Jackson Care Connect
Primary Care Payment Model

2021 Program Description

Jackson Care Connect™
Your Community Health Plan

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Overview

At the local, state and national level, efforts are underway to achieve the triple aim of health care and encourage movement away from traditional volume-based health care payments. In line with this goal, The Oregon Health Authority (OHA) has included annual value-based payment targets that Coordinated Care Organizations (CCOs) will be held accountable to from 2020 – 2024. The OHA has aligned implementation of this strategy with the Centers for Medicare and Medicaid Services (CMS) Health Care Payment Learning and Action Network (LAN) framework, a nationally accepted methodology. Additional information on this state and national work can be found on The OHA's value-based payment website. [1]

Jackson Care Connect (JCC) has aligned with these strategies through the Primary Care Payment Model (PCPM) Program. The Program invests in critical services that are not adequately represented by fee for service (FFS) billable codes, and endeavors to shift healthcare dollars from acute, to outpatient preventive services with the goal of improving the health of our communities, while also shifting reimbursement away from FFS models.

The aim of the Program is to support primary care transformation in the JCC network by facilitating:

1. Knowledge of and accountability for engaging assigned populations in a timely and clinically appropriate manner.
2. Reduction of health disparities through trauma-informed, culturally responsive, and inclusive care.
3. Integration of oral health and primary care.
4. Integration of behavioral health services into primary care.
5. Active contribution to reducing total cost of care.

What's New?

If your clinic has previously participated in a JCC payment model, you may notice a few changes:

- ✓ Four Focus Areas.
  The new JCC PCPM Program includes four focus areas that are folded into a single application, Letter of Agreement, and reporting process. Focus areas include Clinical Quality, Behavioral Health integration, Oral Health Integration, and Cost of Care.
- ✓ Improvement-Based Performance with Benchmarks.
  Our intention was that participating clinics would be evaluated based on their improvement from a baseline. *However, due to the Covid-19 pandemic, all clinical quality metrics are reporting only.*
- ✓ Simplified Reporting.
  Reporting for the new PCPM Program includes fewer quality measures and streamlined reporting requirements.
- ✓ Accountability for Equity.
  Clinics are required to submit a narrative report attesting to the advancement of language access within their organizations.
- ✓ Oral Health Focus Area.
  A new focus area will be based on clinic performance on a single oral health measure.
- ✓ CCO-specific Measures.
  Clinical quality measures are specifically focused as identified by the respective regional CCO: Health Share of Oregon, Jackson Care Connect, or Columbia Pacific CCO.

[1] Value-based Payment. Oregon Health Authority. Retrieved from https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx.

Jackson Care Connect PCPM At a Glance

The Jackson Care Connect Primary Care Payment Model has four Focus Areas.

1. *Clinical Quality Focus Area*
   The Clinical Quality Focus Area drives outcomes and equity through five CCO-focused quality measures, one access & engagement measure; and one equity narrative report.

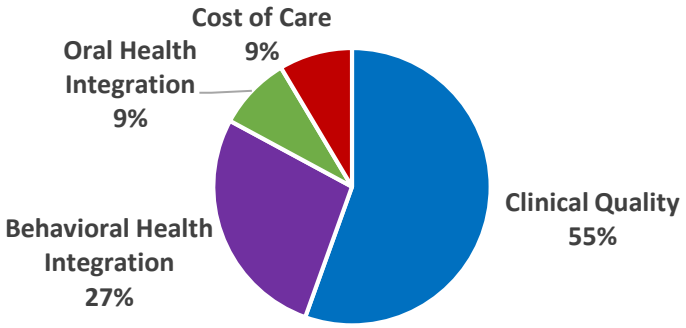
2. *Behavioral Health Integration Focus Area*
   The Behavioral Health Integration (BHI) Focus Area funds clinics that attest to following the JCC BHI Program Model.

3. *Oral Health Integration Focus Area*
   The Oral Health Integration Focus Area strives to promote collaboration and coordination by aligning priorities and incentives across both physical and oral health.

4. *Cost of Care Focus Area*
   The Cost of Care Focus Area invests in clinics that are using the primary care medical home model—Primary Care Patient Centered Home (PCPCH)—to reduce unnecessary utilization and total cost of care of their patients.

