Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

July 20, 2023 BCC Agenda Date/Item: _____

Board of County Commissioners
Clackamas County

Approval of revenue agreement with CareOregon for the Primary Care Payment Model Program. Agreement Value is $1,630,000 for 1 year. Funding is through CareOregon. No County General Funds are involved.

Previous Board Action/Review	June 9, 2022, 20220609 II.D.11 Briefed at Issues August 18, 2023		
Performance Clackamas	1. Individuals and families in need are healthy and safe. 2. Ensure safe, healthy, and secure communities.		
Counsel Review	Yes: Andrew Naylor	**Procurement Review**	No
Contact Person	Sarah Jacobson	**Contact Phone**	503-201-1890

EXECUTIVE SUMMARY: Clackamas County Health Centers Division (CCHCD) of the Health, Housing & Human Services Department requests the approval of contract #11173, a revenue agreement with CareOregon for the Primary Care Payment Model Program.

CareOregon offers payment incentives to organizations qualified as a Patient Centered Primary Care Homes and with a Primary Care Payment Model letter of agreement with CareOregon. The estimated revenue amount for the period of this contract is $1,630,000.00 CCHCD is eligible for revenue generated per member per month depending on the level of achievement at the Beavercreek, Sunnyside, Gladstone, and Sandy clinics.

This agreement is effective July 1, 2023, and expires on June 30, 2024.

RECOMMENDATION: Staff recommends approval of this contract.

Respectfully submitted,
Rodney A. Cook
Rodney A. Cook
Director of Health, Housing & Human Services

For Filing Use Only

CareOregon, Inc.

Letter of Agreement

Primary Care Payment Model

This Letter of Agreement ("LOA") is between CareOregon, Inc. ("CareOregon") and Clackamas County acting by and through its Health, Housing and Human Services Department, Health Centers Division ("Provider"), to enable Provider's participation in the Primary Care Payment Model (PCPM) Program ("PCPM Program"). For purposes of this LOA, CareOregon, and Provider shall each be referred to individually as a "Party" and collectively as the "Parties".

RECITALS

A. Health Share of Oregon ("CCO") is contracted with the Oregon Health Plan ("OHA") via a Health Plan Services, Coordinated Care Organization Contract and Cover All Kids Health Plan Services Contract (intentionally referred to in the singular as the "CCO Contract") to operate as a Coordinated Care Organization for the Oregon Health Plan ("OHP").

B. CCO and Provider entered into a Provider Agreement ("Provider Agreement") whereby Provider has been providing and continues to provide services to Members enrolled in OHP. As stipulated in the Provider Agreement, Provider is subject to all the laws, rules, regulations, and contractual obligations that apply to OHP.

C. Through this LOA, CCO and Provider endeavor to improve the health of its Member community through efforts focused on outpatient preventive services, quality focused reimbursement models, and the provision of additional financial support to participating providers.

Now, therefore, in consideration of the mutual promises herein, the Parties agree as follows:

AGREEMENT

I. Administration/Interpretation of LOA.

The Parties agree and understand that the foregoing Recitals, and Exhibit A through Exhibit F to this LOA are incorporated herein by reference with the same force and effect as if fully set forth in this LOA.

The Parties agree and understand that this LOA is supplemental to the Provider Agreement and that the applicable provisions of the Provider Agreement are incorporated by reference into this LOA. Nothing in this LOA may be construed to waive any of the obligations or other commitments Provider has made pursuant to the Provider Agreement. Thus, the Parties acknowledge and agree that this LOA is subject to the terms and conditions of the Provider Agreement and all applicable Policies. Notwithstanding the foregoing and to the extent that the Provider Agreement and this LOA includes provisions that are applicable, all Policies shall be consistent with the Provider Agreement.

For purposes of this LOA, any capitalized words not otherwise defined in this LOA shall have the meaning set forth in the Provider Agreement.

II. Term and Termination

A. **Term.** This LOA is effective as of **July 1, 2023** ("Effective Date") and shall remain in effect through **June 30, 2024** ("Termination Date") unless sooner terminated as stipulated for herein.

B. **Termination**. Other than as modified and expressly stated immediately below, the Termination provisions found in the Provider Agreement will remain as described therein.

   i. Either Party may terminate this LOA with or without cause upon providing 30 days written notice to the other Party.

   ii. CCO, in its sole discretion, may terminate this LOA immediately for any of the following reasons:

a. an employee, agent, contractor, or representative of either Party actively participating in performing the responsibilities hereunder has violated any applicable laws, rules, or regulations;
b. fraud, dishonesty, substance abuse, or personal conduct of an employee, agent, contractor, or representative of either Party which may harm the business and/or reputation of either Party;
c. inability to perform the responsibilities hereunder or incompetence demonstrated in performance of responsibilities under this LOA; or,
d. the termination of the Provider Agreement.

iii. The Party initiating the termination, under any circumstance, shall render written Legal Notice of termination to the other Party and must specify the Termination provision giving the right to termination, the circumstances giving rise to termination, and the date on which such termination will become effective.

iv. Upon Termination under any circumstance, funding will cease immediately, any payments not yet made by CCO to Provider shall not be made, and any remaining balance of payment disbursed in advance under this LOA that has not been used for, or committed to, this Program shall be promptly returned to CCO prorated from the date of termination to the end of the Term of this LOA.

