Oregon's Primary Care Transformation Initiative

2019 Progress Report

Primary Care Payment Reform Collaborative

April 2020

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Oregon Health Authority

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Executive Summary

Background

The Primary Care Payment Reform Collaborative ("Collaborative") is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA).[1] The Collaborative advises and assists OHA in implementing the Primary Care Transformation Initiative ("Initiative") to:

- Use value-based payment (VBP) methods to increase investment in primary care, align primary care reimbursement, and improve reimbursement methods, including by investing in the social determinants of health;
- Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care; and
- Facilitate the integration of primary care behavioral and physical health care.

The legislation directs the Collaborative to develop strategies that support the implementation of the Initiative, including the provision of technical assistance to payers and providers; the aggregation of data and alignment of metrics with the Health Plan Quality Metrics Committee; and evaluation of the Initiative.

The Collaborative includes 41 members representing a range of providers, payers and other primary care stakeholders; membership categories are defined in statute. Over the last year, the Collaborative met quarterly, with monthly meetings for work groups focused on implementation, technical assistance, evaluation and metrics.

This report reviews the Collaborative's 2018 recommendations, outlines the group's work in 2019 to implement those recommendations, and concludes with steps for making progress in 2020.

2018 recommendations

In its 2018 progress report, the Collaborative endorsed aligned payment models, infrastructure to support payment innovation, and strategies for implementation. The Collaborative recommended the following:

1. **Adopting complementary multi-payer value-based payment models**
   VBPs promote quality and value of health care services, shifting away from pure volume-based payment (fee-for-service). The Collaborative recommended that payers and providers adopt two complementary VBP models — a primary care payment model based on the federal Comprehensive Primary Care Plus (CPC+) program and a primary care and behavioral health integration payment model. The Collaborative's recommendation of these payment models seeks to align, facilitate and hasten the adoption of innovative payment across Oregon.

[1] Chapter 575 Oregon Laws; Senate Bill [SB] 934 [2017].

2. **Developing an infrastructure to support the Primary Care Transformation Initiative**
The Collaborative recommended a strong, sustainable infrastructure to support success of this transformative work. The infrastructure should include technical assistance, monitoring, evaluation, data collection and aggregation, and a standardized process for identifying eligible clinics to participate in the VBP models.

3. **Enlisting stakeholder support for implementation and coordination of the Initiative**
The Collaborative's recommendations require support and coordination from multiple stakeholders including the Oregon Legislature, all health care payers that provide coverage in Oregon, all primary care providers in Oregon, all contracting health systems in Oregon, the Oregon Health Authority and the Department of Consumer and Business Services.

2019 activities to advance the Initiative

In 2019 the Collaborative took the following actions to support implementation of the 2018 recommendations:

- **Assessed technical assistance (TA) resources:** The TA Work Group conducted an initial assessment of technical assistance resources across the state that could be aligned with the Collaborative's efforts. The work group found that, while TA resources exist, lack of funding prevents leveraging those resources to build an infrastructure that supports the Initiative.
- **Developed an evaluation plan:** The Evaluation Work Group worked with the Oregon Health & Science University Center for Health System Effectiveness to develop four evaluation options for review by Collaborative members.
- **Established a framework for matching patients and providers:** The Collaborative partnered with the Oregon CPC+ Payer Group to develop a framework and set of definitions to promote clarity and identify opportunities for alignment around attribution.
- **Agreed on a measure set:** The Metrics Work Group developed a measure set to be used in the performance-based incentive payment component of the primary care payment model to support improved patient outcomes.
- **Identified existing resources for implementation:** The Collaborative and OHA staff identified existing state resources and programs that could be leveraged to implement and advance the Initiative, including the OHA Patient-Centered Primary Care Home (PCPCH) Program, the Primary Care Spending Report, the All Payer All Claims (APAC) Reporting Program and the Transformation Center.
- **Monitored payment model implementation:** The Collaborative considered how to best monitor the implementation of the model by payers and providers. The Collaborative began the development of reporting templates and received updates from the first group of payers implementing the payment model.

What's next for 2020

In 2020, the Collaborative will continue to advance primary care payment reform. The group will address implementation challenges including lack of statewide infrastructure, voluntary implementation and variation in attribution approaches. The Collaborative also will monitor and align with national and state initiatives, learn from other regions, and explore funding to support evaluation.

Introduction

The Primary Care Payment Reform Collaborative ("Collaborative") is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA)[2]. The Collaborative advises and assists OHA in implementing a Primary Care Transformation Initiative ("Initiative") to:

- Use value-based payment (VBP) methods that are not paid on a per-claim basis to:
    - Increase the investment in primary care,
    - Align primary care reimbursement by all purchasers of care, and
    - Continue to improve reimbursement methods, including by investing in the social determinants of health;
- Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care; and
- Facilitate the integration of primary care behavioral and physical health care.

The legislation directs the Collaborative to support the implementation of the Initiative through the following strategies:

- Provide technical assistance to clinics and payers in implementing the Initiative;
- Aggregate the data from and align the metrics used in the Initiative with the work of the Health Plan Quality Metrics Committee; and
- Evaluate whether the goals of the Initiative were met by December 31, 2027.

The Collaborative includes 41 members representing a broad range of provider, payer and other primary care stakeholders; membership categories are defined in statute. At the start of 2019 the Collaborative formed four work groups: Implementation, Technical Assistance, Evaluation and Metrics. By late 2019, the Implementation and Technical Assistance Work Groups merged to foster efficiency and alignment. OHA hosted four Collaborative meetings and 23 work group meetings in 2019. Details about the Collaborative's process and work are in the group's charter in Appendix A and workplan in Appendix B.

This report reviews the Collaborative's 2018 recommendations, outlines the group's work in 2019 to implement those recommendations, and concludes with steps for making progress in 2020.

Primary Care Transformation Initiative: 2018 Recommendations

The Collaborative's recommendations to advance the Initiative fall into the following categories: payment models, infrastructure and implementation. These recommendations are complementary and should be considered as a whole, rather than as separate parts.

[2] Chapter 575 Oregon Laws; Senate Bill [SB] 934 [2017].

Recommendation: Adopt complementary multi-payer payment models

VBPs, which are foundational to the Initiative, are strategies used by payers to promote quality and value of health care services. The goal of VBPs is to shift from pure volume-based payment (fee-for-service) to payments that reward providers for "value" of care, including improvements in quality, utilization and health outcomes.