Payment Structure

Each Focus Area contributes to a total per member per month (PMPM) payment amount approximately in these proportions if provider participates in all focus areas.



Reporting and Payment Schedule

Payment adjustments once and are based on data submission performance.

● Data submission ▲ Payment adjustment

2020												2021					
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Lookback Measurement Period													●				▲
												Letter of Agreement (LOA) effective 1/1/21 – 6/30/21					

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Eligibility Requirements for Participation

Eligibility requirements must be met at the time of JCC PCPM application deadline.

✓ **500+ assigned JCC Members.**
A minimum of 500 JCC members must be assigned to provider organization, when combined across all contracted clinics.

✓ **Tier 3+ Oregon PCPCH Recognition.**
All participating clinics must hold Oregon PCPCH recognition of Tier Three (3) or above.

Program Rates

Each focus area corresponds with a per member per month (PMPM) payment level, depending on performance and the CareOregon determined clinic risk. Each focus area is combined to make up a total PMPM payment.

Focus Area	Level 0 PMPM	Level 1 PMPM	Level 2 PMPM	Level 3 PMPM
Clinical Quality	$ 0.00	$ 3.40	$ 4.95	$ 8.10
Behavioral Health Integration	$ 0.00	$ 2.00	$ 4.00	N/A
Oral Health Integration	$ 0.00	$ 1.25	N/A	N/A
Cost of Care	$ 0.00	$ 1.25	N/A	N/A

Example:

Clinic A achieved payment level 3 for Clinical Quality, level 1 for Behavioral Health Integration, level 1 for Oral Health Integration, and level 0 for Cost of Care. Based on their performance, Clinic A's total payment would be $11.35 PMPM.

Focus Area	Level 0 PMPM	Level 1 PMPM	Level 2 PMPM	Level 3 PMPM	Total PMPM
Clinical Quality	$0.00	$3.40	$4.95	$8.10	$ 11.35 PMPM
Behavioral Health Integration	$0.00	$2.00	$4.00	N/A	
Oral Health Integration	$0.00	$1.25	N/A	N/A	
Cost of Care	$0.00	$1.25	N/A	N/A	

Risk Adjustment

Program rates displayed above reflect the minimum rates assigned to each payment level. Clinic PMPM rates may be adjusted higher than the program rates displayed above depending on risk assignment. CareOregon and Jackson Care Connect review clinic risk assignment on an annual basis.

Risk adjustment methodology is based on the Chronic Illness & Disability Payment System (CDPS) risk adjustment program used by OHA in the rate-setting process. Clinics are assigned to a specific risk tier based on the average risk score for the CareOregon members assigned to their clinic.

Clinical Tracks and Focus Area Measures

One of two (2) clinical tracks must be selected for each participating clinic in the program application that best aligns with each clinic's patient population: Family Practice/Internal Medicine or Pediatric. Each clinical track includes 11 total measures across all four focus areas.

Focus Area	#	Family Practice/Internal Medicine Track	Pediatric Track
Clinical Quality	1	Colorectal Cancer Screening	Kindergarten Readiness: Well-Child Visits 3-6 yo
	2	Cigarette Smoking Prevalence	Childhood Immunization Status (Combo 2)
	3	Alcohol and Drug Misuse: SBIRT	Alcohol and Drug Misuse: SBIRT
	4	Screening for Depression and Follow-Up Plan	Screening for Depression and Follow-Up Plan
	5	Diabetes: HbA1c Poor Control	Immunizations for Adolescents (MCV4, Tdap, HPV)
	6	JCC 12-Month Engagement Rate; ***or*** State APCM Care STEPs Rate	JCC 12-Month Engagement Rate; ***or*** State APCM Care STEPs Rate
	7	Equity Narrative Report: Improving Language Access	Equity Narrative Report: Improving Language Access
BHI*	8	JCC Population Reach	JCC Population Reach
	9	Choice of Sub-Population: - Patients with Positive SBIRT; ***or*** - Patients with Diabetes: HbA1c > 9	Choice of Sub-Population: - Patients with Positive SBIRT; ***or*** - Patients with Positive Depression Screen
Oral Health Integration	10	Oral Evaluation for Adults with Diabetes	Preventive Dental Visits for Ages 1-14
Cost of Care	11	Family Practice/Internal Medicine Cost of Care Narrative Report	Pediatric Cost of Care Narrative Report

*Only clinics that attest to delivering integrated behavioral health in alignment with the CareOregon/JCC's BHI Model of Care are required to submit BHI Population Reach data.