III. Description of PCPM Program; Incentive Payment Components, and Reporting Requirements. Provider agrees to assume the duties, obligations, rights, and privileges applicable to participating in PCPM Program pursuant to the designated exhibits, parts, and sections of this LOA.

A. **Description of PCPM Program.** Provider agrees to participate in the Primary Care Payment Model Program ("PCPM Program") the description and obligations of which are further stipulated in Exhibits A through F to this LOA.

B. **Payment Components.** CCO agrees to make payments to Provider based on the terms specified in Exhibit B of this LOA.

C. **Reporting Requirements.** From time to time, CCO may request certain information or the submission of certain reports concerning various aspects of this LOA including but not limited to any progress made towards any identified targets, compliance with the terms of

this LOA, number of members served, etc. At the reasonable request of CCO, Provider shall provide such information or submit such reports and shall make its personnel available to discuss expenditures, records, the progress of PCPM Program or other topics related to this LOA. CCO shall provide reasonable notice along with detailed instructions on any material requested to Provider, should any such request be made.

To qualify for payment, Provider agrees to prepare and submit reports as defined in Exhibits C, D, and E of this LOA.

D. **Provider Contact**. Provider agrees that the Provider contact named below is responsible for all aspects of the LOA, including monitoring progress and performance, obtaining all necessary data and information, and notifying CCO of any significant obstacles in pursuit of this LOA. Provider will notify CCO if the Provider contact changes.

Provider Contact: Angie Amundson
Phone: 503-719-2227
E-mail: aamundson@clackamas.us

IV. Representations and Warranties.

A. **General Warranty**. Provider represents and warrants that Provider, its agents, and its representatives possess the knowledge, skill, experience and valid licensure necessary to perform the services contemplated under this LOA and will perform such services in a timely manner and with the maximum reasonable degree of quality, care, and attention to detail.

B. Provider expressly represents and warrants to CCO that Provider is eligible to participate in and receive payment pursuant to this LOA. In so doing, Provider certifies by entering into this LOA that neither it nor its employees, agents, and representatives are: (1) placed on the Tier Monitoring System by CCO's Peer Review Committee;(2) have documented contract and/or compliance issues; or (3) are presently declared ineligible or voluntarily excluded from entering into this LOA by any federal or state department or agency.

V. General Provisions. To the extent applicable and only as related to the services contemplated under this LOA, the provisions below supplement the relevant sections in the Provider Agreement.

A. Provider understands and agrees that Provider is not eligible to participate in or receive funding from CCO if Provider is placed on the Tier Monitoring System by CCO's Peer Review Committee or has documented contract and/or compliance issues. Should it be determined that Provider was ineligible to receive payments from CCO pursuant to this LOA, Provider expressly agrees to promptly repay all such payments disbursed to it under this LOA and all funding associated with this LOA will be discontinued until Provider is removed from the CCO Tier Monitoring System or has resolved compliance issue(s) to CCO's satisfaction. Any discontinued funding that has been withheld will not be disbursed.

B. Provider authorizes CCO to withhold or deduct from amounts that may otherwise be due and payable to Provider under this LOA any outstanding amounts that Provider may owe CCO for any reason, including but not limited to overpayments made by CCO under the Provider Agreement, in accordance with CCO's recoupment policy and procedure.

C. **Force Majeure**. Neither Party shall be deemed in default of this LOA to the extent that any delay or failure in the performance of its obligations results from any cause beyond its reasonable control and without its negligence provided such Party gives notice to the other Party, as soon as reasonably practicable, specifying the nature and the expected duration thereof. Failure of a Party to give notice shall not prevent such Party from relying on this Section except to the extent that the other Party has been prejudiced thereby. Notwithstanding the foregoing, any dates and obligations specified in this LOA shall be subject to change at CCO's discretion, without liability on either Party.

D. **Amendments and Waivers**. No amendment, modification, assignment, discharge, or waiver of this LOA shall be valid or binding without prior written consent (which shall not be unreasonably withheld) of the Party against whom enforcement of the amendment, modification, assignment, discharge or waiver is sought. A waiver or discharge of any of the terms

and conditions hereof shall not be construed as a waiver or discharge of any other terms and conditions hereof.