Two complementary VBP models — a primary care payment model and a primary care and behavioral health integration payment model — are central to the Collaborative's recommendations. While payers and providers have been working together over the years to identify and implement alternative ways to invest in and pay for primary care, the Collaborative's recommendation of these two multi-payer payment models seeks to facilitate, hasten and align the adoption of innovative payment mechanisms across Oregon.

Primary care payment model

The multi-payer primary care payment model recommended by the Collaborative supports the implementation of the Oregon Patient-Centered Primary Care Home (PCPCH) model of care and fosters alignment of payment methodologies. The payment model aims to standardize payment methodologies and reduce administrative burden for payers and providers. It is the Collaborative's intent that all payers and providers adopt this model.

The payment model aligns with the Centers for Medicare & Medicaid Services' (CMS) Comprehensive Primary Care Plus (CPC+) advanced primary care medical home VBP model, in which Oregon participates. The payment model extends the CPC+ framework to all payers in Oregon and to non-CPC+ clinics, including pediatric practices, federally qualified health centers, and rural health clinics.

The Collaborative recommends all health care payers that provide coverage in Oregon implement an aligned payment model with the four following components:

1. *Advanced primary care infrastructure payments (per-member, per-month [PMPM] payments)*
   These are risk-adjusted, population-based PMPM payments that sustainably support a high-functioning primary care system.
2. *Performance-based incentive payments (PBIP)*
   These are payments for performance on priority accountability measures, such as population-based quality metrics and utilization.
3. *Fee-for-service (FFS) payments*
   FFS is the traditional health care payment model for most payers.
4. *Comprehensive primary care payments (prospective, up-front payment)*
   These are prospective, population based PMPM or lump sum payments calculated from historical FFS payments for a defined set of primary care services.

All clinics participating in the payment model must be recognized as a PCPCH by OHA and use federally certified electronic health record technology. Clinics with 1,000 or more patients are required to participate in at least two of the three VPB components of the payment model.

All clinics meeting the criteria and expectations will be eligible to participate in the payment model within three years of its implementation following a phased schedule.

To ensure success of the Initiative, all health care payers that provide coverage in Oregon are expected to implement the model; be accountable for shared and equitable VBP investment; implement the model broadly across populations and practice types; and share data. The recommendations also include VBP targets. The VBP targets align with categories in the Health Care Payment Learning and Action Network (HCP LAN) framework and include both category-specific targets and targets for all VBPs to primary care combined. The targets are intended to be aspirational but achievable and will be re-evaluated and refined by the Collaborative over time based on experience and evaluation evidence.

Primary care and behavioral health integration payment model

Integrating behavioral health services with primary care is a foundational tenet of Oregon's health system transformation efforts. The Collaborative's three recommendations below comprise a payment model that supports primary care and behavioral health integration. The payment model seeks to address finance and payment barriers through fostering alignment of payment and performance methodologies.

1. *Health plan contracting structure*
   Payers, providers and other contracting entities (such as independent practice associations) should work together to develop contractual mechanisms with integrated primary care clinics where all services delivered at the clinic are included in the same contract with the health plan.

2. *Improved access to integrated behavioral health care for patients*
   Payers should remove pre-authorization requirements for behavioral health services delivered in an integrated primary care clinic, as with other primary care services. Payers should remove double co-pays for patients who see a primary care provider and behavioral health clinician on the same day. Payers should remove policies that reject two payments for services provided on the same day by a primary care provider and behavioral health clinician.

3. *Sustainable payment approach*
   Payers should provide population-based payments to integrated primary care clinics that meet PCPCH behavioral health integration standards. In addition to population-based (PMPM) payments, payers should reimburse primary care providers and behavioral health clinicians working in a clinic with integrated health care for an agreed-upon set of FFS codes with no pre-authorization requirements.

Recommendation: Develop an infrastructure to support the Primary Care Transformation Initiative

The Collaborative is recommending a strong, sustainable infrastructure to achieve the success of this transformative work. The statewide infrastructure will:

- Provide payer and provider technical assistance;
- Monitor participating payers and providers (including through reporting mechanisms and practice eligibility oversight);
- Oversee and coordinate evaluation of the Initiative;
- Provide a standardized process for identifying eligible clinics to participate in the value-based payment models; and
- Provide a common portal for data collection and aggregation to minimize administrative costs and maximize timeliness of reporting and reliability of data. Oregon's Clinical Quality Metrics Registry and the CPC+ data aggregation solution may be leveraged for this purpose in the future. In addition to collecting and aggregating data from providers, data policies and infrastructure should support access to data needed by payers and providers to fully participate in value-based payment arrangements.

Recommendation: Enlist stakeholder support for implementation and coordination of the Initiative

The Collaborative is recommending the spread of mechanisms to support primary care transformation, with an emphasis on innovative payment models supported by a statewide infrastructure. This effort requires support and coordination. Outlined below are the requests the Collaborative made in 2018 of each stakeholder group to ensure progress.

Oregon Legislature

- Support the development of a statewide infrastructure, as outlined above, with sustainable funding so stakeholders can successfully implement and evaluate the Initiative. This infrastructure is foundational for success.
- Facilitate the establishment of a structure and framework to support the spread of aligned value-based payments in primary care, while avoiding codifying details of the Collaborative's payment model recommendations that could impede flexibility to learn from and build on work underway.
- Amend Section 4(3) and Section 7 of Senate Bill 934 (2017) to include all payers in Oregon, not just those participating in a national primary care medical home payment model (CPC+).

All health care payers that provide coverage in Oregon

- Adopt, implement and report on all the payment model strategies outlined in this report.
- In the spirit of transparency and to foster alignment, share pay-for-performance VBP model structures in a public reporting process. This would not include detailed information that could put payers at risk of violating antitrust law.

All primary care providers in Oregon

- Adopt, implement and report on the payment model strategies outlined in this report, including participation in VBP models with the payers the clinic contracts with, now or in the future.
- Apply for and maintain clinic PCPCH recognition from OHA.

All contracting entities in Oregon

- Support all primary care clinics to transition to the PCPCH model of care and to the VBP model components outlined in this document.

