Tab Named "PCPCH"

PCPCH Tier	Clinic Revenues	Clinic Annual Member Months	Average PMPM dollar amount
Tier 1 clinics	$ -	$ -	
Tier 2 clinics	$ -	$ -	
Tier 3 clinics	$ 1,421,949.35	$ 124,682	11.40
Tier 4 clinics	$ 19,670,876.45	$ 1,450,945	13.56
Tier 5 clinics	$ 5,570,685.20	$ 396,266	14.06
TOTALS	**$ 26,663,511.00**	**$ 1,971,893**	**13.52**

Tab Named "Hospital care CDA VBP Data"

Does not include 4C activity

Tab Named "Maternity care CDA VBP Data"

Does not include 4C activity

CONTRACTOR/CCO NAME: Health Share of Oregon (CareOregon IDN)
REPORTING PERIOD: **1/1/2021 - 12/31/2021**

Enter the per-member-per-month (PMPM) dollar amount you paid clinics participating in the Patient Centered Primary Care Home (PCPCH) program. If the PMPMs vary for a given tier, you may enter a range. Otherwise, enter a single dollar amount. In the "Average PMPM" column, enter the average PMPM payment for each tier, weighted by enrollment. If you paid one 'Tier 1' clinic $9.50 PMPM and another 'Tier 1' clinic $10.00 PMPM, and the first clinic had three times the number of members attributed as compared to the second clinic, then the average weighted PMPM would be $9.625. ($9.50 x 0.75 + $10.00 x 0.25 = $9.625). The weighting may be calculated using number of members or number of member months.

Evaluation Criteria for this worksheet: Response required for each highlighted cell, even if there are no current clinics in your service area at that tier level. Non response in a highlighted cell will not be approved.

PCPCH Tier	Number of contracted clinics	PMPM (or range) dollar amount	Average PMPM dollar amount	If applicable, note any deviations and rationale from required payment per tier (e.g. no payments to tier 1 clinics because there are none in CCO service area).
Tier 1 clinics				No Tier 1 clinics currently participate in the program
Tier 2 clinics				No Tier 2 clinics currently participate in the program
Tier 3 clinics	13.00	$2.37 - $14.60	$ 11.40	Clinic payment rates vary throughout the year based on quality levels.
Tier 4 clinics	91.00	$5.13 - $17.50	$ 13.56	Clinic payment rates vary throughout the year based on quality levels.
Tier 5 clinics	31.00	$10.00 - $16.74	$ 14.06	Clinic payment rates vary throughout the year based on quality levels.

CONTRACTOR/CCO NAME: Health Share of Oregon (CareOregon IDN)
REPORTING PERIOD: **1/1/2021 - 12/31/2021**

Evaluation Criteria for this worksheet: Response required for each highlighted cell. Non response in a highlighted cell will not be approved.