E. **Confidentiality and Marketing.**
   i. Provider agrees to uphold all confidentiality provisions of the Provider Agreement and this LOA, and specifically to safeguard all confidential information including the health information of Members as it applies to all activities related to this LOA.
   ii. Subject to applicable laws requiring disclosure (including Oregon's relevant public record laws). Both Parties agree that this LOA and all negotiations and related documentation will remain confidential and that no press, news releases, or other publicity release or communication to the general public concerning the obligations contemplated herein will be issued without providing a written copy of the communication to the other Party and receiving the other Party's prior written approval, . In addition, both Parties agree that they must obtain written permission prior to using the other Party's name, trade name, image, symbol, design, or trademark in any marketing, advertising, or promotional campaign in any medium or manner. Email approval by CCO or the Provider Contact specified herein will suffice as written approval.
   iii. **HIPAA and HITECH.** Notwithstanding anything to the contrary, both Parties agree to implement and maintain systems that protect PHI, as required by HIPAA, HITECH, the Provider Agreement, and the Business Associate Agreement, if applicable.

F. **Insurance**. Provider and CCO each agree to maintain, at all times during this LOA and at their own cost and expense, commercial general liability insurance, professional liability insurance, and workers' compensation insurance coverage in amounts standard to its industry. CCO hereby acknowledges Provider is self-insured and such self-insurance satisfies the requirements of this Section F.

G. **Indemnity; Defense**. Each Party agrees to waive any claims, losses, liability, expenses, judgements, or settlements (referred to herein as "Claims") against the other Party for any Claims arising out of or related to the services performed under this LOA which result from the waiving Party's own negligence. Further, each Party hereby agrees to defend, indemnify and hold harmless the other Party, its officers, directors, and

employees from and against third Party claims, loss, liability, expense (including reasonable attorney's fees), judgements or settlement contribution arising from injury to person or property, arising from negligent act or omission on its part or its officers, directors, volunteers, agents, or employees in connection with or arising out of: (a) services performed under this LOA, or (b) any breach or default in performance of any such Party's obligations in this LOA including, without limitation, any breach of any warranty or representation. In the event that either Party, its officers, directors, or employees are made a Party to any action or proceeding related to this LOA then the indemnifying Party, upon notice from such Party, shall defend such action or proceeding on behalf of such Party at the indemnifying Party's sole cost and expense. Each Party shall have the right to designate its own counsel if it reasonably believes the other Party's counsel is not representing the indemnified Party's best interest. Indemnification duties under this LOA shall be at all times limited by the tort claim limits provided in the Oregon Tort Claims Act and the Oregon Constitution. This indemnity provision shall survive termination of this Agreement.

H. **Compliance and Licensure**. Provider and CCO shall, at all times during the term of this LOA comply with all applicable federal, state and local laws, rules and regulations, and shall maintain in force any licenses and obtain applicable permits and consents required for performance of services under this LOA; the Parties shall provide to each other copies of such applicable current valid licenses and/or permits upon request. The Parties represent and warrant that, to the best of their knowledge, officers, directors, employees, subcontractors, agents and other representatives are not excluded from participating in any federal health care programs, as defined under 42 U.S.C. 1320-a7b (f), and to their knowledge, there are no pending or threatened governmental investigations that may lead to such exclusion. Each Party agrees to notify the other of the commencement of any such exclusion or investigation with seven (7) business days of first learning of it. The Parties represent that they and their employees are not excluded from Federal healthcare programs and are not included in the Office of

Inspector General (OIG) and General Services Administration (GSA) exclusion lists. Additionally, if an employee is identified to be on such lists, that employee will immediately be removed from any work related directly or indirectly to this LOA. The Parties shall have the right to immediately unilaterally terminate this LOA upon learning of any such exclusion and shall keep each other apprised of the status of any such investigation.

I. **Relationship of the Parties**. CCO and Provider are independent entities. No provision of this LOA or the Provider Agreement is intended to create nor shall be construed to create an employment, agency, joint venture, partnership or any other business or corporate relationship between the Parties other than that of independent entities.

J. **No Third-Party Benefit.** This LOA shall not create any rights in any third parties who have not entered into this LOA, nor shall this LOA entitle any such third Party to enforce any rights or obligation that may be possessed by such third Party.

K. **Assignment or Delegation**. Except as otherwise specifically provided for herein, the Parties shall not assign or delegate any or all of their rights or responsibilities under this LOA without the prior written consent of the other Party.

Agreed to on behalf of Provider:	**Agreed to on behalf of CareOregon, Inc.:**
_____	_____
Signature	Signature
Name: _____	Name: Teresa Learn
Title: _____	Title: Chief Financial Officer
Date: _____	Date: _____

Exhibit A

Description of PCPM Program Components

For the period of this LOA, participating clinics are eligible to receive a per member per month (PMPM) incentive payment comprised of up to four (4) focus area components based on approval of the submitted program applications and membership assignment volume:

- Clinical Quality Incentive Payment (QIP)
- Equity Focus Area Payment (EFA)
- Behavioral Health Integration Incentive Payment (BHI)
- Oral Health Integration Incentive Payment (OHI)

All PMPM payments will be calculated using CCO membership as of the 5th of each calendar month, where membership is defined as members who are assigned to participating clinics that have primary health plan coverage of CCO Oregon Health Plan and members who are assigned secondary health plan coverage of CCO Oregon Health Plan with primary health plan coverage of CCO Advantage.