Oregon Health Authority

- Continue to serve as convener of the Collaborative with dedicated resources.
- Align agency VBP policies to support the work of the Collaborative and participate in the implementation of the Initiative.
- Collaborate with the Department of Consumer and Business Services to develop a report on progress of Initiative strategies.
- Support necessary infrastructure to facilitate success (see Infrastructure recommendation), including alignment with the PCPCH program as the foundation for establishing eligibility for the payment model, monitoring of transformational activities to ensure compliance with the model, and technical assistance to support peer-to-peer learning and spread of best practices.

Department of Consumer and Business Services

- Align agency VBP policies to support the work of the Collaborative and participate in the implementation of the Initiative.
- Collaborate with OHA to develop a report on progress of Initiative strategies.

2019 Activities to Advance the Initiative

In 2019, the Collaborative took action to advance the Primary Care Transformation Initiative.

Initial assessment of technical assistance resources across state

The Collaborative launched a Technical Assistance (TA) Work Group to identify and leverage current TA resources offered to help practices and payers implement the Initiative, including preparing for and participating in VBP models. The work group conducted an initial assessment of technical assistance resources to understand the TA currently provided across the state that could be aligned to support the Collaborative's work. The main finding was that while TA resources exist, lack of funding prevents leveraging those resources to build an infrastructure that supports the Initiative.

Primary Care Transformation Initiative evaluation options

The Collaborative assembled an Evaluation Work Group to develop and coordinate an evaluation of the Initiative's implementation. The OHA Transformation Center contracted with the Oregon Health & Sciences University Center for Health System Effectiveness (CHSE) to develop evaluation options with Collaborative members and OHA staff.

The CHSE team brought four options to the Evaluation Work Group and Collaborative for feedback. The four evaluation options summarized in the table below are complementary and not mutually exclusive.

Overview of evaluation options for the Primary Care Transformation Initiative

	Option 1: Describe payment arrangements	**Option 2: Cross-state commercial comparison**	**Option 3: Cross-clinic Medicaid comparison**	**Option 4: Qualitative clinic sample**
Key considerations	Evaluates implementation across all payers	• Comparison states strengthen study design • Addresses role of price in total cost of care	• Lack of comparison state weakens study design • CCO-reported data allows for clinic level analysis	• Resource-intensive data collection • Rich information not otherwise available
Population studied	All insurance types	Commercial patients only	Medicaid patients only	Subset of clinics; all insurance types
Evaluated areas				
Increased investment in primary care		X		
Containment of total costs of care and costs to consumers		X		
Adoption of VBP methods	X		X	
Alignment of payment methods	X (by insurance type)		X (clinic-level Medicaid)	
Improvement on utilization and quality measures		X	X	
Adoption of payment methods to address social determinants of health				X
Integration of physical and behavioral health		X	X	X
Reporting requirements	All payers report contracting arrangements by tax ID number and insurance type	None	• CCOs report contracting arrangements and assigned/attributed clinics for each patient • OHA reports clinic participation dates	Clinics respond to surveys and participate in interviews

The CHSE team and OHA Collaborative staff are exploring funding opportunities to support evaluation.

Matching patients and providers: definitions and framework

Collaborative members identified attributing patients to providers as a crucial component of adopting the payment models. In its 2018 report, the Collaborative recommended payers, purchasers, providers and patients adopt a set of principles for patient attribution to ensure more effective VBP investment in primary care. The intent of these principles is to foster alignment and transparency on methodology used to match patients and providers, and to ensure outcome metrics associated with VBPs accurately reflect a clinic's patient population.

This year, the Collaborative expanded on this work by developing a "Matching Patients and Providers: Definitions and Framework" document (Appendix C) in partnership with the Oregon CPC+ Payer Group. The intent of the document is to clarify definitions and provide a framework outlining the components and principles that drive processes that match patients and providers. It is intended that the definitions and framework will be used by members of the CPC+ Payer Group and the Collaborative to communicate the methods used in primary care VBP models.

Payers completed the framework document for each line of business in their health plan, and the information, with an accompanying analysis, will be shared with Collaborative members in 2020. One key outcome could be the identification of common methods across payers to promote alignment.

Initiative measure set

The Primary Care Transformation Initiative Measure Set ("measure set"), which will be used in the performance-based incentive payment component of the primary care payment model, was developed by the Collaborative's Metrics Work Group from August 2018 through December 2019. The purpose of the measure set (Appendix D) is to ensure high quality care to patients and to support the goal of improved patient outcomes. The measures evaluate both quality and utilization, incentivizing payers and providers. The measures are categorized into six domains of health care services, which align with the Health Plan and Quality Metrics domains. These include:

1. Prevention/Early Detection
2. Chronic Disease and Special Health Needs
3. Acute, Episodic and Procedural Care
4. System Integration and Transformation
5. Patient Access and Experience
6. Cost/Efficiency

The measures are intended to be part of the necessary foundational infrastructure, as described in the 2018 recommendations starting on page 6, to support implementation of the Initiative strategies. In addition, this infrastructure should support a standardized method for clinics to report the measure data, such as a common portal for data collection and aggregation to minimize administrative costs and maximize timeliness of reporting and reliability of data.

The Collaborative Metrics Work Group (or comparable technical advisory group) will convene annually to review and make recommendations about revisions to the measure set. Revisions will be informed by payer and provider feedback and the legislative requirements of the Initiative. Challenges remain in creating this measure set as well as additional areas for exploration; the Collaborative will seek to address these issues in 2020.

A significant barrier to VBP implementation is the lack of measure alignment. Payer-specific initiatives and federal and state measure reporting requirements result in multiple reporting requirements from different entities on numerous and varying measures that are burdensome. The volume of measures and variation in data collection methods and benchmarking place an increasing burden on practices transitioning to new payment models.

The Metrics Work Group and the Collaborative discussed the tension between a comprehensive measure set and a focused, limited one to minimize the burden on clinics. The work group endeavored to balance these two needs by creating a measure set informed by and aligned with other state and national measure sets such as the Health Plan and Quality Metrics Aligned Measures, the CPC+ measures and the 2017 PCPCH measure 2.A core and menu metrics. However, the use of the measure set will likely be limited because payers are not required to use it.

Existing state resources and programs that could be leveraged for the Initiative

The Collaborative and OHA staff identified existing state resources and programs that could be leveraged to implement and advance the Initiative.

PCPCH program

The PCPCH program recognizes primary care practices across the state for implementing a model of primary care delivery that supports the triple aim. Over 640 primary care practices are recognized as PCPCHs across Oregon.