Brief description of the five largest, defined by dollars spent, VBPs implemented (e.g. condition-specific (asthma) population-base payment)	**Most Advanced LAN Category in the VBP** (4 > 3 > 2C)	**Additional LAN categories within arrangement**	**Brief description of providers & services involved**	**Please describe if and how these models take into account: - racial and ethnic disparities; & - individuals with complex health care needs**
PCPCH PMPM Payment Program	2C	N/A	Numerically described in the PCPCH tab. Incorporates providers that achieve PCPCH tier recognition, and provides payments based on quality, behavioral health and oral health integration, and cost of care performance.	The PCPCH payments for quality are risk-adjusted into low-, medium-, and high-risk clinics to provide additional funding for providers serving members with complex health care needs.
Capitation	4A	N/A	Primary Care providers receiving a fixed payment monthly based on assigned membership in place of fee for service payments for an identified population of CPT codes.	Our providers receiving primary care capitation serve some of our highest need members. The groups we currently have capitation arrangements with include: - Yakima Valley Farm Workers (FQHC) - Virginia Garcia (FQHC) - North by Northeast (Small community-based clinic serving primarily Black or African-American members in NE Portland) - Housecall Providers (A clinic serving very high-needs members who require home-based care.)
PCP Behavioral Health Integration	2C	N/A	Primary Care providers receive PMPM payments for directly integrating behavioral health services. Not intended to provide specialty behavioral support, but same day access for immediate care needs.	This model is designed to specifically incentivize and reward clinics for providing on-site behavioral health staff to improve the integration of physical health and behavioral health services within the primary care medical home. The model directly benefits members with both physical and behavioral health needs.
MLR Risk Agreement	3B	2C	Yakima Valley Farm Workers is participating in a risk adjusted Medical Loss Ratio risk agreement. All physical health costs are included for assigned members, with limited exclusions (e.g., Hep C drugs) as negotiated with provider partners. Shared savings are gated by quality metric performance.	This model accounts for the risk of assigned members included in the risk share program. Members with higher risk and more complex conditions have a higher cost target and represent higher potential cost savings for the provider. The model takes into account the current year's risk adjustment to incentivize accurate coding and documentation of member conditions by the provider.
Behavioral Health Quality Program	2C	N/A	Includes key Behavioral health providers that are providing Mental Health and/or Substance Use Disorder treatment. Providers must serve Health Share members and meet a minimum threshold of members served/services provided on an annual basis. Providers receive additional payments based on meeting a number of key quality metrics that are specific to the Mental Health and/or SUD services that they provide.	The payment program is based on the amount of services provided so providers that serve fewer but more complex patients would have their payment reflect the level of services that they are providing.

Required implementation of care delivery areas by January 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. Refer to Value-based Payment Technical Guide for CCOs at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf for more information on requirements.

Evaluation Criteria for this worksheet: Response required for each highlighted cell. If question on row 19 and 20 are not applicable, include that as a response or it will not be approved.

CONTRACTOR/CCO NAME:	Health Share of Oregon (CareOregon IDN)
Describe Care Delivery Area (CDA) Note: a VBP may encompass two CDAs concurrently. If your CCO has take this approach, list both CDAs; no more than two CDAs can be combined to meet CDA requirement.	**Hospital Care**
LAN category (most advanced category)	**2C**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	**This payment arrangement incentivizes high quality care within Legacy Hospitals in the Metro Portland region. The program focuses on readmission rates, transition of care, and patient safety indicators. The payment arrangement is across all hospitalizations with the exception of a few types of hospitalizations such as transplant services.**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**This CDA program represents a percent of upside and downside-risk for each hospitalization, so it places greater weight on more complex hospitalizations.**
Total dollars paid	**96,808,725**
Total unduplicated members served by the providers	**10,100**
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	**1,484,222**
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	**1,484,222**
List the quality metrics used in this payment arrangement using the table provide in below. A least one quality component is needed to meet requirement:	

Metric	Metric Steward (e.g. HPQMC, NQF, etc.)	Briefly describe how CCO assesses quality (e.g. measure against national benchmark, compare to providers' previous performance, etc.)	Describe providers' performance (e.g. quality metric score increased from 8 to 10)
Plan All Cause Readmissions	**NCQA**	**Compare to providers' previous year performance**	
TRC - Timeliness of discharge summary within 48 hours of inpatient stay discharge	**HEDIS TRC - component #2**	**Compare to providers' previous year performance**	**new measure for 2022 contract**
TRC - Medication reconciliation post discharge	**HEDIS TRC - component #3**	**Compare to providers' previous year performance**	**new measure for 2022 contract**