Performance reporting for each focus area component will be concurrently submitted from all participating clinics during two (2) measurement reporting submission events due **August 30, 2023** and **February 28, 2024** utilizing the same data collection platform, Sharefile. Sharefile is a secure, HIPAA compliant file sharing system, and is the designated application CCO utilizes for data sharing in this program. CCO will create reporting access for Provider's selected representatives to ShareFile as submitted on the program application form, or as requested by Provider. If Provider is unable to utilize the Sharefile application for data submission, Provider will need to contact CCO for establishing an alternative, approved data submission method.

Any resulting payment level adjustments will occur on the **December 2023** and **June 2024** payment adjustment dates respectively.

A. CLINICAL QUALITY INCENTIVE PAYMENT (QIP):

1. Participating clinics deemed eligible to receive a Clinical Quality Incentive Payment (QIP) PMPM, will have selected a clinic-specific Clinical Quality measurement set.
    a. Each clinical quality measure set includes:
        - Five (5) quality measures with defined specifications
    b. Clinical quality measure set selections slightly differ between the Family Practice/Internal Medicine and Pediatric measure sets.
2. The selected Clinical Quality Measure Set(s) from the program application and the potential PMPM rates based on timely and accurate data submission for all QIP components for the clinics participating in this LOA are:

Clinic(s) Participating in QIP Component	QIP Clinical Track	QIP PMPM Performance-Based Rate*			
		Level 0	Level 1	Level 2	Level 3
1. Beavercreek	Family Practice	$0.00	$3.60	$5.85	$9.55
2. Sunnyside	Family Practice	$0.00	$3.60	$5.85	$9.55
3. Sandy	Family Practice	$0.00	$3.40	$4.95	$8.10
4. Gladstone	Pediatrics	$0.00	$3.40	$4.95	$8.10

**PMPM Rates are risk adjusted 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 CCO members assigned to their clinic.*

    a. The list of measurement(s) and measurement period for each participating clinic are presented in this LOA in Exhibit C.
    b. The initial clinic payment level determination for QIP and all other components are described in Exhibit B, Section B.

B. QUALITY INCENTIVE REPORTING TERMS

1. CCO agrees to send Provider all instructions, system access or templates needed for submitting reporting data at minimum a month prior to data submission due dates.

2. CCO agrees to provide clinics, who are required to report member-level immunization status measures (from an Electronic Health Record (EHR) and/or Alert Immunization Information System (IIS), with a roster at least 30 days prior to data submission deadline, of all assigned CCO members that meet inclusion criteria.

3. If CCO is unable to obtain data for any measure indicated as "EHR/eCQM", Clinics agree to submit member level or aggregate performance data for the Electronic Health Record (EHR)/Electronic Clinical Quality Measure (eCQM). Clinics for which this data is already provided to CCO are not required to submit a duplicate data set.

4. Provider agrees that requests to change clinical quality measures in this LOA will not be granted.

5. Participating clinics agree to submit reporting information for all the Measures as defined in the LOA prior to data submission deadlines including:
   a. Narrative reports
   b. Data for EHR/eCQM measures
   c. Data for clinic reported measures

6. CCO agrees to timely review the QIP data submissions and adjust the QIP component performance payment level if needed as scheduled on the payment adjustment date specified.

C. QUALITY DATA SUBMISSION AND EVALUATION

Clinical quality measure data is to be reported for all items in the measure set to - CCO in a manner that is specific and exclusive to each participating clinic.

1. If data is not submitted by the specified deadline, then the QIP payment level zero (0) will be assigned to that clinic on the payment adjustment date.

2. Data submissions will be accepted by CCO during the LOA if the following requirements are met:
   a. All QIP data is submitted by the deadline using the required reporting process.
   b. All QIP data is submitted in the appropriate format and meets data parameter requirements with data content in all required fields.
   c. Submitted data appears to be reasonable with respect to issues such as the presentation of denominators that are low, valued as zero or greater than the count of CCO member assignment to a clinic. Similarly, where numerators are valued at zero, rate calculations exceed 100%, performance percentages are outside of the typical range or include a higher-than-expected number of exclusions.

3. Any measures not reported or not meeting the data submission requirements would be evaluated as "not met" in the performance calculation.

4. If the submitted data for any of the measures in the clinical quality focus area appear to be invalid or unreasonable based upon review and analysis by CCO, then each measure determined to be invalid will be evaluated as not met.