The PCPCH program has the capability through its application to identify practices that meet some of the eligibility requirements to participate in the two complementary payment models recommended by the Collaborative. The PCPCH program can identify practices by:

- PCPCH tier level (1 through 5 STAR)
- Practice type (for example: pediatrics, federally qualified health center, rural health clinic)
- Clinics with more than 1,000 patients and clinics with fewer than 1,000 patients
- Which certified electronic health record the PCPCH is using

The PCPCH application could be used to identify practices that may be ready to participate in the recommended payment model. Additionally, the PCPCH program produces a number of reports and undertakes activities, including TA associated with site visits, that could facilitate the adoption of VBP. Possible opportunities to leverage the PCPCH program are detailed in Appendix E.

Primary Care Spending in Oregon report

For four years, OHA and the Department of Consumer and Business Services have published the annual *Primary Care Spending in Oregon* report to comply with Chapter 575 Oregon Laws 2015. The report provides statewide information on claims-based and non-claims-based medical spending allocated to primary care across multiple payers. The report is used to measure progress toward the primary care spending target established in Senate Bill 934, enacted in 2017, which requires each CCO and commercial payer to allocate at least 12% of its medical spending to primary care by 2023. This report informs the work of the Collaborative and is used to monitor overall primary care spending in the state.

All Payer All Claims (APAC) Reporting program

The APAC database houses administrative health care data for Oregon's insured populations. It includes medical and pharmacy claims, enrollment data, premium information and provider information for Oregonians who are insured through commercial insurance, Medicaid and Medicare.

Beginning in 2020, payers will report non-claims-based expenditures and VBP arrangements through a designated APAC Payment Arrangement file, which was specifically designed to accommodate reporting on VBPs such as those identified in the Collaborative's recommendations. This data could be used to track compliance with the payment model spending targets in the Initiative.

Transformation Center

The Transformation Center is the hub for innovation and quality improvement for Oregon's health system transformation efforts to achieve better health, better care and lower costs for all. The Transformation Center will provide TA to Oregon's CCOs on the VBP requirements in the CCO contracts over the next five years, which are aligned with payment models in the Initiative. This TA could be beneficial to CCOs as they implement the Collaborative payment models.

Report on payment model implementation progress

In its 2018 recommendations, the Collaborative included an implementation plan for the primary care payment model that leverages the existing multi-payer participation in CPC+. According to that timeline, starting in 2020 all payers that are not participating in CPC+ should be offering the payment model to any of the 159 Oregon clinics participating in CPC+ within the payers' networks.

The following payers are participating in CPC+.

Commercial payers

- CareOregon
- Moda Health Plan, Inc.
- PacificSource
- Providence Health Plan and Providence Health Assurance
- UnitedHealthcare

Coordinated care organizations (CCOs)*

- Advanced Health
- AllCare CCO, Inc.
- Columbia Pacific CCO
- Eastern Oregon CCO
- HealthShare of Oregon (not a CPC+ payer, but represented by other participating Health Share of Oregon payer partners CareOregon and Providence)
- InterCommunity Health Network
- Jackson Care Connect
- PacificSource Central Oregon
- PacificSource Columbia Gorge
- PrimaryHealth
- Trillium CCO
- Willamette Valley Community Health Organization
- Yamhill Community Care Organization

*2019 participating CCOs. List will change for 2020.

At the October 2019 Collaborative meeting, several non-CPC+ payers provided an update on their implementation progress as it aligns with the timeline.

Aetna

Aetna is supportive of the payment model and is pursuing options for implementation in the commercial market. The insurer has implemented innovative primary care payment models for Medicare in other regions and those efforts will inform initiatives in Oregon as Aetna increases its market share. Aetna does not have any Medicaid members in Oregon.

Regence Blue Cross Blue Shield

In 2021 Regence will introduce a VBP model that aligns with the Collaborative's recommendation to clinics in their network with fewer than 1,000 attributed Regence members. Regence has an existing VBP model for medical groups with 1,000 or more attributed members, Total Cost of Care. The payment model will be an advance primary care infrastructure payment and a performance- based incentive payment (PBIP). The PBIP includes fewer than 15 quality metrics, the majority of which align with CCO incentive metrics.

HealthNet Health Plan of Oregon, Inc.

HealthNet Health Plan of Oregon is committed to adopting the Primary Care Payment Reform model. However, it will be an incremental process, and they are interested in pursuing Primary Care First, a recently introduced program from the Centers for Medicare & Medicaid that will be offered in Oregon in 2021.

In addition to the payers above, non-CPC+ payers Tuality Health Alliance and Umpqua Health Alliance were unable to provide an update on their implementation progress at the meeting due to staff and organizational changes.

What's Next for 2020

Looking ahead to 2020, the Collaborative has several key focus areas.

National and state initiatives

The Collaborative plans to monitor national initiatives such as Primary Care First for possible alignment with Oregon's payment reform efforts. In addition, the Collaborative will continue to research and meet with other states that have implemented primary care payment reform collaboratives, primary care spending targets and other related initiatives to inform Oregon's work and align with national best practices. The national Primary Care Collaborative has collected resources on primary care investment at https://pcpcc.org/primary-care-investment.

Initiative evaluation

The Collaborative will continue to explore funding to support evaluation of the Initiative.

Implementation challenges

The Collaborative will discuss issues that may hinder full implementation of the Collaborative's 2018 recommendation. Issues that have been identified include:

- Lack of statewide infrastructure to support TA to practices and payers, evaluation, or to monitor payer and provider participation. A statewide infrastructure was identified as foundational to the success of the Initiative in the Collaborative's 2018 recommendations. The Collaborative and the Technical Assistance and Implementation Work Group identified that significant support will be needed to implement the Initiative for non-CPC+ clinics and populations.
- Voluntary implementation of the recommendations by payers and providers.
- No employers with self-funded health plans are represented on the Collaborative, despite recruitment efforts by OHA and Collaborative members. Self-funded health plans are a significant portion of Oregon's payers, and their lack of participation will impact broad implementation.
- CMS has introduced the Primary Care First payment initiative that could, for some payers and providers, supersede the CPC+ payment model, upon which the Collaborative's model is based.
- Variation in attribution methodology across payers.

The Collaborative made progress in 2019 defining and exploring a number of strategies for successful implementation of the Initiative. Learning from other states and working across stakeholders, the

Collaborative will continue to promote primary care payment reform to meet the triple aim of better health, better quality and lower costs for all Oregonians.

