

CareOregon Primary Care Payment Model

2021 Program Description

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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

CareOregon 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 CareOregon 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 CareOregon payment model, you may notice a few changes:

- ✓ **Four Focus Areas.**
The new CareOregon 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>.

CareOregon PCPM At a Glance

The CareOregon 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, four 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 CareOregon BHI Program Model.

3. *Oral Health Integration Focus Area*

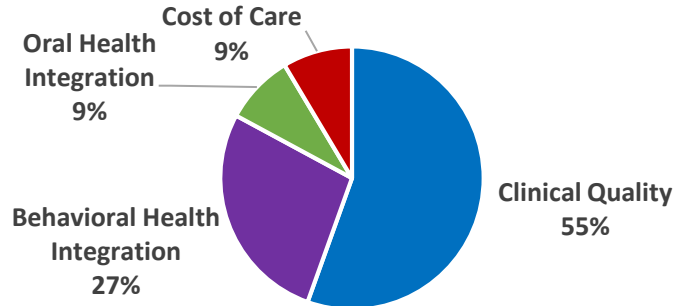
The Oral Health Integration Focus Area strives to promote collaboration and coordination by aligning priorities and incentives across both physical and oral health.

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 occur 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	
<i>Lookback Measurement Period</i>													●					▲
												Letter of Agreement (LOA) effective 1/1/21 – 6/30/21						

Eligibility Requirements for Participation

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



✓ 750+ assigned CareOregon Members.

A minimum of 750 CareOregon 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 reviews 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 three (3) clinical tracks must be selected for each participating clinic in the program application that best aligns with each clinic’s patient population: Family Practice, Pediatric, or Internal Medicine. Each clinical track includes 14 total measures across all four focus areas.

Focus Area	#	Family Practice Track	Pediatric Track	Internal Medicine Track
Clinical Quality	1	Kindergarten Readiness: Well-Child Visits 3-6 yo	Kindergarten Readiness: Well-Child Visits 3-6 yo	Colorectal Cancer Screening
	2	Immunizations for Adolescents (MCV4, Tdap, HPV)	Childhood Immunization Status (Combo 2)	Controlling High Blood Pressure
	3	Diabetes: HbA1c Poor Control	Immunizations for Adolescents (MCV4, Tdap, HPV)	Diabetes: HbA1c Poor Control
	4	Alcohol and Drug Misuse: SBIRT	Alcohol and Drug Misuse: SBIRT	Alcohol and Drug Misuse: SBIRT
	5	Screening for Depression and Follow-Up Plan	Screening for Depression and Follow-Up Plan	Screening for Depression and Follow-Up Plan
	6.1	Engagement Rate: Well-Child Visits 3-6 yo	Engagement Rate: Well-Child Visits 3-6 yo	Engagement Rate: Colorectal Cancer Screening
	6.2	Engagement rate: Immunizations for Adolescents	Engagement rate: Childhood Immunization Status	Engagement rate: Controlling High Blood Pressure
	6.3	Engagement rate: Diabetes Poor Control	Engagement rate: Immunizations for Adolescents	Engagement rate: Diabetes Poor Control
	6.4	Engagement rate SBIRT & Depression	Engagement rate SBIRT & Depression	Engagement rate SBIRT & Depression
	7	Equity Narrative Report: Improving Language Access	Equity Narrative Report: Improving Language Access	Equity Narrative Report: Improving Language Access
BHI*	8	CareOregon Population Reach	CareOregon Population Reach	CareOregon 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	Choice of Sub-Population: Patients with Positive SBIRT; or Patients with Diabetes: HbA1c > 9
Oral Health Integration	10	Oral Evaluation for Adults with Diabetes	Preventive Dental Visits for Ages 1-14	Oral Evaluation for Adults with Diabetes
Cost of Care	11	Inpatient and Emergency Department Utilization for Ambulatory Sensitive Conditions	Pediatric Cost of Care Narrative Report	Inpatient and Emergency Department Utilization for Ambulatory Sensitive Conditions

*Only clinics that attest to delivering integrated behavioral health in alignment with CareOregon’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
	<i>If Equity Narrative Report does not meet all requirements, clinic payment level is reduced by one.</i>			
BHI	\$ 0.00 < 5.0% reach on <i>either</i> measure	\$ 2.00 ≥ 5.0 reach on <i>both</i> measures; < 12.0% on <i>either</i> measure.	\$ 4.00 ≥ 12.0% reach on <i>both</i> 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.