5. Clinical quality measures that result in fewer than twenty (20) assigned CCO members in the denominator, will have performance values calculated using aggregated Provider system data for the affected measure and participating clinic.

6. If a clinical quality measure results in fewer than twenty (20) assigned CCO members in the denominator using aggregated Provider system data for the measure, the measure will be excluded from performance evaluations.

7. For each measure indicated as "Claims" in selected Clinical Quality Measure Set CCO will provide performance using fee-for-service claims data for Provider review and information.

8. For each measure indicated as "Roster", CCO will provide a roster containing the member level information to Provider for verification allowing Provider at least 30 days to review prior to report submission due dates.

9. All other QIP measure results will be evaluated with comparison to the appropriate clinic specific targets listed in Exhibit C. Measures needing to meet improvement percentages will be compared to baseline data from the calendar year of 2022. Baseline data will be obtained from one of these sources, depending upon the specific measure:

    a. EHR/eCQM data submitted to CCO or as made available from OHA as part of the clinic's PCPM program participation for the period of June 2022 through July 2023,
    b. Claims data provided by CCO for the calendar period January through December 2022
    c. The Electronic Health Record data (EHR/eCQM) data provided to and approved by CCO with the program application when requested by CCO.

10. An overall QIP measure performance result will be calculated using the following methodology.

Performance on Clinical Quality Measure Set	**Equity report minimum point score achieved**	**Payment Level**
Meet program targets on 1 or less of the clinical quality measures	Yes	Level 0
	No	Level 0

Meet program targets on 2 of the clinical quality measures	Yes	Level 1
	No	Level 0
Meet program targets on 3 of the clinical quality measures	Yes	Level 2
	No	Level 1
Meet program targets 4 or more of the clinical quality measures	Yes	Level 3
	No	Level 2

D. EQUITY FOCUS AREA PAYMENTS:

1. All participating clinics deemed eligible will receive an Equity Focus Area (EFA) Incentive PMPM Payment.

2. All clinics must complete quarterly reporting for the meaningful language access measure component. This applies to the visit level reporting only. Quarter 1 will be a reporting only activity and will be combined with quarter 2 reporting to determine a score for the purpose of performance calculation and subsequent payment for reporting period #1. Quarter 3 will be a reporting only activity and will be combined with quarter 4 reporting to determine a score for the purpose of performance calculation and subsequent payment for reporting period #2.

3. The Equity Focus Area measure differs between the Family Practice/Internal Medicine and Pediatric clinical tracks however measure performance is calculated using aggregated Provider system data and is determined as follows:

Equity Focus Area performance evaluation criteria for Internal Medicine track	**Payment Level**	**EFA PMPM**
The EFA narrative measure will be deemed as not met if any of the following occur: a. The MLA EFA questionnaires are not submitted b. The MLA EFA measure data is not timely submitted c. The MLA EFA measure result does not meet the Target value	Level 0	$0.00

d. The Diabetes EFA narrative report was not timely submitted e. The Diabetes EFA narrative report was not submitted through the required process f. The Diabetes EFA narrative report does not contain responses to all reporting components g. The Diabetes EFA measure result does not meet the target value		
The EFA measure will be deemed as met if all the following occur: a. Data was timely submitted for the MLA EFA measure c. Either the Diabetes EFA measure Target was met and narrative submitted-OR- the Pediatric Narrative Report is evaluated as meeting the reporting requirement.	Level 1	$1.25
Equity Focus Area performance evaluation criteria for Family Practice Track	**Payment Level**	**EFA PMPM**
The EFA narrative measure will be deemed as not met if any of the following occur: a) The MLA EFA questionnaires are not submitted b) The MLA EFA measure data is not timely submitted c) The MLA EFA measure result does not meet the Target value d) The Pediatric EFA narrative report was not timely submitted e) The Pediatric EFA narrative report was not submitted through the required process f) The Pediatric EFA narrative report does not contain responses to all three reporting components. g) The Diabetes EFA narrative report was not timely submitted h) The Diabetes EFA narrative report was not submitted through the required process	Level 0	$0.00

i) The Diabetes EFA narrative report does not contain responses to all reporting components j) The Diabetes EFA measure result does not meet the target value		
The EFA measure will be deemed as met if all the following occur: a) Data was timely submitted for the MLA EFA measure b) The Pediatric narrative report was timely submitted through the required process and contains responses to all three reporting components c) Either the Diabetes EFA measure Target was met and narrative submitted-OR- the Pediatric Narrative Report is evaluated as meeting the reporting requirement.	Level 1	$1.25
Equity Focus Area performance for pediatric track	**Payment Level**	**EFA PMPM**
The EFA narrative measure will be deemed as not met if any of the following occur: a) The MLA EFA questionnaires are not submitted b) The MLA EFA measure data is not timely submitted c) The MLA EFA measure result does not meet the Target value d) The Pediatric EFA narrative report was not timely submitted e) The Pediatric EFA narrative report was not submitted through the required process f) The Pediatric EFA narrative report does not contain responses to all three reporting components.	Level 0	$0.00

