OHA VBP PCPCH Data and CDA VBP Data Template - General Instructions

1. Complete all yellow highlighted cells on the following worksheets:
"PCPCH"
"Model Descriptions"
"Hospital CDA VBP Data"
"Maternity CDA VBP Data"
"Behavioral Health CDA VBP Data"
"Children's Health CDA VBP Data"
"Oral Health CDA VBP Data"

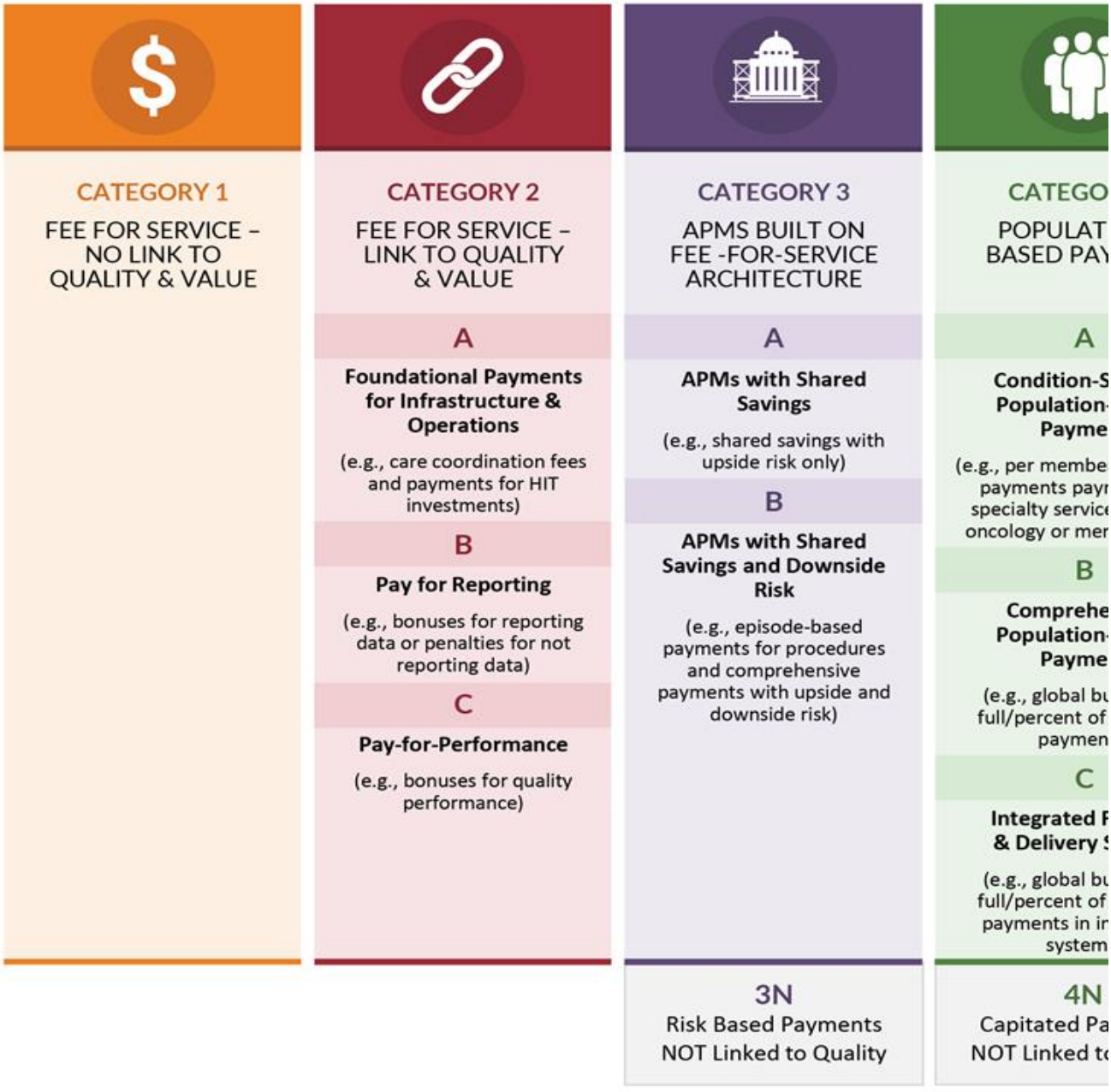
2. For payments that span multiple HCP-LAN categories, use the most advanced category. For example, if you have a contract that includes a shared savings arrangement with a pay-for-performance component – such as a quality incentive pool – then you should put the total value of the annual contract in Category 3A for shared savings because 3A (shared savings) is more advanced than 2C (pay-for-performance).