The Cost of Care measure for the Family Practice Clinical Track has a pre-set improvement target of 3% over baseline for the reporting period (the Pediatric Practice Clinical Track has a required Cost of Care narrative).

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 CareOregon 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.

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

EHR/eCQM Measures

Clinics that do not already provide CareOregon with data, or have data provided to CareOregon 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 CareOregon are not required to submit separately

for PCPM. Please contact PaymentModel@careoregon.org with questions about whether CareOregon 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 Family Practice and Pediatric clinical tracks each include 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, CareOregon will provide clinics with a roster at least 30 days prior to data submission deadline, of all assigned CareOregon 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 CareOregon’s BHI Model of Care are required to submit aggregate data for unique CareOregon 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

CareOregon recognizes that the 2020 COVID-19 pandemic has brought unique challenges that have stretched clinic’s capacity to provide consistent and regular primary care engagement for all patients. In light of changing priorities, and the need to focus on segments of high needs patients, the access and engagement measure has been modified to more closely match currently clinical priority areas. Clinics must 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.

Reporting Deliverable Timeline

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

Application Process

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



1

Attest to eligibility requirements.



2

Attest to BHI Model of Care requirements.



3

Select Clinical Track for each clinic.



4

Define Access & Engagement Measure



5

Submit baseline measurement data.

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 750 CareOregon 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 CareOregon’s BHI Model of Care. CareOregon BHI Model of Care requirements 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, Pediatric, or Internal Medicine.

Step 4: Submit Baseline Measurement Data for Applicable Measures

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

Clinics for which EHR/eCQM measurement data is **not** already provided to Health Share 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. 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.

Application Timeline

January 31, 2020
Revised to November
15, 2020
January 31, 2021

Application is due to CareOregon.
Signed Letter of Agreement is due to CareOregon.
Letter of Agreement becomes effective.

Appendix A: Detailed Measure Sets for Clinical Tracks

1. Family Practice Clinical Track

Measures using the Minnesota Method are denoted with “MM.”

Measure	DataSource	Measurement		Baseline Measurement	Target	Benchmark
		Period				
Clinical Quality Focus Area						
Kindergarten Readiness: Well- Child Visits 3-6 yo (MM)	Claims	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
Diabetes: HbA1c Poor Control (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
Access & Engagement Measures						
Engagement Rate: Well-Child Visits 3-6 yo	EHR/ eCQM	Jan 2020 – Dec 2020		N/A	Reporting Only	N/A
Engagement rate: Diabetes Poor Control	EHR/ eCQM	Jan 2020 – Dec 2020		N/A	Reporting Only	N/A
Engagement rate: Immunizations for Adolescents	EHR/ eCQM	Jan 2020 – Dec 2020		N/A	Reporting Only	N/A
Engagement rate SBIRT & Depression	EHR/ eCQM	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						
CareOregon Population Reach	Clinic Reported	Jan 2020 – Dec 2020		N/A	Tier 1: 5.0% Tier 2: 12.0%	N/A
Choice of Sub-Population:						
CareOregon Sub-Population Reach: Patients with Positive SBIRT <i>or</i> 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						
Inpatient and Emergency Department Utilization for Ambulatory Sensitive Conditions*	Claims	Nov 2019 - Oct 2020	Organization- specific		3% reduction	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		Target	Benchmark
		Period	Baseline Measurement		
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
Immunizations for Adolescents (MCV4, Tdap, HPV) (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
Access & Engagement Measures					
Engagement Rate: Well-Child Visits 3-6 yo	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Engagement rate: Immunization for Adolescents	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Engagement rate: Childhood Immunization Status	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Engagement rate SBIRT & Depression	EHR/ eCQM	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					
CareOregon Population Reach	Clinic Reported	Jan 2020 – Dec 2020	N/A	Tier 1: 5.0% Tier 2: 12.0%	N/A
Choice of Sub-Population:					
CareOregon 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

3. Internal Medicine Clinical Track

Measures using the Minnesota Method are denoted with “MM.”