The EFA narrative measure will be deemed as met if the narrative: a) Data was timely submitted for the MLA EFA measure The Pediatric narrative report is timely submitted using the required process b) The Pediatric narrative report contains responses to all three reporting components and is evaluated as meeting the reporting requirement	Level 1	$1.25

1. Additional information on the Equity Focus Area measure is available in Exhibit D.

E. BEHAVIORAL HEALTH INTEGRATION (BHI) INCENTIVE PAYMENTS:

1. All participating clinics that have attested to delivering behavioral health care in alignment with the CCO's Behavioral Health Integration model of care and have either a Level 1 or Level 2 designation are eligible to receive a Behavioral Health Integration (BHI) Incentive PMPM Payment. Level designation criteria is listed in the table below:

Behavioral Health Integration Criteria

Behavioral Health Integration Criteria	Required structural criteria
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).**	✓

2. BHI payment level for each clinic is determined by a combination of the reported BHI program measure values as defined in Exhibit E for the measurement period**,** and the clinic Behavioral Health Integration Level designation as shown below. Only clinics that meet all Level 2 requirements of CCO's BHI Model of Care are eligible to receive BHI payment level two (2).

Performance on BHI Measures	Payment Level	BHI PMPM
Less than 6.0% reach on either measure	Level 0	$0.00
One of the following conditions is met: • Both measures attain a minimum of 6% and both are less than 14.0% • Both measures attain a minimum of 6% with one measure at 14% or higher. • Clinic has Level **1** designation and attains 14.0% or greater reach on **both** measures.	Level 1	$2.00
Clinic has Level **2** designation and attains 14.0% or greater reach on **both** measures.	Level 2	$4.00

Behavioral Health Incentive Terms of Participation:

1. Provider agrees to employ or provide a Behavioral Health Clinician (BHC) at each Provider location, as defined by the CCO Integrated Behavioral Health Model and the BHC will practice within the scope of their respective license. The Qualifying Behavioral Health Clinicians are listed in the table below:

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
- ✓ 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 CCO's BHI Program.

2. Provider agrees to document clinically relevant patient information in the same medical record at the point of care.

3. Provider agrees to submit to CCO, all claims for services provided by the Behavioral Health Clinician (BHC).

4. Clinics will have selected a clinic-specific BHI Sub Population measure to be reported in addition to the CCO Population Reach measure. This measure selection is documented on Exhibit C.

5. Provider agrees that no changes will be permitted to the selected Sub Population Measure during the period of this LOA.

6. The Behavioral Health reporting is required to be submitted at the same time and method as the other required LOA data submissions.

7. If Sub Population and CCO Population Reach Measurement data is not submitted prior to data submission deadlines, participating clinics will receive payment level zero (0), effective on the payment adjustment date subject to Provider having participated in a previous Behavioral Health Per Member Per Month payment program.

8. Data submitted that is incomplete, invalid, or erroneous will be excluded from the payment level calculation for that reporting event.

9. CCO agrees to timely review BHI data submissions and adjust the BHI component performance payment level if needed as scheduled on payment adjustment date specified.

F. ORAL HEALTH INTEGRATION (OHI) INCENTIVE PAYMENTS:

1. For the period of July through November of this LOA, all participating clinics eligible will receive a $1.25 PMPM Oral Health Integration (OHI) Incentive Payment. For the period of December through June of this LOA, payment will be dependent on measure performance as outlined below.

2. Measure performance is calculated using aggregated Provider system data and is determined as follows.

Oral Health Integration Performance evaluation criteria for each Report Submission	Payment Level	COC PMPM
OHI Subpopulation measure improvement target is not met and/or clinic attests they do not refer patients to dental services	Level 0	$0.00
OHI Subpopulation measure improvement target is met and clinic attests to referring patients to dental services	Level 1	$1.25

3. The Oral Health Integration measure and associated criteria are described in Exhibit C.

Exhibit B

Payment Terms and Other Conditions of Participation

A. Conditions of Payment:

1. CCO agrees to pay participating clinics a monthly PMPM incentive payment, provided this LOA is fully executed, according to the following timelines:
    a. If this LOA is executed prior to June 5th, 2023, PMPM will commence on the LOA effective date.
    b. If this LOA is executed between the 6th and the 15th of June 2022, PMPM will commence in August 2023.
    c. If this LOA is executed after June 15, 2023, -CCO will advise Provider when the first payment processing month can occur due to system requirements.
    d. Due to system processing requirements at CCO, no retroactive payments will be remitted to provider due to late LOA execution.
    e. Measure improvement targets will not be adjusted based on timing of LOA execution.