3. In addition to the HCP-LAN framework, Contractor shall use the VBP Roadmap for Coordinated Care Organizations and the OHA VBP Technical Guide for Coordinated Care Organizations for the VBP specifications and the appropriate LAN VBP category for each payment model, located at https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx

5. The completed template is due to OHA by May 2, 2025, via the Contract Deliverables portal located at https://oha-cco.powerappsportals.us/. The submitter must have an OHA account to access the portal. It may not be submitted as a PDF document and must remain a Microsoft Excel spreadsheet. Please use the following naming convention when submitting the template: CCO + reporting year + title of template (e.g. CCOABC 2025 VBP PCPCH Data and CDA Template).

version 02032025

https://hcp-lan.org/groups/apm-refresh-white-paper/



CCO NAME: Eastern Oregon Coordinated Care Organization
REPORTING PERIOD: 1/1/2024 - 12/31/2024

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. If a question is not applicable, write N/A. Non-response in a highlighted cell will not be approved. Add or subtract additional rows as needed. Guidance can be found on page 12 of the *VBP Technical Guide* : https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf

Tier level	Number of contracted clinics	Average PMPM payment
[redacted]		

Medical group or clinic name (Optional: report medical groups with more than one clinic location, operating at the same tier level, receiving the same PMPM amount as a single line item)	**Tier level** (1-5)	**PMPM dollar amount or range**	**If a PMPM range is provided in column C, rather than a fixed dollar amount, please explain** (e.g. if payment varied over the course of the year)	**If applicable, note any deviations and rationale from required payment**
[redacted]				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A
				N/A

	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A
	N/A

CCO NAME: Eastern Oregon Coordinated Care Organization
REPORTING PERIOD: 1/1/2024 - 12/31/2024