Collaborative Members

- Carolyn Anderson, Clinical Quality Director, Mountain View Medical Center
- Gary Ashby, Health Insurance Specialist, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services
- Maggie Bennington-Davis, Interim CEO and Chief Medical Officer, Health Share of Oregon*
- Beth Black, Employee Benefit Consultant, Hagan Hamilton Insurance Solutions
- Tanveer Bokhari, VP, Quality & Health Equity, Umpqua Health Alliance*
- Bill Bouska, Director of Community Solutions and Government Affairs, Samaritan Health Plans, InterCommunity Health Network CCO
- Will Brake, Chief Operating Officer, AllCare Health
- Damian Brayko, Deputy Director, Public Employees' Benefit Board & Oregon Educators Benefit Board
- Joy Conklin, Vice President of Practice Advocacy, Oregon Medical Association
- Dawn Creach, Health Care Consultant, Creach Consulting, LLC
- Larlene Dunsmuir, Assistant Executive Director for Professional Services, Oregon Nurses Association
- Bill Dwyer, Director of Analytics, Moda Health and Eastern Oregon CCO
- Eleanor Escafi, Assistant Director of Strategy and Execution, Network Management/Provider Partnership Innovation, Regence BlueCross BlueShield of Oregon & Cambia Health Solutions
- Randy Evans, Project Manager, Provider Networking Contracting & Provider Relations, Health Net Health Plan of Oregon Inc. and Trillium Community Health Plan
- Kevin Ferrua, Senior Financial & Contract Analyst, Yamhill Community Care
- Scott Fields, Chief Medical Officer/Chief Informatics Officer, OCHIN
- Kaye Flores, Director, Provider Network, Umpqua Health Alliance (organization will be represented by Tanveer Bokhari in 2020)
- Robin Henderson, Chief Executive of Behavioral Health, Providence
- Juliana Huff, Director of Business Intelligence, Willamette Valley Community Health
- Dale Jarvis, Principal, Dale Jarvis and Associates, LLC
- Kristan Jeannis, Quality Improvement Coordinator, Tuality Health Alliance
- Jen Johnstun, Chief Quality Officer, Siskiyou Community Health Center (previously at Primary Health)
- Mary Kjemperud, Director of Network and Clinical Support, Jackson Care Connect and CareOregon
- Angie Kuzma, Policy & Data Manager, Oregon Community Health Workers Association
- Doug Lincoln, Pediatrician, Metropolitan Pediatrics
- Lynnea Lindsey, Director of Behavioral Health Services, Legacy Health
- Barbara Martin, Director of Primary Care, Central City Concern

- Ben Messner, Chief Operating Officer, Advanced Health
- Justin Montoya, Medical Director of Commercial Programs, PacificSource Health Plans
- Liz Powers, Physician, Winding Waters Clinic
- Colleen Reuland, Director, Oregon Pediatric Improvement Partnership
- Glenn Rodriguez, Physician, Oregon Academy of Family Physicians
- Deborah Rumsey, Executive Director, Children's Health Alliance
- Divya Sharma, Medical Director, Central Oregon Independent Practice Association
- Christa Shively, Senior Director of Quality and Medical Integration, Providence Health Plans
- Christi Siedlecki, Chief Executive Officer, Grants Pass Clinic
- Colleen Smith, Senior Manager of Client Services, Mental Health, Family Health, Network and Housing Services, Willamette Family, Inc.
- Danielle Sobel, Policy Director, Oregon Primary Care Association
- Mindy Stadtlander, Executive Director of Medicaid and Network Services, Columbia Pacific CCO and CareOregon
- Rebecca Tiel, Director of Public Policy, Oregon Association of Hospitals and Health Systems
- Megan Viehmann, Pharmacist, OHSU Family Medicine at Richmond
- Khalid Wahab, Senior Engagement Manager, Aetna
- Charles Wilson, General Counsel, ATRIO Health Plans
- Gayle Woods, Senior Policy Advisor, Oregon Department of Consumer and Business Services

Oregon Health Authority staff and consultants

- Diana Bianco, Collaborative Facilitator, Artemis Consulting
- Summer Boslaugh, Transformation Analyst, Oregon Health Authority Transformation Center
- Tom Cogswell, Project Coordinator, Oregon Health Authority Transformation Center
- Chris DeMars, Director, Oregon Health Authority Transformation Center
- Susan El-Mansy, Operations and Policy Analyst, Patient-Centered Primary Care Home Program, Oregon Health Authority Transformation Center
- Amy Harris, Manager, Patient-Centered Primary Care Home Program, Oregon Health Authority Transformation Center

* New member in 2020

Appendix A

Primary Care Payment Reform Collaborative
2019–2020 Charter

I. Authority

Oregon is required by statute (Chapter 575 Oregon Laws) to convene a Primary Care Payment Reform Collaborative to advise and assist in the implementation of a Primary Care Transformation Initiative. The purpose of the Initiative is to develop and share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. Senate Bill 934 (2017) states that the Initiative should:

- Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care);
- Improve reimbursement methods, including by investing in the social determinants of health; and
- Align primary care reimbursement by purchasers of care.

To achieve the implementation of this Initiative, the Collaborative will support:

- Use of VBP methods;
- Provision of technical assistance to clinics and payers in implementing the Initiative;
- Aggregation of data across payers and providers;
- Alignment of metrics, in concert with work of the Health Plan Quality Metrics Committee established in ORS 413.017; and
- Facilitation of the integration of primary care behavioral and physical health care.

II. Deliverables

Senate Bill 934 (2017) requires the Collaborative to report annually to the Oregon Health Policy Board and the Oregon Legislature on the implementation of the Primary Care Transformation Initiative and progress toward meeting primary care spending targets. The second progress report will be delivered by February 1, 2020. The goals of the Initiative will be met by 2027.

The Collaborative has established four work groups to move the Initiative forward in 2019. These groups will meet regularly in between Collaborative meetings.

1. Implementation: Identify strategies to support implementation of payment models in the Initiative including attribution, data aggregation and reporting.
2. Technical Assistance: Identify technical assistance (TA) resources to support implementation of the Initiative payment models, including leveraging existing TA resources.
3. Evaluation: Identify and recommend evaluation strategies to measure the impact of the Primary Care Transformation Initiative, using the Initiative goals laid out in SB 934.

4. Metrics: Identify a set of measures for the Initiative that is aligned with other statewide metric sets (for example, the Health Plan Quality Metrics Committee aligned measures menu).

Two additional work groups addressing populations not covered by CPC+ and behavioral health integration will meet twice a year; their representatives will share input with the other work groups.

The Collaborative is focused on primary care transformation and reimbursement. Specialty care and inpatient hospital services are not within the scope, except to the extent to which these topics impact the goals of the Initiative.

The Collaborative is committed to coordinating and aligning with related initiatives including, but not limited to, Comprehensive Primary Care Plus (CPC+), Health Plan Quality Metrics Committee, and the Patient-Centered Primary Care Home Program.

III. Dependencies

To the extent directed and supported by OHA, the Committee will coordinate its recommendations to align with national and state health policy initiatives in formal reports submitted to:

- OHA leadership
- Oregon Health Policy Board
- Oregon Legislature

The ability of the Committee to fulfill its statutory duties as outlined in sections I and III is contingent upon support of and direction by OHA, as well as coordination with other health policy advisory bodies.

IV. Membership

In accordance with Chapter 575 Oregon Law, Collaborative membership includes representatives from the following entities:

- Primary care providers
- Health care consumers
- Experts in primary care contracting and reimbursement
- Independent practice associations
- Behavioral health treatment providers
- Third party administrators
- Employers that offer self-insured health benefit plans
- The Department of Consumer and Business Services
- Carriers
- A statewide organization for mental health professionals who provide primary care
- A statewide organization representing federally qualified health centers
- A statewide organization representing hospitals and health systems
- A statewide professional association for family physicians
- A statewide professional association for physicians

- A statewide professional association for nurses
- The Centers for Medicare and Medicaid Services

Additional members may be invited to participate based on their experience and knowledge of primary care. Collaborative member terms are for a minimum of two years, with up to six meetings per year.

V. Resources

Internal staff resources include the following:

- Executive sponsors: OHA Health Policy & Analytics division director; OHA chief medical officer
- Staff support:
    - Health Policy and Analytics Division, Transformation Center (lead)
    - Health Systems Division
    - External Relations Division

Appendix B: Primary Care Payment Reform Collaborative Workplan

TIMELINE		2019	2020 (Y1)	2021 (Y2)	2022 (Y3)	2023 (Y4)
Statewide Infrastructure	Implementation/ TA Work Groups	Identify, support and develop (as needed) TA to payers and providers				
		Identify funding strategies for a sustainable statewide infrastructure				
		Create shared definitions and a framework for connecting patients and providers (attribution)				
		Develop and implement a system to monitor practice accountability				
		Monitor and leverage statewide data aggregation efforts				
			Monitor the use of the agreed-upon metrics for the payment model and quality improvement			
	Evaluation Work Group	Oversee and coordinate evaluation of the Primary Care Transformation Initiative				
	State Agency (OHA/DCBS)	Identify practices eligible and ready to participate in the payment model				
		Monitor payer reporting of implementation progress and attainment of VPB targets				
Payment Model Development/ Implementation	All Payers in Oregon *		Adopt framework for connecting patients and providers (attribution)			
			Offer the payment model to CPC+ Track 2 clinics			
			Meet specific VBP targets identified in the Collaborative recommendations			
			Develop a plan to modify BH contracting structure			

				Report on progress toward implementation of modified BH contracting structure		
				Offer the payment model to CPC+ Track 1 clinics, all non-CPC+ clinics designed as FQHC or RHC and all pediatric clinics		
					Implement modified BH contracting structure	
					Offer payment model to all other non-CPC+ clinics	
	All PCPCH Clinics		Meet participation criteria and expectations of participating clinics described in the Collaborative recommendations			

Appendix C

Matching Patients and Providers: Definitions and Framework

Prepared by the CPC+ Payer Group and the Primary Care Payment Reform Collaborative

The processes used to identify a patient-provider health care relationship are fundamental to population health and value-based payment (VBP) models. Patient attribution both designates the population for whom a provider will accept accountability under the model and forms the basis for performance measurement, reporting and payment.[3]

Lack of clarity and variation of attribution methodologies is a challenge for practices and payers. Benefits of more transparency and alignment include improved cost and quality benchmarking, increased understanding across the health system, building trust between practices and payers, enhancing the ability of practices to focus their efforts and better engage patients, and maximizing the benefits of data aggregation.

The CPC+ Payer Group and the Primary Care Payment Reform Collaborative have prepared this document to clarify definitions and provide a framework outlining the components and principles that drive processes that "match" patients and providers. The definitions and framework will be used by members of the CPC+ Payer Group and the Collaborative to communicate the methods used in primary care VBP models. Described below are four distinct methods commonly used to identify a patient-provider relationship: member selection, health plan assignment, enrollment, and use of claims or encounter data.

Purposes of shared definitions and framework:

- To agree to shared definitions of terms, enabling consistent use and intention
- To provide a framework for describing attribution methodologies to stakeholders, particularly providers
- To provide educational materials about attribution for practices
- To reduce complexity and confusion for payers and practices
- To build trust and transparency around attribution methodologies
- To facilitate the reliable identification of a provider-patient relationship

[3] Health Care Payment Learning & Action Network. Accelerating and Aligning Population-Based Payment: Patient Attribution. June 30, 2016.

Shared Definitions

Member selection

According to the Health Care Payment Learning & Action Network, patient choice is the ideal way to connect a patient and a provider.[4] Member selection is a prospective process in which a payer solicits from a health plan member the selection of a primary care provider or clinic. Often this is part of the health plan enrollment process. In CMS payment models like CPC+ and Primary Care First, this process of using the patient identification of the PCP/clinic is called "voluntary alignment." In some health plan products, the selected PCP is tied to the plan benefit structure.

Assignment

Assignment is a prospective process in which a payer matches a health plan member with a primary care provider based on specific criteria such as zip code, availability, age or other considerations. Some payers encourage member selection of a PCP prior to using the assignment process and members have the option to change their assigned PCP. Outreach to patients may be conducted as part of the health plan enrollment process, particularly if an assigned PCP is tied to the health plan benefit structure. Some payers share rosters with providers that combine member selections and health plan assignments since both are prospective and do not rely on claims history of prior visits. Primary care clinics are often encouraged by payers to contact patients on the roster to establish a relationship so patients may choose a provider or team (empanelment).

