**OHA VBP PCPCH Data and CDA VBP data template - General Instructions**

1. Complete all yellow highlighted cells on the "PCPCH" tab, the "Model_descriptions" and the "CDA VBP Data" tab/s. CDA tabs are voluntary for this reporting year.

2. For payments that span multiple HCP-LAN categories, use the most advanced category. If for example 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 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 the following URL: https://www.oregon gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Technical-Guide.pdf

4. Note: Due to disruptions in the health care delivery system as a result of COVID -19, CCOs are now required to develop care delivery area (CDA) VBPs in 2021 but NOT required to implement them until 2022. If your CCO did not implement a CDA in 2020, you may leave CDA worksheets blank.

5. The completed VBP PCPCH Data and CDA VBP data template must be submitted to the following email address: OHA.VBP@dhsoha.or.us no later than May 6, 2021. 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 2020 VBP PCPCH Data and CDA Template).

CONTRACTOR/CCO NAME: Columbia Pacific CCO
REPORTING PERIOD: **1/1/2021 - 12/31/2021**

| Brief Description of VBP 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:<br>- racial and ethnic disparities; &<br>- individuals with complex health care needs |
|---|---|---|---|---|
| Behavioral Health Capitation | 4B | N/A | Assertive Addictions Recovery, ACT, EASA, Supported Employment, ICM, CSS, Intensive OP Services, and Wraparound Services paid via capitation payments with quality metric submissions from participating providers required and driving incentive payments | These models are meant to support members with complex behavioral health needs |
| Total Cost of Care Community Risk Agreement | 3B | N/A | Primary Care, Hospital, and Behavioral Health providers participating in a risk adjusted total cost of care risk agreement. All physical health costs are included for assigned members, with limited exclusions (e.g., Hep C drugs) as negotiated with provider partners. Upside/downside payments are limited by a risk corridor and min/max risk exposure levels. Shared savings are gated by quality metric performance. | Analytics available to providers help identify members with chronic conditions for targeted outreach and population health management. |
| 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 quality component includes a health equity/language access requirement to advance work to mitigate health disparities. |
| 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. | Supports members unique behavioral health needs while receiving standard primary care services |
| PCP Oral Health Integration | 2C | N/A | Primary Care providers receive PMPM payments for achieving performance benchmarks relative to oral health integration related quality metrics | |
| MLR Risk Agreement | 3B | 4A | FQHC is participating in a risk adjusted Medical Loss Ratio risk agreement. All physical health costs and Maternity 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. |
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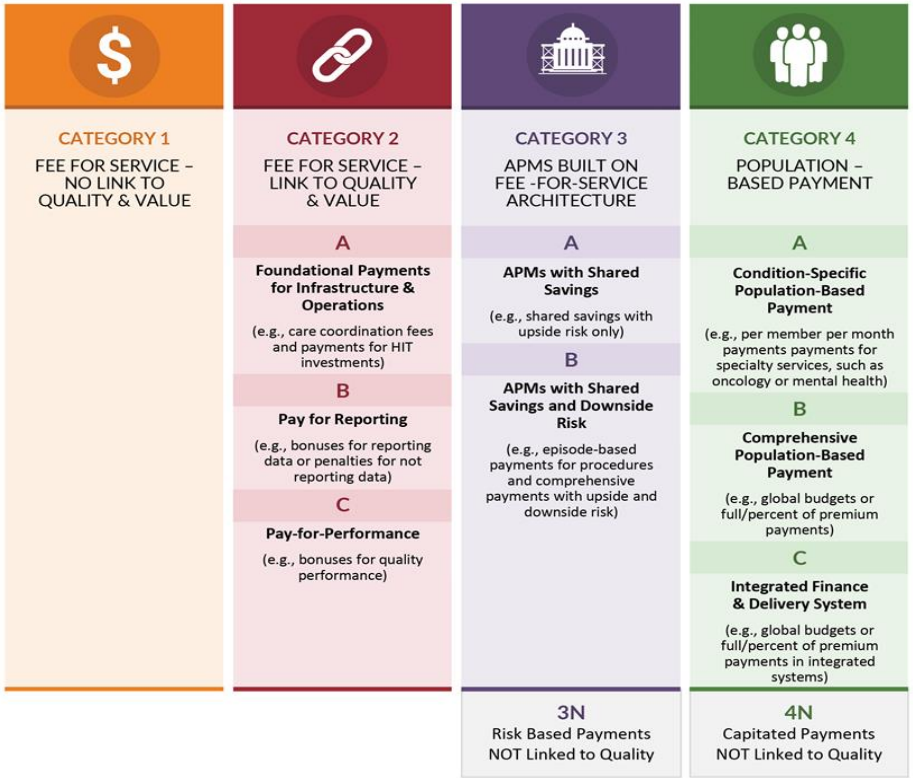
CONTRACTOR/CCO NAME: Columbia Pacific CCO
REPORTING PERIOD: **1/1/2021 - 12/31/2021**