2. CCO shall deliver the PMPM payments to the same location that fee for service claims payments are paid unless provider has requested CCO to use an alternate bank for the PMPM payments.

3. EFT/Remittance Advice. If Provider is able to accept payments and remittance advice electronically CCO will provide the appropriate forms to Provider for requesting PMPM payments be directly deposited to their designated bank account using Electronic Fund Transfers (EFT). Provider shall promptly complete and return the forms to CCO for receiving payments via electronic funds transfer.

4. Providers participating in an APM program at time of LOA execution will continue to receive APM payments in the same manner and/or bank location unless revised instructions are provided to CCO.

5. CCO will not adjust prior PMPM payments due to membership assignment revisions.

6. CCO may suspend payments for one or more program PMPM components to participating clinics that cease to meet eligibility requirements. CCO may subsequently resume payments upon notification of eligibility fulfillment during the LOA period. Provider is encouraged to contact CCO to discuss circumstances in cases where unusual, unforeseen or extenuating situations exists that inhibit Provider from meeting program requirements.

B. Initial Payment Levels

Initial clinic PMPM payment levels at the time of LOA Execution for participating clinics will be calculated as described in the table below. These initial PMPM's depend on the clinic participation status in a CCO PCPM program at time of LOA Execution.

	Payment Level 0	Payment Level 1	Payment Level 2	Payment Level 3
Clinical Quality	**$ 0.00**	**$3.40 to $4.60 (Unique to Each Clinic)**	**$4.95 to $6.75 (Unique to Each Clinic)**	**$8.10 to $11.00 (Unique to Each Clinic)**
	✓ Clinics currently participating in PCPM with Quality payment level 0 at time of LOA effective date.	✓ Clinics currently participating in PCPM with Quality payment level 1 at time of LOA effective date. ✓ All clinics new to participation in a PCPM Quality Component.	✓ Clinics currently participating in PCPM with Quality payment level 2 at time of LOA effective date.	✓ Clinics currently participating in PCPM Track 2 with Quality payment level 3 at time of LOA effective date.
BHI	**$ 0.00**	**$ 2.00**	**$ 4.00**	
	✓ Clinics currently participating in CCO BHI with payment level 0 at time of LOA effective date. ✓ Clinics that do not attest to CCO BHI Model of Care.	✓ Clinics currently participating in CCO BHI with payment level 1 at time of LOA effective date. ✓ Clinics new to BHI will start at payment level 1.	✓ Clinics currently participating in CCO BHI with payment level 2 at time of LOA effective date.	
Oral Health Integration		**$ 1.25**		
		✓ All clinics participating in PCPM will begin at Level 1 the Oral Health Component of Program.		
Equity Focus Area	**$ 0.00**	**$ 1.25**		
	✓ Clinics currently participating in PCPM with Equity payment level 0 at time of LOA effective date.	✓ Clinics currently participating in PCPM with Equity payment level 1 at time of LOA effective date. ✓ All clinics new to participating in PCPM		

a. Clinics that are not participating in a CCO PCPM program prior to the LOA effective date will initially receive QIP payment level one (1).
b. Clinics participating in a CCO PCPM program as of June 1, 2023, will continue to receive the same June 2023 QIP and EFA payment levels assigned.
c. Clinics that are participating in the CCO BHI program as of June 1, 2023 with payment level 0 will initially receive the same BHI payment level 0. Clinics that do not attest to providing the CCO BHI Model of Care or that choose not to participate in the BHI component of the program will receive BHI payment level 0 and considered to not be participating in the BHI component.

C. Other Conditions of Program Participation:

1. To ensure appropriate payment of funds under this LOA, Provider will ensure clinic-specific billing for each participating clinic. Clinic-specific billing requires claims submission using professional claims forms (CMS-1500 or 837P) with a clinic-specific National Provider Identifier (NPI) submitted as the billing provider (CMS-1500 item 33a or 837 loop ID 2010AA).

2. If the State of Oregon or the contracted Coordinated Care Organization changes the requirements for Patient Centered Primary Care Home (PCPCH) Supplemental Payment, this LOA will be re-evaluated.

3. Provider agrees to notify CCO within thirty (30) days of any changes that may affect any participating clinic's ability to maintain any of the eligibility requirements of the CCO PCPM.

4. Provider agrees that payments received will be used to support the appropriate participating clinic(s) located in the CCO service area.

5. This LOA may be amended by CCO upon written notice to Provider to reflect immaterial programmatic changes to the CCO PCPM. Any other

changes to this LOA can only be amended by a written agreement signed by the parties hereto.