Performance Evaluation

Performance is evaluated individually for each participating clinic. Clinics may achieve the PMPM amount that corresponds with the payment level based on performance in each focus area. Each focus area PMPM is combined to make up a total PMPM payment.

	Payment Level 0	Payment Level 1	Payment Level 2	Payment Level 3
Clinical Quality	$ 0.00 Improvement target or benchmark met on **< 50% measures**	$ 3.40 Improvement target or benchmark met on **≥50% measures**	$ 4.95 Improvement target or benchmark met on **≥60% measures**	$ 8.10 Improvement target or benchmark met on **≥80% measures**
	If Equity Narrative Report does not meet all requirements, clinic payment level is reduced by one.			
BHI	$ 0.00 < 5.0% reach on ***either*** measure	$ 2.00 ≥ 5.0 reach on ***both*** measures; < 12.0% on ***either*** measure.	$ 4.00 ≥ 12.0% reach on ***both*** measures.	
Oral Health Integration	$ 0.00 Improvement target **not met**	$ 1.25 Improvement target **met**		
Cost of Care	$ 0.00 Improvement target **not met**	$ 1.25 Improvement target **met**		

Improvement Targets

Due to the Covid-19 pandemic, all clinical quality metrics and access & engagement measures will be reporting only.

Behavioral health integration measures have a pre-set benchmark for population reach in lieu of an improvement target.

Data Submission Information

Performance evaluation occurs once in the 6-month contract and determines payment level. Various measure types are included in performance evaluation. Detailed measure specifications can be found in Appendix B.

Claims Measures

Performance on claims-based measures is calculated using JCC claims data. Clinics are not required to submit data for claims-based measures; however, clinics are provided with the opportunity to review performance data and to submit corrected claims prior to finalizing performance. Supplemental data without corrected claims will not be accepted.

Jackson Care Connect will provide member-level and aggregate performance data to participating clinics quarterly, at a minimum.

EHR/eCQM Measures

Clinics that do not already provide JCC with data, or have data provided to JCC by another entity on the clinic's behalf, for CCO EHR/eCQM measures, must submit member-level or aggregate performance data on all EHR/eCQM measures. Clinics for which this data is already provided to JCC are not required to submit separately for PCPM. Please contact AltPayment@careoregon.org with questions about whether JCC already receives this data for your clinic.

All data for EHR/eCQM measures must be submitted according to OHA specifications, which can be found on the OHA website: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/YearEightGuidanceDocumentation_final.pdf

Roster Measures

The Pediatric clinical track includes one measure for which clinics are required to submit member-level immunization status from the EHR and/or Alert Immunization Information System (IIS). For these measures, JCC will provide clinics with a roster at least 30 days prior to data submission deadline, of all assigned JCC members that meet inclusion criteria.

Equity Narrative Report

All participating clinics are required to submit a narrative report describing efforts to improve language access. Equity Narrative Report specifications can be found in Appendix B.

BHI Population Reach Measures

Clinics that attest to delivering integrated behavioral health in alignment with JCC's BHI Model of Care are required to submit aggregate data for unique JCC members that received a qualifying service from a behavioral health clinician (BHC). Additional information about BHI measures can be found in Appendix B.

Access & Engagement Clinic-Defined Measure

Clinics have the option of choosing one of two Access & Engagement measures: Jackson Care Connect 12-month Engagement Rate or State APCM Care STEPs Rate. Specifications for both Access & Engagement measures can be found in Appendix B.

Clinics that opt to utilize the State APCM Care STEPs Rate measure, must be submit data according to the specifications defined in Appendix B.

Report Only Measures

Measures that indicate a target as "Report Only" in Appendix A, require only the submission of data to specifications to meet the requirements for that measure during the specified data submission period.

Annual Quality Pool Report

Each year Jackson Care Connect makes a one-time pay-for-performance payment to eligible clinics to recognize their contributions to the CCO incentive measure program. A portion of the money that Jackson Care Connect earns in the state CCO Quality Pool Program are passed directly to PCP clinics through this one-time payment. **Note: eligibility for PCPM program does not guarantee eligibility for the annual quality pool payment.**

Reporting Deliverable Timeline

January 1, 2020	Lookback measurement period begins.
February 28, 2021	Data submission due to JCC for lookback measurement period.
June 1, 2021	Payment adjustment effective based on data submission.

Application Process

Applications that had been returned to JCC via email to AltPayment@careoregon.org prior to January 31, 2020, were utilized to prepare the Agreements for the period of January 2021 through June 2021.

Step 1: Attest to Eligibility Requirements

All participating clinics must hold Oregon PCPCH recognition of Tier Three (3) or above. Participating clinics must also belong to a system with at least 500 JCC members assigned.

Step 2: Attest to BHI Model of Care Requirements

To receive the BHI PMPM, clinics must attest to delivering integrated behavioral health services in alignment with JCC's BHI Model of Care. Jackson Care Connect BHI Model of Care requirement can be found in Appendix C.

Step 3: Select Clinical Track for Each Participating Clinic

A clinical track must be selected for each participating clinic, determining the measure set by which each clinic will be measured for performance: Family Practice/Internal Medicine or Pediatric.

Step 4: Define Access & Engagement Measure

Clinics are required to choose one of two Access & Engagement measures. Depending on the measure chosen, clinics may be required to submit baseline data for each participating clinic. Access & Engagement measure requirements can be found in Appendix B.

Step 4: Submit Baseline Measurement Data for Applicable Measures

Baseline data need not be submitted if EHR/eCQM data is already provided to JCC on a clinic's behalf.

Clinics for which EHR/eCQM measurement data is ***not*** already provided to JCC must submit member-level or aggregate performance data on all EHR-based measures.

All data for EHR/eCQM measures must be submitted according to OHA specifications, which can be found on the OHA website: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/YearEightGuidanceDocumentation_final.pdf

Clinics that are unable to submit baseline data for improvement target calculation may not be eligible to receive the highest Clinical Quality payment level.

Application Timeline

January 31, 2020	Applications were due to Jackson Care Connect.
Revised to 12/1/2020	Signed Letter of Agreement is due to Jackson Care Connect.
January 1, 2021	Letter of Agreement becomes effective.

Appendix A: Detailed Measure Sets for Clinical Tracks

1. Family Practice/Internal Medicine Clinical Track

Measures using the Minnesota Method are denoted with "MM."

Measure	DataSource	Measurement Period	Baseline Measurement	Target	Benchmark
Clinical Quality Focus Area					
Colorectal Cancer Screening (MM)	Claims	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Cigarette Smoking Prevalence (MM)	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Alcohol and Drug Misuse: SBIRT	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Screening for Depression and Follow-Up Plan	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Diabetes: HbA1c Poor Control (MM)	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Access & Engagement Measures					
JCC 12-month Engagement Rate ***or*** State APCM Care STEPs Rate	Claims ***or*** Clinic Reported	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Equity Narrative Report					
Improving Language Access	Narrative Report	Jul 2020 – Dec 2020	N/A	Meet narrative requirements	N/A
Behavioral Health integration Focus Area					
JCC Population Reach	Clinic Reported	Jan 2020 – Dec 2020	N/A	Tier 1: 5.0% Tier 2: 12.0%	N/A
Choice of Sub-Population:					
JCC Sub-Population Reach: Patients with Positive SBIRT ***or*** Patients with Diabetes: HbA1c > 9	Clinic Reported	Jan 2020 – Dec 2020	N/A	Tier 1: 5.0% Tier 2: 12.0%	N/A
Oral Health Integration Focus Area					
Oral Evaluation for Adults with Diabetes (MM)	Claims	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Cost of Care Focus Area					
Family Practice/Internal Medicine Cost of Care Narrative Report	Narrative Report	Nov 2019 - Oct 2020	N/A	Meet narrative requirements	N/A

**Measure is aggregated to the system/organization-level instead of clinic-level.*

2. Pediatric Clinical Track

Measures using the Minnesota Method are denoted with "MM."

Measure	DataSource	Measurement Period	Baseline Measurement	Target	Benchmark
Clinical Quality Focus Area					
Kindergarten Readiness: Well-Child Visits 3-6 yo (MM)	Claims	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Childhood Immunization Status (Combo 2) (MM)	Roster	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Alcohol and Drug Misuse: SBIRT	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Screening for Depression and Follow-Up Plan	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Immunizations for Adolescents (MCV4, Tdap, HPV) (MM)	Roster	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Access & Engagement Measures					
JCC 12-month Engagement Rate	Claims				
or	***or***				
State APCM Care STEPs Rate	Clinic Reported	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Equity Narrative Report					
Improving Language Access	Narrative Report	Jul 2020 – Dec 2020	N/A	Meet narrative requirements	N/A
Behavioral Health integration Focus Area					
JCC Population Reach	Clinic Reported	Jan 2020 – Dec 2020	N/A	Tier 1: 5.0% Tier 2: 12.0%	N/A
Choice of Sub-Population:					
JCC Sub-Population Reach: Patients with Positive SBIRT ***or*** Patients with Positive Depression Screen	Clinic Reported	Jan 2020 – Dec 2020	N/A	Tier 1: 5.0% Tier 2: 12.0%	N/A
Oral Health Integration Focus Area					
Preventive Dental Visits for Ages 1-14 (MM)	Claims	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Cost of Care Focus Area					
Pediatric Cost of Care Narrative Report	Narrative Report	Nov 2019 - Oct 2020	N/A	Meet narrative requirements	N/A

Appendix B: Measure Specifications

1. Clinical Quality Measure Specifications

The following measures will follow specifications as defined by the Oregon Health Authority:

a) Colorectal Cancer Screening
b) Cigarette Smoking Prevalence
c) Alcohol and Drug Misuse: SBIRT
d) Screening for Depression and Follow-Up Plan
e) Diabetes: HbA1c Poor Control
f) Kindergarten Readiness: Well-Child Visits 3-6 yo
g) Childhood Immunization Status (Combo 2)
h) Immunizations for Adolescents (MCV4, Tdap, HPV)

Measure specifications can be found at the Oregon Health Authority's website:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx?wp6488=se:%222019%22

The most current specifications provided by the OHA will be used at the time of the performance evaluation. Participants shall be responsible for monitoring specification updates.

2. Access and Engagement Measure Specifications

State APCM Care STEPs

A Care STEP is a specific direct interaction between the Health Center staff and the patient, the patient's family or authorized representative(s) through in-person, digital, group visits, or telephonic means. It was developed by the Oregon Health Authority and Oregon Primary Care Association for the state FQHC Advanced Payment and Care Model. There are currently 18 Care STEPs, grouped into four categories:

1) New Visit Types;

2) Education, Wellness and Health Promotion;

3) Coordination and Integration; and

4) Reducing Barriers to Health

Care STEPs documentation can demonstrate the range of ways in which Health Center teams are providing access to services and value to patients. Care STEPs data are collected and submitted quarterly to OHA, in order to better understand the non-billable and non-visit-based care and services that are being delivered, as the Patient-Centered Primary Care Home model advances under APCM.[2]

Please see the attached APCM Care STEPs Report document for more detailed specifications.

https://www.oregon.gov/oha/HSD/OHP/Tools/Care%20STEPs%20Gallery%20-%20Definitions%20and%20Use.pdf

Jackson Care Connect 12-Month Engagement Measure

Description

Jackson Care Connect 's 12-Month Engagement Rate Measure, captures the percent of assigned members who were engaged in primary care services with their assigned provider within the previous 12-months.

Numerator

Jackson Care Connect members with at least one primary care service in the previous 12-months with *any* primary care clinic or primary care provider within their assigned clinic's organization.

Denominator

Active JCC members with primary physical health coverage through JCC assigned to clinic.

Technical Notes

1. Primary care visits are identified by claim form type (1500) and provider specialty.

2. Specialty types designated as "primary care" include: family practice, adolescent medicine, general practice, geriatrics, internal medicine, naturopathic medicine, pediatrics, preventive medicine, physician assistant.

[2] https://www.oregon.gov/oha/HSD/OHP/Tools/APM%20FAQs.pdf

3. Equity Narrative Report Specifications: Improving Language Access

The pursuit of the highest standard of health for all people is the heart of JCC's values and mission. We recognize that the process of achieving health equity includes the intentional deployment of resources to identify disparities and redress them when found. It also requires giving special attention to the needs of those at greatest risk of poor health, based on social conditions and socially defined constructs, such as racial categories, language and poverty. In this program, we ask that clinics work to improve language access systems and processes for Limited English Proficient JCC members.

Limited English Proficient (LEP) persons are individuals who are unable to communicate effectively in English because their primary language is not English, and they have not developed fluency in the English language. A person with Limited English Proficiency may have difficulty speaking or reading English. An LEP individual will benefit from an interpreter who will translate to and from the person's primary language. An LEP individual may also need documents written in English translated into his or her primary language so that person can understand important documents related to health and human services. (Source: CMS Strategic Language Access Plan 2014 Updates).

This is a reporting only requirement. Measure will be passed provided that the clinic submits the equity narrative report, responds fully to each section and demonstrates advancement of project activities. Clinics will be asked to show improvement, through process or policy, in the provision of services in a member's preferred language. You will be asked to upload a word document with your responses and any accompanying documentation or workflows. If your organization has multiple locations, you do not need to provide a separate report for each location. However, indicate whether responses are relevant to all. In addition, please provide data in reporting component 1 for each clinic location.

Reporting Component 1: CLAS Standards

1a. How does the clinic offer language assistance to individuals who have limited English proficiency and/or other communication needs to facilitate timely access to all health care and services?

1b. How does the clinic ensure that LEP patients know that language assistance services are offered at no cost to them, regardless of their payer?

1c. How does the clinic inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing?

1d. How does the clinic ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided? Please address individuals serving as interpreters and staff providing in-language services separately.

Reporting Component 2: Opportunities to improve language access for LEP members

2a. Please identify one area from above where clinic policies or procedures could improve to better meet the needs of LEP patients. Please provide an improvement plan for this area.

4. BHI Population Reach Measure Specifications

Measure	Numerator (n) and Denominator (d) Descriptions	
JCC Member Population Reach	n	Members in denominator with a service by BHC during measurement period.
	d	Unique JCC members seen by clinic during measurement period.

5. BHI Sub-Population Measure Specifications

Measure	Numerator (n) and Denominator (d) Descriptions	
Depression (Pediatric only)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique JCC members with a positive depression screen as indicated by the measurement tool during measurement period.
Diabetes: HbA1c > 9 (Family Practice/Internal Medicine only)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique JCC members with a Diabetes: HbA1c > 9 during measurement period.
Alcohol & Drug Screening (Any clinical track)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique JCC members with a positive SBIRT screen during measurement period.

Numerator and Denominator Specification Notes

Inclusion criteria for patients seen by BHC (numerator):

- ✓ All billable services, paid and unpaid, including face-to-face and telehealth interventions both scheduled and same-day appointments.
- ✓ Visits where the BHC assists in service delivery along with the medical provider resulting in increased medical complexity that is billed under the medical provider.
- ✓ Non-billable services including, but not limited to:
    - Documented introductions of the patient and/or patient support system to the BHC. These BHC introductions are sometimes referred to as a warm hand-off.
    - Documented consultations and shared care planning with internal primary care team members.
    - Documented consultations, care coordination and case management with external partners such as specialty behavioral health, hospitals, schools, families, etc.
    - Care management activities that include outreach and engagement services.
    - Non-billable services can be documented via EHR portal messages, phone encounters, letters documented in the patient record, interim notes, etc.