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.

| 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 | 0 | | | No Tier 1 clinics currently participate in the program |
| Tier 2 clinics | 0 | | | No Tier 2 clinics currently participate in the program |
| Tier 3 clinics | 14 | $0.85 - $14.50 | $ [redacted] | No deviations |
| Tier 4 clinics | 97 | $0.85 - $19.60 | $ [redacted] | No deviations |
| Tier 5 clinics | 21 | $7.50 - $16.25 | $ [redacted] | No deviations |

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



Due to disruptions in the health care delivery system as a result of COV D -19, care delivery areas (CDA) VBPs are now required to be developed in 2021 and implemented in 2022 (i.e. pushing the requirement back a year). If your CCO did not implement a CDA in 2020, you may leave this blank. Required implementation of care delivery areas for 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024.

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|---|---|
| CONTRACTOR/CCO NAME: | Columbia Pacific CCO |
| REPORTING PERIOD: | 1/1/2021 - 12/31/2021 |
| | |
| Care Delivery Area (CDA) (may be multiple) | Hospital Care and Behavioral Health |
| | |
| 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) | Community Total Cost of Care Risk Share agreement including hospitals, PCPs, and BH providers. The agreement includes all assigned members, including those with chronic conditions and specific health needs |
| | |
| If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities | The agreement aligns incentives for PCPs, hospitals, and BH providers to better coordinate care for those with chronic conditions, and significant behavioral health support needs |
| | |
| Total dollars paid | [redacted] *total FFS claims paid through March 22 |
| | |
| Total unduplicated members served by the providers | 15,688 |
| | |
| If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment) | TBD - financial settlement calculations for 2021 currently in progress |
| | |
| If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment) | TBD - financial settlement calculations for 2021 currently in progress |
| List the quality metrics used in this payment arrangement: | |

[redacted]

| 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 3-6 yo | NCQA | Reporting only | |
| Immunizations for Adolescents | NCQA | Reporting only | |
| Alcohol and Drug Misuse SBIRT | NCQA | Reporting only | |
| Screening for Depression and Follow-up Plan | NCQA | Reporting only | |
| Diabetes HbA1c Poor Control | NCQA | Reporting only | |
| HEDIS Adults' Access to Preventive/Ambulatory Services | NCQA | Reporting only | |
| HEDIS Children and Adolescents' Access to Primary Care | NCQA | Reporting only | |
| Equity Narrative Report improving language access | CareOregon/CPCCO developed metric in service to language access metric | Pass/No Pass | |
| **hospitals are also held to BH metrics listed in the BH CDA VBP Data sheet as part of the county risk share model* | | | |
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| Due to disruptions in the health care delivery system as a result of COVID -19, care delivery areas (CDA) VBPs are now required to be developed in 2021 and implemented in 2022 (i.e. pushing the requirement back a year). If your CCO did not implement a CDA in 2020, you may leave this blank. Required implementation of care delivery areas for 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. | |
| CONTRACTOR/CCO NAME: | Columbia Pacific CCO |
| REPORTING PERIOD: | **1/1/2021 - 12/31/2021** |
| | |
| Care Delivery Area (CDA) (may be multiple) | |
| | |
| LAN category (most advanced category) | |
| | |
| Briefly describe he payment arrangement and he types of providers and members in the arrangement (e.g. pediatricians and asthmatic children) | |
| | |
| If applicable, describe how his CDA serves populations with complex care needs or those who are at risk for health disparities | |
| | |
| Total dollars paid | - |
| | |
| Total unduplicated members served by the providers | - |
| | |
| 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: | |