Exhibit C
Detailed Measure Sets for Clinical Tracks

CareOregon Metro
Family Practice Track

CHC Beavercreek Health Center

Measure	DataSource	Measurement Period 1	Measurement Period 2	Baseline Measurement	Target 1 (Measurement Period 1)	Target 2 (Measurement Period 2)	Benchmark
Clinical Quality Focus Area							
Well-Child Visits 3-6 yo	Claims	Jan 2023 - June 2023	Jan 2023 – Dec 2023	63.9%	32.2%	64.4%	68.6%
Immunizations for Adolescents (MCV4, Tdap, HPV)	Roster	Jan 2023 - June 2023	Jan 2023 – Dec 2023	25.7%	13.4%	26.8%	36.9%
Diabetes: HbA1c Poor Control	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	27.0%	26.8%	26.8%	24.8%
Drug and Alcohol Misuse - Screening, Brief Intervention and Referral to Treatment (SBIRT) Rate 1	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	74.3%	73.5%	73.5%	66.6%
Drug and Alcohol Misuse - Screening, Brief Intervention and Referral to Treatment (SBIRT) Rate 2	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	23.9%	24.4%	24.4%	28.7%
Screening for Depression and Follow-Up Plan	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	90.1%	87.2%	87.2%	61.0%
Behavioral Health Integration Focus Area							
CareOregon Population Reach	Clinic Reported	July 2022 – June 2023	Jan 2023 – Dec 2023	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Choice of Sub-Population:							
Patients with Diabetes: HbA1c	Clinic Reported	July 2022 - June 2023	Jan 2023 - Dec 2023	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Oral Health Integration Focus Area							
Oral Evaluation for Adults with Diabetes	Claims	Jan 2023 - June 2023	Jan 2023 – Dec 2023	39.7%	20.4%	40.7%	26.4%
Equity							
Meaningful Language Access	Clinic Reported	Jan 2023 - June 2023	Jan 2023 – Dec 2023	N/A	40	40	N/A
Pediatric Narrative Report: Social Emotional Health	Clinic Reported	Jan 2023 – June 2023	Jan 2023 – Dec 2023	N/A	Successful Qualitative Submission	Successful Qualitative Submission	N/A

CareOregon Metro
Family Practice Track

CHC Sunnyside Health Center

Measure	DataSource	Measurement Period 1	Measurement Period 2	Baseline Measurement	Target 1 (Measurement Period 1)	Target 2 (Measurement Period 2)	Benchmark
Clinical Quality Focus Area							
Well-Child Visits 3-6 yo	Claims	Jan 2023 - June 2023	Jan 2023 – Dec 2023	65.1%	32.7%	65.5%	68.6%
Immunizations for Adolescents (MCV4, Tdap, HPV)	Roster	Jan 2023 - June 2023	Jan 2023 – Dec 2023	19.0%	10.4%	20.8%	36.9%
Diabetes: HbA1c Poor Control	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	30.9%	30.3%	30.3%	24.8%
Drug and Alcohol Misuse - Screening, Brief Intervention and Referral to Treatment (SBIRT) Rate 1	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	79.7%	78.4%	78.4%	66.6%
Drug and Alcohol Misuse - Screening, Brief Intervention and Referral to Treatment (SBIRT) Rate 2	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	17.6%	18.7%	18.7%	28.7%
Screening for Depression and Follow-Up Plan	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	90.3%	87.4%	87.4%	61.0%
Behavioral Health Integration Focus Area							
CareOregon Population Reach	Clinic Reported	July 2022 – June 2023	Jan 2023 – Dec 2023	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Choice of Sub-Population:							
Patients with Diabetes: HbA1c	Clinic Reported	July 2022 - June 2023	Jan 2023 - Dec 2023	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Oral Health Integration Focus Area							
Oral Evaluation for Adults with Diabetes	Claims	Jan 2023 - June 2023	Jan 2023 – Dec 2023	31.7%	16.3%	32.7%	26.4%
Equity							
Meaningful Language Access	Clinic Reported	Jan 2023 - June 2023	Jan 2023 – Dec 2023	N/A	40	40	N/A
Pediatric Narrative Report: Social Emotional Health	Clinic Reported	Jan 2023 – June 2023	Jan 2023 – Dec 2023	N/A	Successful Qualitative Submission	Successful Qualitative Submission	N/A

CareOregon Metro
Family Practice Track

CHC Sandy Health Center

Measure	DataSource	Measurement Period 1	Measurement Period 2	Baseline Measurement	Target 1 (Measurement Period 1)	Target 2 (Measurement Period 2)	Benchmark
Clinical Quality Focus Area							
Well-Child Visits 3-6 yo	Claims	Jan 2023 - June 2023	Jan 2023 – Dec 2023	50.0%	25.9%	51.9%	68.6%
Immunizations for Adolescents (MCV4, Tdap, HPV)	Roster	Jan 2023 - June 2023	Jan 2023 – Dec 2023	20.9%	11.3%	22.5%	36.9%
Diabetes: HbA1c Poor Control	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	29.3%	28.9%	28.9%	24.8%
Drug and Alcohol Misuse - Screening, