialist attribution.	2021-2024

2022 response:

Listed below are the VBP initiative milestones back to Year One. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethroughs. Any dates that have changed will have a strikethrough on the previous date and will have the revised date next to it.

VBP Strategy 3 - Implement and/or develop a comprehensive list of measures that align with state efforts to standardize measures in VBP arrangements to share with provider partners in VBP arrangements

This strategy does not have any significant changes from the last roadmap. The expansion of new measures has transitioned to an annual standard work process and will be ongoing. PCS did evaluate some platforms in 2021 to support measure calculation a year ahead of the roadmap activities and chose not to make a transition at the time.

Activities	Milestones and/or Contract Year
Compare the Aligned Measures Menu with existing Quality Incentive Measure, HEDIS, and other standard quality measures to identify any gaps for development.	2019-2020 (complete)
Add measures to existing care report gaps and the Member Insight and Provider Insight.	2019–2020 (complete)
Build workflows to share updated reports with provider partners.	2019-2020 (complete)
Continue development to align measures in our value-based arrangements with the OHA Aligned Measures Menu as measures are added or changed.	2021-2024 (ongoing)
Evaluate software to support measure calculation measures and changes to specifications.	2022-2024
Continue to annually evaluate changes to measure sets and incorporate changes.	2021-2024

Listed below are the VBP initiative milestones back to year one. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethroughs. Any dates that have changed will have a strikethrough on the previous date and will have the revised date next to it.

VBP Strategy 4 - Provider attribution supports accurate payment incentives for primary care and specialist physical health providers

Summary: Over 2020 and 2021, PCS tested a sample of specialist attribution of episodes of care with a small group of provider partners. As part of the process, PCS identified that changes with provider mapping needed to occur to better attribute specialist providers to these episodes. In 2022, PCS is improving the mapping to better address the specialist attribution. Once this process is complete, broader distribution of specialist episodes of care reporting will occur to help inform specialists of their performance relative to their (de-identified) peers.

Activities	Milestones and/or Contract Year
PCP Attribution - Implement modifications to claims based PCP attribution methodology in alignment with HCPLAN Patient Attribution white paper where applicable https://hcp-lan.org/pa-whitepaper/.	2020–2021 (in process)

Specialist Attribution - Implement software to attribute specialist providers to members for procedures and condition-based episodes of care.	2020 (complete)
Specialist Attribution - Develop standard Tableau reports based on specialist attribution.	2020 (complete)
Specialist Attribution - Pilot reports that use the software's specialist provider attribution logic.	2020 (complete)
Specialist Attribution - Test with provider that mapping of providers into software and attribution to episodes are accurate.	2020-2021 (complete)
Specialist Attribution - Develop attribution capability to inform specialists about their performance related to peers.	~~2021-2022~~ 2022-2024
PCP Attribution - Compare claims-based PCP attribution to PCP assignment to identify changes in PCP assignment.	2021-2024 (ongoing)
NEW PCP Attribution- Collective pilot of "Assigned/Not Established Patients" functionality, which creates the ability to assign or attribute a population of patients to a specific provider or clinic in Collective, easing the provider's ability to meet value-based payment performance metrics by establishing care with patients from the health plans with whom they work.	2022
Specialist Attribution - Develop and distribute standard reports based on specialist attribution.	~~2021-2024~~ 2023-2024

Listed below are the VBP initiative milestones back to Year One. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethroughs. Any dates that have changed will have a strikethrough on the previous date and will have the revised date next to it.