Exclusion criteria for patients seen by BHC (numerator):

- ✓ Mass email/EHR messages to patients
- ✓ Telephone encounters where you are leaving a message
- ✓ Reminder messages (phone/EHR/text)
- ✓ Text messaging

Inclusion criteria for patients seen in Primary Care (denominator):

- ✓ Any PCP or BHC appointment (i.e. 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99401, 99402, 99403, 99404, 99411, 99412, G0507, G0505, 96156, 96158, 96159, 96164, 96165,96167, 96168, 99408, G0396, 99409 G0397, 99406, G0436, 99407, G0437, 96110, 96127, 90791, 90832, 90834, 90837, 98966, 98967, 98968).

Lists are not all inclusive, the intent is that services provide some sort of clinical intervention or insight to the patient or on the patient's behalf.

6. Oral Health Integration Measure Specifications

The following measures will follow specifications as defined by the Oregon Health Authority:

a. Oral evaluation for adults with diabetes
b. Preventive dental visits for ages 1-14

Measure specifications can be found at the Oregon Health Authority's website:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx?wp6488=se:%222019%22

The most current specifications provided by the OHA will be used at the time of the performance evaluation. Participants shall be responsible for monitoring specification updates.

7. CCO Cost of Care Measure Narrative Report

1) Family Practice/Internal Medicine Measure Track Cost of Care Narrative Reporting Specifications

The Family Practice/Internal Medicine Cost of Care Payment will be awarded provided that the clinic submits the cost of care report for clinics that elected to participate in the FP/IM Measure Track and fully responds to each section described below. Provider is to submit written narrative responses to questions within a Word template that will be provided by CareOregon. The template will be in Word Format and uploaded to the reporting location with other data submissions.

Reporting Component 1: Population segmentation for medical and social complexity

Population segmentation refers to the practice of identifying medical and social complexity using a standardized methodology and grouping patients by complexity, based on their relative resource needs. Please describe:

1a. Describe your clinic's capability in risk stratifying your clinic population and interventions put in place to appropriately support the identified needs. Provide specific examples of how the risk stratification methodology identifies patients with high emergency department, hospital, and/or specialist utilization patterns. Also discuss how social determinants of health are identified and included with physical health to identify a patient's total risk.
1b. Describe your clinic's established training plans, policies or practices to support the build or maintenance of a trauma informed environment with specific attention on the topics of Adverse Childhood Experiences (ACEs), cultural responsiveness, and implicit bias. Additionally, how does your clinic orient and train new and existing clinical staff and care team members?
If you do not currently have a process in place for new and existing staff, please describe your plans to implement in 2020.

2) Pediatric Measure Track Cost of Care Narrative Report Specifications

The Pediatric Cost of Care Payment will be awarded provided that the clinic submits the cost of care report for clinics that elected to participate in the Pediatric Measure Track and fully responds to each section described below. Provider is to submit written narrative responses to questions within a Word template that will be provided by CareOregon. The template will be in Word Format and uploaded to the reporting location with other data submissions.

Reporting Component 1: Population segmentation for medical and social complexity

Population segmentation refers to the practice of identifying medical and social complexity using a standardized methodology and grouping patients by complexity, based on their relative resource needs. Please describe:
1a. Describe your clinic's capability in risk stratifying your pediatric population and interventions put in place to appropriately support the identified needs. Provide specific examples of how the risk stratification methodology identifies patients with high emergency department, hospital, and/or specialist utilization patterns. Also discuss how social determinants of health are identified and included with physical health to identify a pediatric patient's total risk.
1b. Describe your clinic's established training plans, policies or practices to support the build or maintenance of a trauma informed environment with specific attention on the topics of Adverse Childhood Experiences (ACEs), cultural responsiveness, and implicit bias. Additionally, how does your clinic orient and train new and existing clinical staff and care team members?

If you do not currently have a process in place for new and existing staff, please describe your plans to implement in 2020.

Reporting Component 2: Care coordination for children with medical and/or social complexity

2a. Describe the process for social-emotional screening among pediatric patients' birth through five (5) years. How does the clinic address concerns identified by the screening in a timely manner?
2b. Describe how the clinic identifies pediatric patients as having a special healthcare need. Once identified, describe how needs are assessed for appropriate and timely referrals to specialists or other appropriate resources.
2c. Describe or provide policy/procedure of clinic's process for ensuring pediatric patients receive psychotropic medication that are for medically accepted indications. Please identify any specific populations of focus based on complexity (e.g. those in DHS custody).

Appendix C: Behavioral Health Integration Model of Care

1. Structural Behavioral Health Integration Criteria

Behavioral Health Integration Criteria	Tier 1	Tier 2
Staffing: ✓ At least 0.5 FTE licensed behavioral health clinician (BHC) as defined by subset of ORS 414.025 (Table 4) is on-site, located in the same shared physical space as medical providers. ✓ Mental Health, Substance Use Disorder, and Developmental Screening strategy is established with documentation for on-site local referral resources and processes. ✓ BHC(s) provide care at a ratio of 1 FTE BHC for every 6 FTE Primary Care Clinicians.	✓ ✓ ✓	✓ ✓ ✓
Communication around Shared Patients: ✓ Primary care clinicians, staff, and BHCs document clinically relevant patient information in the same medical record at the point of care. ✓ Care team and BHC routinely engage in face-to-face collaborative treatment planning and co-management of shared patients.	✓ ✓	✓ ✓
BHC as an Integrated Part of the Primary Care Team: ✓ Warm hand-offs/introductions between care team members and BHC. ✓ BHC is a regular part of practice activities (i.e. team meetings, provider meetings, quality improvement projects, case conferences). ✓ Pre-visit planning activities (i.e. scrubbing and/or huddling for behavioral health intervention opportunities).	✓ ✓ ✓	✓ ✓ ✓
Same-Day Access: ✓ On average, ***≥ 25%*** **of BHC hours** at the practice each week are available for same-day services (may include average weekly late-cancelation/no-shows converted to same-day services).	✓	
Same-Day Access: ✓ On average, ***≥ 50%*** **of BHC hours** at the practice each week are available for same-day services (may include average weekly late-cancelation/no-shows converted to same-day services).		✓

2. Qualifying Behavioral Health Clinicians

Qualifying Behavioral Health Clinicians (BHC)*:
- ✓ Licensed psychologist
- ✓ Licensed clinical social worker
- ✓ Licensed professional counselor or licensed marriage and family therapist
- ✓ Certified clinical social work associate
- ✓ Intern or resident who is working under a board-approved supervisory contract in a clinical mental health field

*This list is a subset of ORS 414.025 and indicates the exhaustive list of BHCs that qualify as part of JCC's BHI Program.

Appendix D: What Payment Level Will I Start At?

Prior participation and performance in JCC alternative payment models determines which payment level each participating clinic is initiated when the Letter of Agreement becomes effective, January 1, 2021. The below information indicates which payment levels clinics can be initiated at for each focus area.

	Payment Level 0	Payment Level 1	Payment Level 2	Payment Level 3
Clinical Quality	$ 0.00 ✓ Clinics currently participating in PCPM Track 2 with Quality payment level 0 at time of LOA effective date.	$3.40 ✓ Clinics currently participating in PCPM Track 2 with Quality payment level 1 at time of LOA effective date. ✓ All clinics not currently participating in PCPM Track 2.	$ 4.95 ✓ Clinics currently participating in PCPM Track 2 with Quality payment level 2 at time of LOA effective date.	$ 8.10 ✓ Clinics currently participating in PCPM Track 2 with Quality payment level 3 at time of LOA effective date.
BHI	$ 0.00 ✓ Clinics currently participating in JCC BHI with payment level 0 at time of LOA effective date. ✓ Clinics that do not attest to JCC BHI Model of Care.	$ 2.00 ✓ Clinics currently participating in JCC BHI with payment level 1 at time of LOA effective date. ✓ All clinics not currently participating in JCC BHI.	$ 4.00 ✓ Clinics currently participating in JCC BHI with payment level 2 at time of LOA effective date.	
Oral Health Integration	$ 0.00	$ 1.25 ✓ All participating clinics.		
Cost of Care	$ 0.00 ✓ Clinics currently participating in PCPM Track 2 with Cost of Care payment level 0 at time of LOA effective date.	$ 1.25 ✓ Clinics currently participating in PCPM Track 2 with Cost of Care payment level 0 at time of LOA effective date. ✓ All clinics not currently participating in PCPM Track 2.		