Required implementation of care delivery areas by January 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. Refer to Value-based Payment Technical Guide for CCOs at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf for more information on requirements. Evaluation Criteria for this worksheet: Response required for each highlighted cell. If question on row 19 and 20 are not applicable, include that as a response or it will not be approved.	
CONTRACTOR/CCO NAME:	Health Share of Oregon (CareOregon IDN)
Describe Care Delivery Area (CDA) Note: a VBP may encompass two CDAs concurrently. If your CCO has take this approach, list both CDAs; no more than two CDAs can be combined to meet CDA requirement.	**Maternity Care**
LAN category (most advanced category)	**2B**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	**PMPM payments made to providers to support MAT/SUD services, and the necessary coordination and supports in a primary care setting. This program specifically focuses on pregnant people.**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**This program is specifically focused on the intersection of behavioral health and physical health needs. Members served represent the pregnant population that have been identified as benefitting from MAT/SUD services.**
Total dollars paid	**564,247**
Total unduplicated members served by the providers	**68**
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	
List the quality metrics used in this payment arrangement using the table provide in below. A least one quality component is needed to meet requirement:	

Metric	Metric Steward (e.g. HPQMC, NQF, etc.)	Briefly describe how CCO assesses quality (e.g. measure against national benchmark, compare to providers' previous performance, etc.)	Describe providers' performance (e.g. quality metric score increased from 8 to 10)
Agreements are currently reporting only, with data sharing between partners. Agreements will continue to evolve to include quality metrics with performance directly influencing payment. CareOregon is also planning to work to implement broader VBP agreements covering maternity services more comprehensively.	**N/A**	**N/A**	**N/A**

Required implementation of care delivery areas by January 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. Refer to Value-based Payment Technical Guide for CCOs at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf for more information on requirements.

Evaluation Criteria for this worksheet: Response required for each highlighted cell. If question on row 19 and 20 are not applicable, include that as a response or it will not be approved.

CONTRACTOR/CCO NAME:	Health Share of Oregon (CareOregon IDN)
Describe Care Delivery Area (CDA) Note: a VBP may encompass two CDAs concurrently. If your CCO has take this approach, list both CDAs; no more than two CDAs can be combined to meet CDA requirement.	**Behavioral Health**
LAN category (most advanced category)	**2C**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	**Performance incentive payments driven by quality metric performance related to mental health and substance use disorder services. Providers are evaluated on a range of metrics specific to either mental health or SUD services and calibrated to the services they provide.**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**This program specifically focuses on members that receive mental health or SUD services. The payments to providers are based on the level of services they provide so the size of the payments would be higher for providers that serve more complex patient populations or offer more complex treatment modalities.**
Total dollars paid	**$36,894,717**
Total unduplicated members served by the providers	**5,093**
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	
List the quality metrics used in this payment arrangement using the table provide in below. A least one quality component is needed to meet requirement:	

Metric	Metric Steward (e.g. HPQMC, NQF, etc.)	Briefly describe how CCO assesses quality (e.g. measure against national benchmark, compare to providers' previous performance, etc.)	Describe providers' performance (e.g. quality metric score increased from 8 to 10)
Access to Care - third next available non-urgent OP MH assessment appt	**Mutually agreed/created by plan and provider**	**internally agreed upon benchmark based on regional benchmarks**	**performance is based on days out for third next available thresholds**
Case Management for Clients with Schizophrenia - % of clients with schizophrenia diagnosis who received at least one case management service for every 90 days in service	**Mutually agreed/created by plan and provider**	**internally agreed upon benchmark based on regional benchmarks**	**first funded year, so targets are set to maintain baseline (2020) year performance**
SUD follow-up care after withdrawal managmement - % of withdrawal management episodes where clients receive or more SUD treatment services during the episode or within 14 days after episode ends	**Mutually agreed/created by plan and provider**	**compare to provider's previous performance**	**first funded year, so targets are set to maintain baseline (2020) year performance**

Primary Care Visit - for clients without prior primary care, the % of all outpatient SUD treatment episodes with one or more primary care encounters during the episode or within 30 days after episode ends	Mutually agreed/created by plan and provider	compare to provider's previous performance	first funded year, so targets are set to maintain baseline (2020) year performance