Enrollment

The enrollment method is similar to member selection and is sometimes used to prospectively recruit members to a specific program that has selection criteria, for example, the Primary Care First Seriously Ill Population (SIP) released by CMS in 2019. According to CMS, patients lacking a primary care practitioner will have an opportunity to enroll in care with a Primary Care First practice that opts in to participate in the SIP payment model. To identify the SIP-eligible population, CMS will run claims attribution and identify "un-attributable" Medicare beneficiaries to use as a roster for potential enrollment. In enrollment models, members sometimes enroll in the program in the primary care office (for example, Chronic Care Management) or with the payer/health plan (for example, SIP). Enrollment is important in cases where the services will result in member cost share because it enables the member to make an active choice.

Attribution by analyzing claims- or encounter-based data

This attribution method is a retrospective process in which a health plan uses a member's prior claims experience or encounter data to infer a patient-provider health care relationship. Each payer's attribution algorithms have a defined look-back period, a claims code set, criteria for eligible

[4] Id. p. 8. "The ideal method for patient attribution is active, intentional identification or self-reporting by patients."

providers, and rules regarding most recent visits and plurality of visits in cases where a patient saw multiple PCPs during the lookback period. The strategy and frequency of running attribution may vary by payer. Although all attribution methods are inherently retrospective (relying on prior visits to infer a patient-provider relationship) the application of attributed populations can be used either retrospectively or prospectively:

- An example of a retrospective application could be a pay-for-performance program: attribution reports completed at the end of the performance period determine the patient population of the pay-for-performance program.
- An example of a prospective application could be care management fees paid prospectively: attribution reports completed at the beginning of a payment period would prospectively determine the population of patients for a care management fee. Another example is a total cost of care, risk-based payment made prospectively to a large clinic system, using claims-based attribution reports completed at the beginning of a payment period to determine the population of patients and estimated costs.

Attribution Framework

CPC+ payers and Collaborative members will use the following framework to describe their methods of attributing patients to primary care practitioners in a common format.

[insert heath plan logo]

Attribution Framework for [health plan] [primary care VBP program name]

1. Statement of purpose and uses in a primary care payment model

This paper describes the attribution methods used to calculate [for example, CPC+ care management fees/performance-based payments/PCP capitation payments].

The methods of attribution used include [for example, member selection/assignment/enrollment/attribution by analyzing claims- or encounter-based data].

2. Eligible providers

Eligible providers include [primary care providers, nurse practitioners, physician assistants, and any applicable specialists].

The health plan attributes members at the [practitioner level/clinic level/medical group level] and uses [NPI/TIN] identifiers.

3. Frequency

The health plan produces updated rosters and shares with providers [monthly/quarterly]. Rosters are distributed [by posting on the provider portal/via secure email/via mail].

4. Data used

The health plan uses [member attestation, preventive and wellness visit, evaluation and management codes (E&M)]

5. Data parameters

Claims lag
Lookback period of [12 months/24 months/36 months].

Rules regarding most recent/majority/plurality/total cost of care

Continuous enrollment requirements prior to attribution

Decedents – included, pro-rated, or excluded entirely

Primary/secondary insurance coverage

6. Reconciliation/true-up rules

Including frequency and report out

7. Other components of methodology not covered above

Appendix D: Primary Care Transformation Initiative Measure Set

Background

As directed by Senate Bill 934, the Primary Care Payment Reform Collaborative ("Collaborative") is to advise and assist the Oregon Health Authority (OHA) in the development and implementation of a Primary Care Transformation Initiative ("Initiative"), which will:

- Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care);
- Improve reimbursement methods, including by investing in the social determinants of health; and
- Align primary care reimbursement by purchasers of care.

The Primary Care Transformation Initiative Measure Set ("measure set") was developed by the Collaborative. The measure set will be utilized in the performance-based incentive payment component of the primary care payment model and as part of the overall evaluation of the Initiative. The purpose of the measures is to ensure high quality care to patients and to support the goal of improved patient outcomes.

The measure set has been informed by and aligns with other statewide metric sets such as the Health Plan and Quality Metrics (HPQM) Aligned Measures, Comprehensive Primary Care (CPC+) measures and the 2017 Patient-Centered Primary Care Home Measure 2.A Core and Menu metrics.

The measures are intended to be part of the foundational infrastructure necessary to support the implementation of the Initiative strategies. This infrastructure should support a standardized method for clinics to report the measure data, such as a common portal for data collection and aggregation to minimize administrative costs and maximize timeliness of reporting and reliability of data.

Core and menu measure set

To foster alignment and reduce administrative burden, this measure set includes a subset of five required core adult measures and three core pediatrics measures. The other measures are intended to be a menu from which payers and providers should collaborate to select clinic-reported measures for performance-based incentive payments. Selected measures should reflect a clinic's entire patient population. All payer-reported measures are required. Unless otherwise noted in the table below, the technical specifications for this measure set will align with the current National Quality Forum (NQF) specifications.

The measures evaluate both quality and utilization, incentivizing payers and providers. The measures are categorized into six domains of health care services, which align with the HPQM domains. These include:

1. Prevention/Early Detection
2. Chronic Disease and Special Health Needs
3. Acute, Episodic and Procedural Care
4. System Integration and Transformation
5. Patient Access and Experience
6. Cost/Efficiency

The measures reflect all age groups across the life span.

Benchmarks and improvement targets

Payers and providers should select measure benchmarks that are challenging, but achievable to motivate improvement. Benchmarks can be obtained from national sources such the Centers for Medicare and Medicaid Services Quality Payment Program: Merit-Based Incentive Payment System (MIPS) or the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS).

In addition to selecting benchmarks, measures could also include improvement targets for the provider, clinic or contracting entity. Improvement targets can be determined using several different methodologies. For example, an improvement target could be 3–5% improvement over the past 12 months or meeting a percentage of a national benchmark. The collaborative recommends payers and providers work together to determine the best methodology for setting improvement targets.

Future work

The Collaborative Metrics Work Group (or comparable technical advisory group) will convene annually to review and make recommendations about revisions to the measure set. Recommended revisions will be informed by the Initiative evaluation, payer and provider feedback and the legislative requirements of the Initiative. Future measures could include: BMI; screening for clinical depression; social determinants of health and others.

Primary Care Transformation Initiative Measure Set as of September 2019								
Performance Category	Measure	Clinic reported	Payer reported	Specs	Data Source	HPQM	CPC+	Core
Prevention and Early Detection	Tobacco Use: Screening and Cessation Intervention	x		NQF 0028	Claims/ clinical data	x	x	x
	Colorectal Cancer Screening	x		NQF 0034	Claims/ clinical data	x	x	x
	Cervical Cancer Screening	x		NQF 0032	Claims/ clinical data	x	x	x
	Developmental Screening in the First Three Years of Life	x		NQF 1448	Claims	x		x (peds)
	Adolescent Well-Care Visits	x		HPQM #6	Claims/ clinical data	x		x (peds)
	Well-Child Visits in the First 15 Months of Life (6 or more visits)	x		NQF 1392	Claims/ clinical data	x		x (peds)
	Effective Contraceptive Use Among Women at Risk of Unintended Pregnancy *(benchmark for 18 years + only)*	x		HPQM #12	Claims	x	x	
	Pneumococcal Vaccination Status for Older Adults	x		NQF 0043	Clinical data		x	
	Flu Vaccinations for Adults Ages 18 and Older	x		NQF0041	Clinical data			
	Chlamydia Screening (benchmark for 18 years + only)	x		NQF 0033	Claims/ clinical data	x	X	
	Postpartum Follow-Up and Care Coordination [i]	x			Clinical data	x		
	Screening for Clinical Depression and Follow-Up Plan (age 12 and up)	x		NQF 0418	Clinical data	x	x	
	Immunization Rates for Children (combo 7)	x		NQF 0038	Claims/ clinical data	x		
	Immunization Rates for Adolescents	x		NQF 1407	Claims/ clinical data	x		X (peds)

	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	x		NQF 1516	Claims/ clinical data	x		X (peds)
Chronic Disease and Special Health Needs	Controlling High Blood Pressure	x		NQF 0018	Clinical data	x	x	x
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	x		NQF 0059	Clinical data	x	x	x
	Statin Therapy for Patients with Cardiovascular Disease	x		HPQM #27	Clinical data	x	x	
	Statin Therapy for Patients with Diabetes	x		HPQM #28	Clinical data	x	X	
	Optimal Asthma Control [ii]	x			Clinical data			
	Alcohol and Drug Misuse: SBIRT	x		HPQM 20	Clinical data		x	
	Depression Response at 6 Months – Progress Towards Remission [iii]	X		NQF 1884	Clinical data			
	PCPCH Standard 3.C.3 Behavioral Health Integration	x		PCPCH 3.C.3	Clinical data/surveys			
	PCPCH Standard 5.C. Complex Care Coordination	x		PCPCH 5.C	Clinical data/surveys			
System Integration & Transformation	Ambulatory Care: Emergency Department Utilization		x	HEDIS	Claims		X	
	Plan All-Cause Readmission (within 30 days)		x	NQF 1768	Claims	x	X	
Patient Access and Experience	CAHPS Clinician & Group Survey (CG-CAHPS) or other provider level survey [iv]	x		PCPCH 6.A.0	Clinical data/surveys			
	PCPCH Standard 2.C. Patient & Family Involvement in Quality Improvement	x		PCPCH 2.C	Clinical data/surveys			
Cost and Efficiency	Total Cost of Care Population-based PMPM Index (primary care)		x	NQF 1604	Claims	x		
	Total Resource Use Population-based PMPM Index		x	NQF 1598	Claims	x		
	Ambulatory Care: Avoidable Emergency Department Utilization		x	HEDIS	Claims			

[i] Replacing *Prenatal & Postpartum Care – Postpartum Care* on HPQM Aligned Measure Set in 2021. Specifications: Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care within 8 weeks of giving birth who received a breastfeeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, and family and contraceptive planning.

[ii] Replacing *Absence of Controller Therapy* on HPQM Aligned Measure Set in 2021. Specifications: Percentage of pediatric (5–17 years of age) and adult (18–50 years of age) patients who had a diagnosis of asthma and whose asthma was optimally controlled during the measurement period as defined by achieving BOTH of the following (1) asthma well-controlled as defined by the most recent asthma control tool result available during the measurement period and (2) patient not at elevated risk of exacerbation as defined by less than two ED visits and/or hospitalizations due to asthma in the last 12 months.

[iii] From NQF technical specifications: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at six months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.

[iv] HPQM 2020 Aligned Measure Set includes CAHPS Health Plan, Dental Plan, and Hospital surveys.

Appendix E: Potential OHA Infrastructure Support for the Primary Care Transformation Initiative

"This infrastructure would build upon the work of the Patient-Centered Primary Care Home (PCPCH) program and the OHA Transformation Center. In addition, it would leverage and avoid duplication of existing TA supports already implemented across the state." – 2018 Collaborative Report

Infrastructure need	Task to support infrastructure	Possible with existing capacity and resources	Possible with additional capacity and resources	Possible with significant additional capacity and resources
Provide payer and provider technical assistance (TA)	PCPCH recognition TA	Site visits – 100 per year, post-site visit TA for clinics from PCPCH staff for up to 6 months TA Guide on PCPCH Standards; TA support by phone and email; website	Increased number of annual site visits and provision of TA to clinics [5] Webinars	TA for clinics that have not received a site visit – individualized practice coaching from PCPCH staff More frequent site visits Mid-year phone check-ins with PCPCHs Learning collaboratives
	CPC+ milestones TA [6]	N/A	N/A	N/A
	Value-based payment (VBP) TA	2020 PCPCH model may include a measure related to VBP participation *(to be proposed)*. If adopted, the program will develop basic TA resources.	CCO 2.0 TA for CCOs could be expanded to include commercial.	N/A
	Electronic health record functionality	N/A	N/A	N/A

[5] New PCPCH site visitor positions anticipated in Q4 2019

[6] TA for CPC+ is federally funded and provided to participating clinics through the end of the CPC+ project

Monitor participating payers[7] and providers	Provide a standardized process for identifying eligible clinics to participate in the value-based payment models	List of PCPCHs, which includes tier level and points attested to payers each month	PCPCH recognition web-based application could be expanded to fill this function	
	Provide a common portal for data collection and aggregation	Clinical Quality Metrics Registry (managed through OHA's Office of Health Information Technology; limited use at this time)		
Oversee and coordinate evaluation of the Initiative	Evaluate whether the Initiative achieved its legislatively mandated (SB 934) goals		Transformation Center could provide financial and staff resources to partially support an evaluation	Robust evaluation possible with contributions across Collaborative members

[7] The Primary Care Spending Report in Oregon includes APM data by payer and line of business