| Metric | Metric Steward (e.g. HPQMC, NQF, etc.) | Briefly describe how CCO assesses quality (e.g. measure against national benchmark, compare providers' previous performance, etc.) | Describe providers' performance (e.g. quality metric score increased from 8 to 10) |
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| Due to disruptions in the health care delivery system as a result of COVID -19, care delivery areas (CDA) VBPs are now required to be developed in 2021 and implemented in 2022 (i.e. pushing the requirement back a year). If your CCO did not implement a CDA in 2020, you may leave this blank. Required implementation of care delivery areas for 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. | |
| CONTRACTOR/CCO NAME: | Columbia Pacific CCO |
| REPORTING PERIOD: | 1/1/2021 - 12/31/2021 |
| | |
| Care Delivery Area (CDA) (may be multiple) | Behavioral Health |
| | |
| LAN category (most advanced category) | 4B |
| | |
| Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children) | Capitated payment agreement, with incentive dollars available for report submissions, and quality metric performance |
| | |
| If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities | The agreement provides funding for necessary services for members with significant specialty behavioral health needs. The agreement also incentivizes providers to manage performance relative to related quality metrics specific for the type of service. |
| | |
| Total dollars paid | [redacted] |
| | |
| , | 4,833 |
| | |
| 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) | [redacted] |
| List the quality metrics used in this payment arrangement: | |

| Metric | Metric Steward (e.g. HPQMC, NQF, etc.) | Briefly describe how CCO assesses quality (e.g. measure against national benchmark, compare providers' previous performance, etc.) | Describe providers' performance (e.g. quality metric score increased from 8 to 10) |
|---|---|---|---|
| Oregon Center of Excellence for Assertive Community Treatement (OCEACT) | OCEACT quarterly reporting | Provider must maintain a score on the DACT fidelity scale at better than established benchmarks | Pending quarterly report review |
| Initiation and Engagement - ACT services | N/A | Reviews claims data to ensure combination of monthly codes indicates appropriate engagement, 95% of members must have necessary level of engagement for provider to pass | Pending quarterly report review |
| Psychiatric IP Readmission - members enrolled in ACT with subsequent readmissions | N/A | [redacted]mprovement from 2019 performance | Pending quarterly report review |
| EASA - submit to plan quarterly reports sent to EASA Center for Excellence | N/A | Quarterly reports reviewed to evaluate program | Pending quarterly report review |
| Initiation and Engagement - EASA services | N/A | % of new clients who have a 2nd appointment within 30 days. [redacted] target | Pending quarterly report review |
| Wrap - DHS Assessment | CCO incentive metric | % of OHP youth referred to Wraparound that receive mental health assessment within 60 days. Target[redacted] | Pending quarterly report review |
| Wrap - CANS | Quarterly CANS reporting to OHA | [redacted]of OHP youth enrolled in this program will have a strength and needs assessment completed within 30 days | Pending quarterly report review |
| Supported Employment | N/A | % of members in SE that have competitive integrated employment. Target [redacted] | Pending quarterly report review |
| ICM and CSS - subsequent IP readmissions | N/A | [redacted]improvement from 2019 performance | Pending quarterly report review |
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