VBP Strategy 2 - Implement and develop measures for VBP arrangements that focus on provider efficiency and potentially wasteful care

Activities	Milestones and/or Contract Year
Integrate Milliman MedInsight software in PCS IT environment.	2019 (complete)
Model output files in enterprise data warehouse in preparation for reporting.	2020 (complete)
Gather reporting requirements.	2020 (complete)
Develop and pilot initial set of provider-facing reports.	2020 (complete)

Develop and deliver phase 1 reports for use in 2021 VBP contracts.	~~2021~~ 2022
Develop later phase reports for use in 2022-2025 VBP contracts, including member level detail.	~~2022-2024~~ 2023-2024

2023:
Listed below are the VBP initiative milestones back to Year One. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethroughs. Any dates that have changed will have a strikethrough on the previous date and will have the revised date next to it.

VBP Strategy 3 - Implement and/or develop a comprehensive list of measures that align with state efforts to standardize measures in VBP arrangements to share with provider partners in VBP arrangements. This strategy has moved to standard work. Every year, PCS reviews measure changes relevant to VBP goals and ensures that new measures are available to report in contracting.

Activities	Milestones and/or Contract Year
Compare the Aligned Measures Menu with existing Quality Incentive Measure, HEDIS, and other standard quality measures to identify any gaps for development.	2019-2020 (complete)
Add measures to existing care report gaps and the Member Insight and Provider Insight.	2019-2020 (complete)
Build workflows to share updated reports with provider partners.	2019-2020 (complete)
Continue development to align measures in our value-based arrangements with the OHA Aligned Measures Menu as measures are added or changed.	2021-**2024** (ongoing)
Evaluate software to support measure calculation measures and changes to specifications.	2022-2024
Continue to annually evaluate changes to measure sets and incorporate changes.	2021-2024

VBP Strategy 2 - Implement and develop measures for VBP arrangements that focus on provider efficiency and potentially wasteful care. This strategy continues to be a focus where efforts align with quality incentive measures and care delivery area goals.

Activities	Milestones and/or Contract Year
Integrate Milliman MedInsight software in PCS IT environment.	2019 (complete)
Model output files in enterprise data warehouse in preparation for reporting.	2020 (complete)
Gather reporting requirements.	2020 (complete)
Develop and pilot initial set of provider-facing reports.	2020 (complete)
Develop and deliver phase 1 reports for use in 2021 VBP contracts.	~~2021~~ 2022
Develop later phase reports for use in 2022-2025 VBP contracts, including member level detail.	**~~2022-2024~~ 2023-2024**

VBP Strategy 4 - Provider attribution supports accurate payment incentives for primary care and specialist physical health providers. PCS continues to execute this strategy to improve primary care attribution and specialist attribution methods. One active project is an improvement to the provider specialty information going into the specialist episode tool to improve the responsible provider's attribution of the condition or procedure episode.

Activities	Milestones and/or Contract Year
PCP Attribution - Implement modifications to claims based PCP attribution methodology in alignment with HCPLAN Patient Attribution white paper where applicable https://hcp-lan.org/pa-whitepaper/.	2020-2021 (in process)
Specialist Attribution - Implement software to attribute specialist providers to members for procedures and condition-based episodes of care.	2020 (complete)
Specialist Attribution - Develop standard Tableau reports based on specialist attribution.	2020 (complete)
Specialist Attribution - Pilot reports that use the software's specialist provider attribution logic.	2020 (complete)
Specialist Attribution - Test with provider that mapping of providers into software and attribution to episodes are accurate.	2020-2021 (complete)
Specialist Attribution - Develop attribution capability to inform specialists about their performance related to peers.	~~2021-2022~~ 2022-2024

PCP Attribution - Compare claims-based PCP attribution to PCP assignment to identify changes in PCP assignment.	2021-2024 (ongoing)
NEW PCP Attribution- Collective pilot of "Assigned/Not Established Patients" functionality, which creates the ability to assign or attribute a population of patients to a specific provider or clinic in Collective, easing the provider's ability to meet value-based payment performance metrics by establishing care with patients from the health plans with whom they work.	2022
Specialist Attribution - Develop and distribute standard reports based on specialist attribution.	~~2021-2024~~ 2023-2024

PCS continues to utilize consistent tools to deliver information to providers such as SFTP, PCS portal, secure e-mail, Collective, Reliance and Connect Oregon.

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.**

PCS' approach remains consistent with prior years responses.

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

PCS' approach remains consistent with prior years responses.

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

PCS continues to utilize consistent tools to deliver information to providers such as SFTP, PCS portal, secure e-mail, PointClickCare (formerly Collective), Reliance and Connect Oregon

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 uses 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 response:

VBP Strategy 5 - Implement information sharing processes with providers that identify members who will most benefit from outreach, intervention, or care management support

Summary: As mentioned in the 2020 progress response below, PCS made additional progress integrating additional sources of data into infrastructure to help identify which members will most benefit from these types of support. In support of this work, PCS has developed a proprietary prescriptive Care Program Identification Algorithm (CPIA) that allows it to identify and place members into best-fit programs. Today, population health information (including risk scores, provider/patient assignment, care program eligibility, gaps in care, ED visit rates and other key data) is shared via our Member Insight Provider Insight (MiPi) dataset. This dataset continues to be expanded to support providers in population health management. It is our vision that it will be further expanded to include SDOH information. As mentioned in other parts of this narrative, PCS will be receiving information about SDOH screening and will be looking to integrate it into algorithms and population-level reporting to help understand the needs of our members via our MiPi Platform and other means. Providers have access to MiPi in a number of different ways including our provider portal, Secure File Transfer Protocol (SFTP), and secure email, depending on their preferences.

Activities	Milestones and/or Contract Year
Annually implement new tools and algorithms.	2021-2024
Design and develop reports that will leverage data from the tools implemented in earlier years.	2021-2024
Integrate CPIA program identification into new PCS ██████ Population Health solution.	2021 (Q4)
Define pertinent visualizations and weave them into our standard reporting structure.	2021-2024
Integrate provider efficiency tools into self-service platforms. Enhance reporting available through provider portals.	2021-2024

VBP Strategy 6 - Improve risk stratification reporting to include enrollment in care management and other support programs and data from clinical and other non-claims sources

Summary: In 2020, PCS was able to add additional care management program information into its MiPi tool via CPIA. We share these care program enrollments externally with providers via our InTouch Portal, SFTP transfer, and in some cases via encrypted e-mail to help providers identify PCS programs in which members are enrolled. MiPi also includes a current and prior risk score to support risk stratification. We will continue to add new external data sources to the care program algorithm to expand the information set used to identify and prioritize members for care management programs.

Activities	Milestones and/or Contract Year
Annual update reporting with data from provider insight and care program identification.	2021-2024
Explore the applicability of SDOH information to augment clinical risk scores.	2021-2024

2022 response:
Listed below are the VBP initiative milestones back to year one. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethroughs. Any dates that have changed will have a strikethrough on the previous date and will have the revised date next to it.

VBP Strategy 5 - Implement information sharing processes with providers that identify members who will most benefit from outreach, intervention, or care management support

Summary: PCS continues to further develop and refine metrics and algorithms to support provider partners in identifying members who will most benefit from outreach, intervention, or care management support. PCS is engaged with implementing a new population health management platform that will receive and contain logic and information necessary for care management support. PCS also has been working with Collective Medical to create cohorts for intervention, which can be shared with participating provider partners via the platform. This is further explained in the HIT Roadmap under the Hospital Event Notification (HEN) section.