Measure	DataSource	Measurement		Target	Benchmark
		Period	Baseline Measurement		
Clinical Quality Focus Area					
Colorectal Cancer Screening (MM)	Claims	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Controlling High Blood Pressure (MM)	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
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
Access & Engagement Measures					
Engagement Rate: Colorectal Cancer Screening	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Engagement rate: Diabetes Poor Control	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Engagement rate: Controlling High Blood Pressure	EHR/ eCQM	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Engagement rate SBIRT & Depression	EHR/ eCQM	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					
CareOregon Population Reach	Clinic Reported	Jan 2020 – Dec 2020	N/A	Tier 1: 5.0% Tier 2: 12.0%	N/A
Choice of Sub-Population:					
CareOregon 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	Claims	Jan 2020 – Dec 2020	N/A	Reporting Only	N/A
Cost of Care Focus Area					
Inpatient and Emergency Department Utilization for Ambulatory Sensitive Conditions*	Claims	Nov 2019 - Oct 2020	Organization - Specific	3% reduction	N/A

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

Appendix B: Measure Specifications

1. Clinical Quality Measure Specifications

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

- a. Kindergarten Readiness: Well-child visits 3-6 yo
- b. Immunizations for adolescents (MCV4, Tdap, HPV)
- c. Diabetes: HbA1c Poor Control
- d. Alcohol and Drug Misuse: SBIRT
- e. Screening for Depression and Follow-Up Plan
- f. Childhood immunization status (Combo 2)
- g. Colorectal cancer screening
- h. Controlling high blood pressure

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. Clinic-Defined Access & Engagement Measure Requirements

CareOregon recognizes that the 2020 OVID-19 pandemic has brought unique challenges that have stretched clinic’s capacity to provide consistent and regular primary care engagement for all patients. In light of changing priorities, and the need to focus on segments of high needs patients, the access and engagement measure has been modified to more closely match currently clinical priority areas.

Clinics will be asked to report on the percent of the population associated with each clinical quality metric engaged by their organization in the past 12 months. Engagement is defined as having a billable encounter for an in-person, video or telephone visit with any member of the care team.

FAMILY PRACTICE TRACK

Measure	Numerator (n) and Denominator (d) Descriptions	
Engagement Rate: Well-Child Visits 3-6 yo	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members 3-6 old on the last day of the measurement period
Engagement Rate: Immunizations for Adolescents	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members 9-13 old on the last day of the measurement period
Engagement Rate: Diabetes Poor Control	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members with a diabetes diagnosis
Engagement Rate: SBIRT & Depression	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members 12 or older on the last day of the measurement period

PEDIATRIC TRACK

Measure	Numerator (n) and Denominator (d) Descriptions	
Engagement Rate: Well-Child Visits 3-6 yo	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members 3-6 old on the last day of the measurement period

Engagement Rate: Immunizations for Adolescents	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members 9-13 old on the last day of the measurement period
Engagement Rate: Childhood Immunization Status	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members 2 years old on the last day of the measurement period
Engagement Rate: SBIRT & Depression	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members 12 or older on the last day of the measurement period

INTERNAL MEDICINE TRACK

Measure	Numerator (n) and Denominator (d) Descriptions	
Engagement Rate: Colorectal Cancer Screening	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members due for a colorectal cancer screen
Engagement Rate: Controlling High Blood Pressure	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members with a hypertension diagnosis
Engagement Rate: Diabetes Poor Control	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members with a diabetes diagnosis
Engagement Rate: SBIRT & Depression	n	Members in denominator with a visit during the measurement period
	d	Assigned CareOregon members 12 or older on the last day of the measurement period

CareOregon recognizes that primary care medical home model looks different in every organization. The aim of a clinic-defined Access & Engagement measure is to support the work clinics are already doing around improving access to services or improving member engagement.