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 models, defined by dollars spent and VBPs implemented (e.g. condition-specific (asthma) population-based payment)	**Most advanced LAN category in the VBP model** (4 > 3 > 2C) *Note: For models listed at a LAN category 3B or higher, please list the risk sharing rate*	**Percentage of payments made through this model at the highest indicated LAN category**	**Additional LAN categories within arrangement**	**Total dollars involved in this arrangement**	**Quality metric(s)**	**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**
Example: Shared risk arrangement with hospital-based maternity providers	3B (Risk Sharing Rate: 30%)	90%	1 (FFS)	$3,543,231	Timeliness of Prenatal and Postnatal Care	A hospital participates in a shared risk arrangement where the CCO will make a retrospective payment to the hospital if the actual spending on the hospital's attributed maternity/obstetric population is less than expected spending and the hospital performs well on specific performance measures; or the hospital will make a payment to the CCO if actual spending is more than expected spending.	Inadequate postpartum care can contribute to persistent racial and ethnic disparities in maternal and infant health outcomes.
EOCCO shared risk model- total cost of care risk sharing agreement and quality performance payment for primary care practices	3B (Risk sharing rate 30%)	Over 90% of all costs are included in the shared risk calculation. The total amount of shared risk bonus payments has typically averaged around 5-10% of total payments. 2023 bonus amounts have not been determined yet.	1A, 2A, 2C, 3A, 3N, 4A	$243M (2024 est.)	Adolescent immunizations, Assessments for children in DHS custody, Childhood immunizations, Cigarette Prevalence, Depression screening, Diabetes HbA1C Poor Control, Initiation and engagement in drug or alcohol treatment, Meaningful Language Access, Preventive Dental Service, SBIRT, Well-child visits for 3-6 years old and 7-21 years old, Plan all-cause readmissions, Post-partem care, children's health care and oral health CDAs	Most EOCCO providers participate in this model. Hospitals, specialists, and PCPs share in risk for meeting an EOCCO-wide budget PMPM. A 10% withhold is applied in the event of a deficit. PCPs have upside risk only; others have two-sided risk. Nearly all claims are included, though not all providers take risk (e.g. independent labs are not managing care; they do not take risk, but doctors and hospitals do take risk on the labs' claims). Note that this model overlaps several other models, so there is going to be double-counting of dollars in this report. For example, some but not all providers are also capitated for primary care (4A) in addition to participating in shared risk. This model also satisfies the requirement for the maternity care CDA, since a maternity quality measure for OB/GYNs was added in 2022. The hospital, children's and oral health CDA are also considered in this model as well.	The budget is based on rate group which takes into account individuals with complex health care needs. Also carveouts apply to augment this. EOCCO has strategies in place for addressing health equity, which will help ensure that VBPs do not have adverse effects on any underserved population. These include strategies targeting both processes and outcomes. Examples of process strategies include the following: 1) EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data; 2) Disparity populations are evaluated and monitored through subcommittees of the EOCCO Quality Improvement Committee which has oversight of the TQS; 3) EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis. 4) EOCCO creates and shares cultural competence training programs that is available to its workforce, provider network, and community partners. 5) The EOCCO Quality Improvement Team analyzes Unite Us CIE [Connect Oregon] data to identify social determinant of health (SDOH) prevalence and social need trends across our service area. This informs the implementation of community-driven, system-level, strategies to address any identified SDOH disparities. 6) The EOCCO Quality Improvement Team stratifies incentive measures by race, ethnicity, language, disability, and other demographic data to identify disparities in care or health outcomes. The team will then implement targeted interventions to address the identified disparities.
Primary care total cost of care model	4A	Approximately 5%	1A, 2A, 2C, 3B (Risk sharing rate 30%)	$40.2M (2024 est.)	Adolescent immunizations, Assessments for children in DHS custody, Childhood immunizations, Cigarette Prevalence, Depression screening, Diabetes HbA1C Poor Control, Initiation and engagement in drug or alcohol treatment, Meaningful Language Access, Preventive Dental Service, SBIRT, Well-child visits for 3-6 years old and 7-21 years old, Plan all-cause readmissions, Post-partem care	Custom shared risk model for this provider. Provider takes risk on all claims from all providers for members assigned to their PCPs, with a few carveout exceptions. Upside and downside risk. Model based on controlling trend, rather than hitting a fixed PMPM budget. This provider is also capitated for primary care (4A).	