Activities	Milestones and/or Contract Year
Implement reporting of additional information to provider partners that supports population health management and quality of care.	2020 (ongoing)
Assess new types of information for addition to integrated database such as clinical, SDOH-E, and consumer data.	2020 (ongoing)
Assess validity of integrated data.	2020 (complete)
Alter Provider Insight to capitalize on available information.	2020 (complete)
Evaluate and implement new Tableau tools and algorithms that compare provider efficiency and quality of services provided.	2020 (complete)
Give providers actionable data about improvements.	2020 – 2021 (ongoing)
NEW Add high-value customized cohorts and reports built around the specific needs of internal users (HEN Strategy 1).	2020 - 2024 (ongoing)

Annually implement new tools and algorithms.	2021-2024 (ongoing)
Design and develop reports that will leverage data from the tools implemented in earlier years.	2021-2024 (in process)
Integrate CPIA program identification into new PCS Population Health solution.	~~2021 (Q4)~~ 2023
Define pertinent visualizations and weave them into our standard reporting structure.	2021-2024
Integrate provider efficiency tools into self-service platforms. Enhance reporting available through provider portals.	2021-2024

VBP Strategy 6 - Improve risk stratification reporting to include enrollment in care management and other support programs and data from clinical and other non-claims sources

Summary: In 2021, PCS participated in the Integrated Care for Kids initiative with OHA. As part of the work to support the initiative, PCS implemented Seattle Children's Pediatric Medical Complexity algorithm. PCS also developed logic to identify several social complexity factor flags for children and adults in the household and integrated information about member housing insecurity and SDOH factors collected by HIE and CIE partners. This helped PCS augment the medical and social information coming from OHA via the Childhood Health Complexity algorithm and allows it to apply the logic to children in all lines of business. The outcome of this work has been to integrate it into the PCS internal Care Program Identification Algorithm.

Activities	Milestones and/or Contract Year
Complete the third version of the care program identification algorithm to integrate non-claims-based data sources.	2020 (complete)
Integrate care program information into reporting for provider partners.	2020 (complete)
NEW Development of pediatric social and medical complexity identification algorithm to help risk stratify pediatric members for care management.	2021 (complete)
NEW Develop enhanced SDOH identification methods that incorporate data from multiple sources (such as Connect Oregon/Unite Us, claims, Collective, etc.) to improve member stratification.	2021 (complete)
Annual update reporting with data from provider insight and care program identification.	2021-2024 (in process)
NEW Staging screening and other data from Unite Us CIE into Enterprise Data Warehouse	2021-2024 (on-going)
Explore the applicability of SDOH information to augment clinical risk scores.	2021-2024 (in process)

2023 response:

Listed below are the VBP initiative milestones back to year one. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethroughs. Any dates that have changed will have a strikethrough on the previous date and will have the revised date next to it.

VBP Strategy 5 - Implement information sharing processes with providers that identify members who will most benefit from outreach, intervention, or care management support

Summary: Consistent with prior years PCS continues to further develop and refine metrics and algorithms to support provider partners in identifying members who will most benefit from outreach, intervention, or care management support. PCS is currently engaged with the second phase of implementation of a new population health management platform that will receive and contain logic and information necessary for care management support. PCS continues to work with Collective Medical to create cohorts for intervention, which can be shared with participating provider partners via the platform.

Activities	Milestones and/or Contract Year
Implement reporting of additional information to provider partners that supports population health management and quality of care.	2020 (ongoing)
Assess new types of information for addition to integrated database such as clinical, SDOH-E, and consumer data.	2020 (ongoing)
Assess validity of integrated data.	2020 (complete)
Alter Provider Insight to capitalize on available information.	2020 (complete)
Evaluate and implement new Tableau tools and algorithms that compare provider efficiency and quality of services provided.	2020 (complete)
Give providers actionable data about improvements.	2020 – ~~2021 2024~~ (ongoing)
Add high-value customized cohorts and reports built around the specific needs of internal users	2020-2024 (ongoing)
Annually implement new tools and algorithms.	2021-2024 (ongoing)
Design and develop reports that will leverage data from the tools implemented in earlier years.	2021-2024 (in process)

Integrate CPIA program identification into new PCS [redacted] Population Health solution.	~~2021 (Q4) 2023~~ 2024
Define pertinent visualizations and weave them into our standard reporting structure.	2021-2024
Integrate provider efficiency tools into self-service platforms. Enhance reporting available through provider portals.	2021-2024

VBP Strategy 6 - Improve risk stratification reporting to include enrollment in care management and other support programs and data from clinical and other non-claims sources

Summary: Recently, a new decision support tool was developed to support the Health Services team in stratifying members into specific care management programs. This tool integrates data from Collective, Reliance, Connect Oregon, lab result data, claims, and other sources to help identify member needs. This tool is part of the CPIA program identification algorithm and presents aspects of that tool as responses to specific questions used by the member support specialists as part of their workflow. The Connect Oregon data is integrated from the data staged from Unite Us.

Activities	Milestones and/or Contract Year
Complete the third version of the care program identification algorithm to integrate non-claims-based data sources.	2020 (complete)
Integrate care program information into reporting for provider partners.	2020 (complete)
NEW Development of pediatric social and medical complexity identification algorithm to help risk stratify pediatric members for care management.	2021 (complete)
NEW Develop enhanced SDOH identification methods that incorporate data from multiple sources (such as Connect Oregon/Unite Us, claims, Collective, etc.) to improve member stratification.	2021 (complete)
Annual update reporting with data from provider insight and care program identification.	2021-2024 (in process)
Staging screening and other data from Unite Us CIE into Enterprise Data Warehouse	2021-2024 (on-going)
Explore the applicability of SDOH information to augment clinical risk scores.	2021-2024 (in process)

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

With the changes to the Care Management program OARs PCS has been working on additional updates to existing tools and algorithms to support the PCS care team these new risk stratification requirements. PCS is currently participating in a workgroup with OHA to help inform the changes to the risk stratification method and process and is awaiting some clarity on OHAs direction around the risk stratification methods desired before implementing

any changes. We expect that those changes will be implemented over the next several months.

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 and 2022 responses:

PCS educates its providers on HIT Tools and VBP-related data via a team of staff that includes Population Health Strategists, Quality Performance Coaches, HIE Clinical Strategists, Provider Representatives, and others. When we meet with providers, we review dashboards and gap lists to ensure that provider partners and their staff understand how to use and "work" the reporting. During this review, we discuss what these numbers mean, how to drill down into the detail, and what the organization can take away as action items. The data can also help drive workflow changes that improve performance and efficiency. The reporting we developed is updated regularly and is immediately actionable.

2023: PCS' approach remains consistent with 2021 and 2022 responses.

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

PCS' approach remains consistent with prior years responses.

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

Estimated percentage	Reporting method
50%	Excel or other static reports
0	Online interactive dashboard that providers can configure to view performance reporting for different CCO populations, time periods, etc.
0	Shared bidirectional platform (example: Arcadia) that integrates electronic health record data from providers with CCO administrative data.
50%	Other method(s): Data Extracts
[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)?

Our delivery of reporting is consistent across distinct types of providers. We also provide summary CCO and Community Level summary of performance.

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

2021 response:

VBP Strategy 2 - Implement and develop measures for VBP arrangements that focus on provider efficiency and potentially wasteful care

Summary: In 2020, we developed visualizations as part of our Provider Insight platform that demonstrated provider performance with Milliman Health Waste Calculator measures. The Waste Calculator is a stand-alone software tool designed to help health care organizations leverage value-based principles by identifying wasteful services, as defined by national initiatives, such as Choosing Wisely and the U.S. Preventive Services Task Force. This tool can add significant value to existing cost and quality reporting capabilities, specifically those efforts designed for efficiency and effectiveness measurement. Measure categories range from diagnostic testing, screening tests to preoperative evaluation, and routine follow up and monitoring. We piloted a set of provider-facing reports with a group of provider partners and got their feedback on improvements. This work aligned well with release of the *Better Health for Oregonians: Opportunities to Reduce Low-Value Care* released by Oregon Health Leadership Council (OHLC) and Oregon Health Authority (OHA).

Activities	Milestones and/or Contract Year
Integrate Milliman MedInsight software in PCS IT environment.	2019 (complete)
Model output files in enterprise data warehouse in preparation for reporting.	2020 (complete)
Gather reporting requirements.	2020 (complete)
Develop and pilot initial set of provider-facing reports.	2020 (complete)

VBP Strategy 3 - Implement and or develop a comprehensive list of measures that align with state efforts to standardize measures in VBP arrangements to share with provider partners in VBP arrangements

Summary: In 2020, we developed and implemented a limited set of four of the Aligned Measures Menu set out to our provider partners via the existing gap care reports and Excel Member Insight. We also evaluated the entire set and developed the longer-term implementation plan which continues in 2021. We also identified that we might need to augment the Aligned Measures Menu with additional measures specific to Behavioral Health to meet the goals of our emerging Behavioral Health VBP arrangements more closely.

Activities	Milestones and/or Contract Year
Compare the Aligned Measures Menu with existing Quality Incentive Measure, HEDIS, and other	2019-2020 (ongoing)

standard quality measures to identify any gaps for development.	
Add measures to existing care report gaps and the Member Insight and Provider Insight.	2019-2020 (ongoing)
Build workflows to share updated reports with provider partners.	2019-2020 (ongoing)

VBP Strategy 4 - Provider attribution supports accurate payment incentives for primary care and specialist physical health providers

Summary: In 2020, we began the process to better align our PCP based claims attribution logic with the HCPLAN patient attribution white paper to improve and align our methods with these national standards. These improvements will be used to inform PCP assignment changes. Additionally, we implemented the Optum Episode Treatment Groups and Procedures Episode groups which contain a responsible provider attribution method that allows us to identify a specialist provider to an episode of care. We built a set of Tableau visualizations as part of Provider Insight Platform and have been piloting views with provider groups to inform how their cost and utilization of services compare with others.'

Activities	Milestones and/or Contract Year
PCP Attribution - Implement modifications to claims based PCP attribution methodology in alignment with HCPLAN Patient Attribution white paper where applicable https://hcp-lan.org/pa-whitepaper/.	2020–2021 (in process)
Specialist Attribution - Implement software to attribute specialist providers to members for procedures and condition-based episodes of care.	2020 (complete)
Specialist Attribution - Develop standard Tableau reports based on specialist attribution.	2020 (complete)
Specialist Attribution - Pilot reports that use the software's specialist provider attribution logic.	2020 (complete)
Specialist Attribution - Test with provider that mapping of providers into software and attribution to episodes are accurate.	2020–2021 (in process)

VBP Strategy 5 - Implement information sharing processes with providers that identify members who will most benefit from outreach, intervention, or care management support

Summary: In 2020, we made additions to our provider reporting suite to add additional elements to the Member Insight about participation in care management programs as well as new gap in care measures in our gap in care reporting to help providers identify additional measures and information for outreach and intervention. Additionally, there was significant effort to integrate new data sources such as SDOH screening information,

REAL+D information from the enrollment files, claims, etc., to help prepare for future data sharing of that information with providers.

Activities	Milestones and/or Contract Year
Implement reporting of additional information to provider partners that supports population health management and quality of care.	2020 (ongoing)
Assess new types of information for addition to integrated database such as CIE data, SDOH-E, and consumer data.	2020 (ongoing)
Assess validity of integrated data.	2020 (complete)
Alter Provider Insight to capitalize on available information.	2020 (complete)
Evaluate and implement new Tableau tools and algorithms that compare provider efficiency and quality of services provided.	2020 (complete)
Give providers actionable data about improvements.	2020-2021 (ongoing)

VBP Strategy 6 - Improve risk stratification reporting to include enrollment in care management and other support programs and data from clinical and other non-claims sources

Summary: In 2020, we were able to add additional care management program information into our Member Insight tool which we share externally with providers via our InTouch Portal, SFTP transfers and, in some cases, via encrypted e-mail to help providers identify which PCS programs members are enrolled in and members' risk stratification.

Activities	Milestones and/or Contract Year
Complete the third version of the care program identification algorithm to integrate non-claims-based data sources.	2020 (complete)
Integrate care program information into reporting for provider partners.	2020 (complete)

2022 response:
In 2021, in support of the new COVID vaccine measure, PCS created COVID vaccine reporting for providers that included data from Alert vaccine registry, Reliance, Collective Medical, claims, and the COVAX registry to help providers identify which members were meeting the COVID vaccine measure and which members had gaps in care. To help support providers with the risk stratification of members, PCS added Normalized Census Tract Area Deprivation Index (ADI) and Normalized Census Block Group ADI to the Excel MI Insight reporting that is shared with provider partners. The Area Deprivation Index (ADI) is a

measure of socioeconomic neighborhood deprivation using census data. The index is a composite of different neighborhood characteristics such as poverty, housing, employment, and education. This information helps providers stratify and identify members who may have needs for additional social supports.

In 2021, PCS added eight additional measures, as previously mentioned throughout this narrative, for use in VBP contracts as part of the Aligned Measure Menu strategy.

2023 response:
PCS integrated claims data into Reliance HIE to help support closing information gaps at the point of care. The data that PCS sends to providers is currently limited to the Central Oregon and Columbia Gorge regions, where provider data contribution is currently most prevalent, and the Marion-Polk region, where data feeds began flowing to Reliance in 2022. PCS expects to add all claims for all regions and all lines of business to Reliance in 2023.

IET Report Pilot: With PCS support, Reliance and COHIE held a pilot with four health organizations in Central Oregon to test and validate its new IET notification report, which is an alerting service to notify care management teams of IET index events in their patient population. The pilot used PCS member data and ran for six months at no cost to the participating clinics. Participants primarily focused on validating the IET notifications, data timeliness and accuracy, and patient attribution to the clinic. Some also used the IET notifications to operationalize patient tracking and outreach.

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

In 2023, we expanded our data sharing with Reliance to include all claims data for all Oregon members across all lines of business, not just Medicaid.

An issue uncovered by the 2022 IET Report pilot was that there is currently little to no visibility of patient activity in Reliance from BH or substance treatment facilities that fall under the 42 CFR Part 2 consent model. This creates difficulty for caregivers to discover whether a patient has engaged with a SUD treatment facility. In 2023, Reliance worked on a proposed design to address data related to this consent challenge; they are currently working through internal testing and iterative bug fixes of the consent functionality that will potentially allow the use of 42 CFR Part 2 content in a range of reporting, including IET reports used by clinics in the PCS-served communities. Reliance expects a more robust testing program to occur with its Participating Partners during the first half of 2024. Reliance intends to revisit the restrictions on 42 CFR Part 2 information with its legal counsel in early 2024 to determine how data released through the consent process may be used. Restrictions on redisclosure of protected information may restrict the use of the information in reports like IET. Based on guidance received from counsel, Reliance will start working to incorporate claims-based data that may be 42 CFR Part 2 covered content into IET Reporting in early 2024. The use of the claims-based data in IET and other reporting will be available without restrictions related to consent.

In December 2023, COPIA reported to PCS that for Central Oregon CCO Quality measures, the community met the IET metric for the very first time. COIPA deployed many tactics and efforts to address this measure and noted they believe a big piece of that success was the IET Report. BH organizational exchange with the HIE and visibility for primary care will continue to enrich the IET Report further, providing even better actionable data for practices doing care coordination.

In Q1 2024, Reliance released its new Community Health Record & Behavioral Health Dashboard, which includes the Initiation and Engagement of Substance Use Disorder Treatment (IET) Report as well as a Screening, Brief Intervention and Referral Treatment (SBIRT) Report and a report of Depression screening for patients aged 12 and older screened for clinical depression.