Thus, participating clinics may select a measure of access or engagement that they already track and monitor as part of their ongoing continuous quality improvement work.

Access Measure Defined: A measure of the potential or capacity for patients to access primary care services (e.g. third next available appointment).

Engagement Measure Defined: A measure of actual use of primary care services by members (e.g. % of assignment members who had at least 1 visit or care touch with the primary care team during the previous 12 months).

As part of the application process, clinics must provide the following information to define their selected Access & Engagement measure.

Standard or Custom Measure

Name of Measure

Measure Description

CareOregon Members Only or Total Patient Population?

Baseline Period

Measurement Period

If standard measure:

Link to Measure Specifications

If custom measure:

Numerator Inclusion Criteria

Denominator inclusion Criteria

Exclusion Criteria

For this measure, baseline data must also be submitted for each participating clinic.

CareOregon will review the selected measure for suitability and will contact clinic for follow-up as needed.

3. Equity Narrative Report Specifications: Improving Language Access

The pursuit of the highest standard of health for all people is the heart of CareOregon'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 CareOregon 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: LEP Member Data

1a. Number of LEP persons with CareOregon coverage engaged by clinic. Use data collected by the clinic staff as the source for reporting *not* data provided by CareOregon.

1b. Number of unique languages spoken by persons with CareOregon coverage engaged by clinic.

Reporting Component 2: Process Improvement or Policy Development Project Narrative Report

Please plan and implement a process improvement or policy development activity in your clinic related to improving language access for LEP patients. Your narrative report should address the following areas:

2a. Project description and plan.

What project was selected and why? What is the expected impact of making a change? What are the specific activities and timelines associated with your project and which have been successfully completed?

2b. Process data collected

What data did you collect for your project? Please provide any quantifiable numbers related to process or outcomes. E.g. number of staff trained, number of documents or signage translated, number of staff tested for proficiency, number of interpreted appointments, number of huddles that included interpreters as part of the care team.

2c. Sustainability plan

Please describe how you will sustain the process or policy you developed. Are there activities you did not complete or wish to conduct in the future? If so, what is your plan to continue the work?

4. BHI Population Reach Measure Specifications

Measure	Numerator (n) and Denominator (d) Descriptions	
CareOregon Member Population Reach	n	Members in denominator with a service by BHC during measurement period.
	d	Unique CareOregon 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 CareOregon members with a positive depression screen as indicated by the measurement tool during measurement period.
Diabetes: HbA1c > 9 (Family Practice or Internal Medicine only)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique CareOregon 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 CareOregon members with a positive SBIRT screen during measurement period.

Numerator and Denominator Specification Notes
<p>Inclusion criteria for patients seen by BHC (numerator):</p> <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ○ 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. <p>Exclusion criteria for patients seen by BHC (numerator):</p> <ul style="list-style-type: none"> ✓ Mass email/EHR messages to patients ✓ Telephone encounters where you are leaving a message ✓ Reminder messages (phone/EHR/text) ✓ Text messaging <p>Inclusion criteria for patients seen in Primary Care (denominator):</p> <ul style="list-style-type: none"> ✓ 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). <p>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.</p>

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. Cost of Care Measure Specifications

The Cost of Care incentive payment is based on a composite measure including inpatient admissions and emergency department visits per 1,000 member months for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

Numerator

Discharges and emergency department visits that meet the inclusion and exclusion rules for the numerator in any of the following Prevention Quality Indicators (PQI):

- PQI #1 Diabetes Short-Term Complications Admission Rate
- PQI #3 Diabetes Long-Term Complications Admission Rate
- PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
- PQI #7 Hypertension Admission Rate
- PQI #8 Heart Failure Admission Rate
- PQI #11 Bacterial Pneumonia Admission Rate
- PQI #12 Urinary Tract Infection Admission Rate
- PQI #14 Uncontrolled Diabetes Admission Rate
- PQI #15 Asthma in Younger Adults Admission Rate
- PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

More information about the PQIs can be found here:

https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2020.aspx

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Each visit to an ED for one of the above PQIs is included in the numerator.