Risk-adjustment, carveouts, and stop loss provisions are used to take into account complex patients. EOCCO has strategies in place for addressing health equity, which will help ensure that VBPs do not have adverse effects on any underserved population. These include strategies targeting both processes and outcomes. Examples of process strategies include the following: 1) EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data; 2) Disparity populations are evaluated and monitored through subcommittees of the EOCCO Quality Improvement Committee which has oversight of the TQS; 3) EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis. 4) EOCCO creates and shares cultural competence training programs that is available to its workforce, provider network, and community partners. 5) The EOCCO Quality Improvement Team analyzes Unite Us CIE [Connect Oregon] data to identify social determinant of health (SDOH) prevalence and social need trends across our service area. This informs the implementation of community-driven, system-level, strategies to address any identified SDOH disparities. 6) The EOCCO Quality Improvement Team stratifies incentive measures by race, ethnicity, language, disability, and other demographic data to identify disparities in care or health outcomes. The team will then implement targeted interventions to address the identified disparities.
Prospective primary care capitation (Except for model above)	4A	9% (this calculation includes some hospital and specialty care spending in the same contract) Also note substantial overlap with the above models	1A, 2A, 2C, 3A	$141M (2023)	Adolescent immunizations, Assessments for children in DHS custody, Childhood immunizations, Cigarette Prevalence, Depression screening, Diabetes HbA1C Poor Control, Initiation and engagement in drug or alcohol treatment, Meaningful Language Access, Preventive Dental Service, SBIRT, Well-child visits for 3-6 years old and 7-21 years old, Plan all-cause readmissions, Post-partem care	Many EOCCO primary care providers are capitated for primary care services. The capitation agreement covers a specific list of services (procedure codes), and only applies to services billed by PCPs for a member assigned to that PCP or PCP clinic. All providers participating in the capitation agreement also receive PCPCH capitation and participate in the quality incentive and shared risk model. Shared risk for PCPs is upside risk only. Dollars in this model are also included in the EOCCO shared risk model, as all providers in this model participate in both.	Capitation rates are based on rate group which takes into account individuals with complex health care needs. EOCCO has strategies in place for addressing health equity, which will help ensure that VBPs do not have adverse effects on any underserved population. These include strategies targeting both processes and outcomes. Examples of process strategies include the following: 1) EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data; 2) Disparity populations are evaluated and monitored through subcommittees of the EOCCO Quality Improvement Committee which has oversight of the TQS; 3) EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis. 4) EOCCO creates and shares cultural competence training programs that is available to its workforce, provider network, and community partners. 5) The EOCCO Quality Improvement Team analyzes Unite Us CIE [Connect Oregon] data to identify social determinant of health (SDOH) prevalence and social need trends across our service area. This informs the implementation of community-driven, system-level, strategies to address any identified SDOH disparities. 6) The EOCCO Quality Improvement Team stratifies incentive measures by race, ethnicity, language, disability, and other demographic data to identify disparities in care or health outcomes. The team will then implement targeted interventions to address the identified disparities.
Capitation + Incentive with CHMPs	4A	100.00%	2C, 4A	$51,418,358	Providers are at risk for spend above the global capitation paid, which includes routine Behavioral Health access (30% Weight), IET metric (15% Weight), peer delivered services (20% Weight), DHS Metric (20% Weight), attend one OHA approved translator cohort/training per year (10% Weight), and attend two documentation training offered by GOBHI Compliance per year (10% Weight)	Behavioral Health Outpatient Services (both Mental Health and SUD)	Capitation rates are based on rate group which takes into account individuals with complex health care needs. EOCCO has strategies in place for addressing health equity, which will help ensure that VBPs do not have adverse effects on any underserved population. These include strategies targeting both processes and outcomes. Examples of process strategies include the following: 1) EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data; 2) Disparity populations are evaluated and monitored through subcommittees of the EOCCO Quality Improvement Committee which has oversight of the TQS; 3) EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis. 4) EOCCO creates and shares cultural competence training programs that is available to its workforce, provider network, and community partners. 5) The EOCCO Quality Improvement Team analyzes Unite Us CIE [Connect Oregon] data to identify social determinant of health (SDOH) prevalence and social need trends across our service area. This informs the implementation of community-driven, system-level, strategies to address any identified SDOH disparities. 6) The EOCCO Quality Improvement Team stratifies incentive measures by race, ethnicity, language, disability, and other demographic data to identify disparities in care or health outcomes. The team will then implement targeted interventions to address the identified disparities.