Provider organizations must be active data contributors to the Reliance eHealth Exchange to participate and receive access to the BH Dashboard reports, for a nominal annual fee. Reports are available real-time through on-demand retrieval via the Reliance web portal and for a small additional fee, via secure email on a daily, weekly, and monthly cadence.

The IET Report includes patient identifying information and the following:

- Date of Service
- Sending Facility
- Insurance company name
- PCP
- Record Type (ADT, CCD, etc.)
- Cohort (such as alcohol or other drug)
- Cohort Dx
- URL

IET data shared by a 42 CFR Part 2 entity/SUD facility is not included, but claims data provided by a payer that alerts to the event happening, including information about the diagnosis, is included in the report.

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

2021 response:
In 2020, there was significant need for providers to pivot their focus to adapt to COVID-19 impacts, such as implementing and expanding telehealth, among other activities. This caused the focus on contract performance measures to diminish, and contracts moved to reporting-only for 2020. It also meant that the care delivery areas roadmap requirements changed, and our work has since adapted to those changing requirements. While we did continue to share performance measures including new performance measures from the Aligned Measures Menu set, some activities, and deadlines to support this work were adjusted accordingly. The biggest area impacted was provider education and training.

2022 response:
The COVID-related challenges outlined above continued through 2021 and continued to impact provider-facing strategies in 2021.

2023 response:
PCS has built a robust internal data and analytics tool that tracks each measure continuously throughout the year, analyzing both rolling 12-month and year-to-date performance by CCO, PCP and DCO for all eCQMs and claims-based measures. As a

result, our internal logic historically matches the OHA final dashboards within a 0.01 percent variance. For the four eCQMs, our reporting organizations submit data monthly so we can track performance, spot nuances, and address challenges as they arise.

In each of the PCS CCOs, we have full transparency in this program. We share CCO-wide performance by measure across the PCP groups as we believe the population and metrics are cared for by the collective body of providers. Each month our provider partners are shared three sets of documents: CCO Dashboards, Clinic Dashboards and Metric Gap Lists.

The largest set of challenges for this body of work surround the eCQMs. These measures require organizations to have their own technical code writers who can take standard metrics and create custom reporting according to specifications for the Screening, Brief Intervention and Referral to Treatment (SBIRT) and Cigarette Prevalence measures. Since these measures do not use standard HEDIS metrics that most EHR platforms stock as standard workflows, each organization must interpret measure specifications, making this work incredibly challenging. We work hard to support these providers to ensure proper reporting, but the challenges still exist.

We also continue to have difficulty aligning provider inbound specifications to either our old standard or any new aligned standard in support of interoperability (such as FHIR). Disparate and changing data integrations make it more difficult to collect data and use it to calculate clinical measures. Standardization remains a key strategy.

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

As PCS continues to work through the multi-year work plan around the Social Determinants of Health (SDoH) Quality Incentive Measure (QIM) we have identified an opportunity for SDoH QIM to better align with the HEDIS Social Needs Screening Measure (SNS-E)measure specifications. We are anticipating that providers may face some challenges in building and maintaining workflows and HIT Data exchange that meet the needs of both measures particularly for patients like dual eligible members that have both coverages and need to have their screening and referral results meet the needs of both measures.

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?

PCS would appreciate technical assistance in these areas:

- Exploring risk adjustment for social factors if this is a priority for the OHA
- Developing strategies for gathering and maximizing REALD information
- Better understanding of the interplay between VBP's and MMLR requirements

- TA session for provider partners and/or written guidance on how to approach the Exhibit L Supplemental SE form since it is geared toward CCOs.

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

PCS would welcome an established data sharing mechanism to provide CCOs with more complete social risk information than what is currently available, particularly for data elements collected upon enrollment but not shared with CCOs. For example, information such as refugee status or history, incarceration history, poverty level, or tribal affiliation would help ensure more complete and less fragmented data would be available to develop social risk factors to be used to investigate relationships with spending, quality, or potential underservice.

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

Click or tap here to enter text.