Multiple ED visits on the same date of service are counted as one visit. Emergency Department visits are specified by the codes identified in the OHA ED Utilization specifications:

<https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-specs-Disparity-final-update-20200910.pdf>

Required exclusions for numerator: Mental health and chemical dependency services are excluded, using the codes in the above specifications.

Denominator

Member months for all CareOregon assigned population aged 19 and older.

Data elements required denominator: 1,000 Member Months.

Technical Notes:

This measure is aggregated to the organization level. Individual clinics or practice sites within a larger umbrella organization will use the same combined baseline data, measurement data and improvement targets

8. Pediatric Cost of Care Narrative Report Specifications

You will be asked to upload a word document with your responses and any accompanying documentation or workflows. Please limit your response to no more than 1 page per question, no more than 4 pages total. Respond to each section below in accordance with the current processes and procedures of the clinic.

This is a reporting only requirement. Payment will be awarded provided that the clinic submits the cost of care report and responds fully to each section. Each section must address the following areas, A-D:

- A. How the clinic's reported processes address the specific needs of the 0 to 5-year-old population.
- B. How the clinic's reported processes influence appropriate utilization of services and reduces overall (unnecessary) costs.
- C. Clinic's plans for maintaining current processes submitted and any plans to further the work.
- D. 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 locations or certain locations only.

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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ✓ 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)*: <ul style="list-style-type: none"> ✓ 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 CareOregon’s BHI Program.

Appendix D: What Payment Level Will I Start At?

Prior participation and performance in CareOregon 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	<p>\$ 0.00</p> <ul style="list-style-type: none"> ✓ Clinics currently participating in PCPM Track 2 with Quality payment level 0 at time of LOA effective date. 	<p>\$ 3.40</p> <ul style="list-style-type: none"> ✓ Clinics currently participating in PCPM Track 2 with Quality payment level 1 at time of LOA effective date. ✓ <u>All clinics not</u> currently participating in PCPM Track 2. 	<p>\$ 4.95</p> <ul style="list-style-type: none"> ✓ Clinics currently participating in PCPM Track 2 with Quality payment level 2 at time of LOA effective date. 	<p>\$ 8.10</p> <ul style="list-style-type: none"> ✓ Clinics currently participating in PCPM Track 2 with Quality payment level 3 at time of LOA effective date.
BHI	<p>\$ 0.00</p> <ul style="list-style-type: none"> ✓ Clinics currently participating in CareOregon BHI with payment level 0 at time of LOA effective date. ✓ Clinics that do not attest to CareOregon BHI Model of Care. 	<p>\$ 2.00</p> <ul style="list-style-type: none"> ✓ Clinics currently participating in CareOregon BHI with payment level 1 at time of LOA effective date. ✓ <u>All clinics not</u> currently participating in CareOregon BHI. 	<p>\$ 4.00</p> <ul style="list-style-type: none"> ✓ Clinics currently participating in CareOregon BHI with payment level 2 at time of LOA effective date. 	
Oral Health Integration	<p>\$ 0.00</p>	<p>\$ 1.25</p> <ul style="list-style-type: none"> ✓ <u>All participating</u> clinics. 		
Cost of Care	<p>\$ 0.00</p> <ul style="list-style-type: none"> ✓ Clinics currently participating in PCPM Track 2 with Cost of Care payment level 0 at time of LOA effective date. 	<p>\$ 1.25</p> <ul style="list-style-type: none"> ✓ Clinics currently participating in PCPM Track 2 with Cost of Care payment level 0 at time of LOA effective date. ✓ <u>All clinics not</u> currently participating in PCPM Track 2. 		