Required implementation of care delivery areas by January 2025: 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 questions on rows 18 and 20 are not applicable, write N/A.

CCO NAME:	Eastern Oregon Coordinated Care Organization
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	The hospital CDA is specific to all cause in-patient re-admits. The accountability is primary with the hospitals and all hospitals who are participating in EOCCO's Shared Savings Model are included. The target is an improvement (reduction) from the prior year.
LAN category (most advanced category)	**3B**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	The quality incentive arrangement is effective for dates of service incurred from January 1, 2024 through December 31, 2024. Care delivery area payments will be calculated in alignment with the Risk Sharing Model calculations and payment will be incorporated into the settlement The number of acute inpatient stays for patients 18 and older during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, with risk adjustment for the predicted probability of an acute readmission. Each hospital's performance will be determined based on the ratio of observed readmits to expected readmits, where the number of expected readmits is based on the hospital's own case mix. payments in third quarter 2025. EOCCO is continuing this model for
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	This VBP directly targets patients with complex care needs, as they are the ones most likely to experience readmits.
Total dollars paid	[redacted]
Total unduplicated members served by the providers	Approximately 78,000 (those who have a physical health benefit)
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	Hospitals will receive an adjustment to the shared savings model surplus (or deficit), per the table below. [redacted] In the case of a shared savings deficit, the adjustments are reversed; for example, an observed/expected ratio of 1.2 increases the deficit owed by 2%. However, any adjusted shared savings model deficit is still capped at the withhold amount. Observed / Expected Readmit Rate [redacted] >1.3 >1.1 to 1.3 >0.9 to 1.1 >0.7 to 0.9 >0.5 to 0.7 0.5 or less
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	See above

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)
The number of acute inpatient stays for patients 18 and older during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, with risk adjustment for the predicted probability of an acute readmission.	OHA technical Specifications	Comparison of actual readmits to expected readmits based on case mix	More providers performed better under this model in 2023 than they did in 2022 (8 hospitals had a positive adjustment). In 2023, the model was changed to be based on observed vs. expected ratio rather than an absolute readmit rate, so performance in 2023 improved as expected.

Required implementation of care delivery areas by January 2025: 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 questions on rows 18 and 20 are not applicable, write N/A.

CCO NAME:	Eastern Oregon Coordinated Care Organization
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	Outpatient Behavioral Health (both Mental Health and SUD.
LAN category (most advanced category)	4A
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	CMHP responsible for all Outpatient Behavioral Health (Mental Health and SUD).
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	Primary payment is Capitation with incentive payments based on the measures shown below.
Total dollars paid	
Total unduplicated members served by the providers	78,000
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)	Providers are at risk for spend above the global capitation paid.

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)
Routine Behavioral Health Access (30% Weight)	Home grown measure		
IET Metric (15% Weight)	Home grown measure		
Peer Delivered Services (20% Weight)	Home grown measure		
DHS Metric (20% Weight)	Home grown measure		
Attend one OHA approved translator cohort/training per year (10% Weight)	Home grown measure		

Attend two documentation training offered by GOBHI Compliance per year (10% Weight)	Home grown measure		

Required implementation of care delivery areas by January 2025: 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 questions on rows 18 and 20 are not applicable, write N/A.

CCO NAME:	Eastern Oregon Coordinated Care Organization
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	The maternity care CDA is specific to postpartum care. The provider (or physician) group that performed the delivery is held accountable for this CDA. To be eligible for the CDA, the provider group must have at least 10 deliveries within the measurement year. Denominators will be attributed to provider groups based on the rendering provider for the delivery, as identified by codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, and 59622 rendered for births between January 1 – December 31 of the measurement year. EOCCO is using the target as specified by OHA. EOCCO will continue this model for the January 1, 2025 through December 31, 2025 measurement year as well.
LAN category (most advanced category)	3A
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	The Metrics and Scoring Committee selects benchmark and improvement targets for each quality measure for the CCOs. Provider groups will receive a bonus payment based on their performance meeting or exceeding EOCCO's 2023 measure target. EOCCO will publish this rate within 30 days of notification from the Oregon Health Authority. In subsequent years, calculations will be based on a provider group's ability to meet the EOCCO measure target published by OHA and show improvement from the prior year's performance to receive the highest level of bonus percentage calculation. The bonus will be calculated based on the provider group's total reimbursement for professional delivery services as identified by the list of codes above. [redacted] See cells D13:G16 for the rate schedule
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	Inadequate postpartum care can contribute to persistent racial and ethnic disparities in maternal and infant health outcomes.
Total dollars paid	[redacted]
Total unduplicated members served by the providers	[redacted]
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	[redacted]
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	There is no downside risk in this model.

Year	Improved from last year	Met target	Did not meet target
1	N/A	15%	0%
	Yes	20%	10%
2+	No	15%	0%

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)
The percentage of deliveries of live births between January 1 – December 30 of the measurement year that had a postpartum visit on or between 7-84 days after delivery.	OHA technical Specifications	See above for year one and year two assessment. The "met target" is meeting the EOCCO improvement target or benchmark, whichever is less.	EOCCO has continued to meet the PPC measure, which is difficult with the year over year increase until the benchmark is achieved.

Required implementation of care delivery areas by January 2025: 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 questions on rows 18 and 20 are not applicable, write N/A.

CCO NAME:	Eastern Oregon Coordinated Care Organization
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	This CDA was implemented as of January 1, 2023. For oral health services, Members with limited-English proficiency (LEP) who receive interpretation by an OHA qualified or certified health care interpreter or who receive an in-language visit with a qualified provider.
LAN category (most advanced category)	3A
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	The language access quality incentive arrangement is effective for dates of service incurred from January 1, 2024 through December 31, 2024. This CDA includes all dental providers and services that are delivered to EOCCO members. Care delivery area payments will be calculated in alignment with EOCCO's dental organization provider contracts.
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	By providing quality interpreter services, this oral health CDA will assist in providing members who have limited English proficiency and Deaf and hard of hearing, receive quality communication, language access services and the delivery of culturally responsive care.
Total dollars paid	
Total unduplicated members served by the providers	11,200 members
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	Maximum amount for 2024 will be calculated in Q3 2025. We anticipate a decrease in payment for 2024, as the target has changed from just a reporting threshold to a reporting threshold and meeting the CCO target.
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	There is no downside risk in this model.

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)
Report on 80% of member visits for members with interpreter needs, as identified by OHA's eligibility file interpreter flag . Additionally, meet the metric improvement target for EOCCO.	OHA specifications	Oral health/DCOs must meet the EOCCO benchmark or improvement target	Both DCOs were able to report on 80% of their population in 2023. We will start to track the rate once this measure goes to full population, as it would need to be rebased from sample to full population

Required implementation of care delivery areas by January 2025: 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 questions on rows 18 and 20 are not applicable, write N/A.

CCO NAME:	Eastern Oregon Coordinated Care Organization
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	This CDA was implemented as of January 1, 2024 and will continue in 2025. Measure: Well Child Visits ages 7-21 The number of children ages 7-21 that received one or more well-care visits between January 1 – December 31 of the measurement year.
LAN category (most advanced category)	3A
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	Provider groups will be eligible to receive a bonus payment based on their performance meeting or exceeding EOCCO's 2025 measure target calculation. The well child visits ages 7-21 has been added to the well child visits ages 3-6 measure in the Quality Bonus Payment Formula under the Quality Incentive Exhibit. Provider groups must meet both age ranges to achieve the points for the well child measure.
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	Per the CDC, research suggests that many disparities in overall health and well-being are rooted in early childhood. For example, those who lived in poverty as young children are more at-risk for leading causes of illness and death, and are more likely to experience poor quality of life. Interventions, such as ensuring PCP visits annual, support healthy development in early childhood reduce disparities, have lifelong positive impacts, and are prudent investments. Addressing these disparities effectively offers opportunities to help children, and benefits our society as a whole.
Total dollars paid	2024 will be determined in Q3 2025
Total unduplicated members served by the providers	2024 will be determined in Q3 2025
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	2024 will be determined in Q3 2025
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	There is no downside risk for this CDA.

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)

Well Child Visits ages 7-21	HPQMC and NCQA	Since the current 2025 CCO incentivized well child measure is for age range 3-6, the improvement target for the 7-21 age group will be calculated using the methodology selected for the 3-6 age range. The benchmark will be the previous year's statewide CCO rate, calculated by OHA.	TBD, will be evaluated in 2025 for 2024 performance to set baseline rate.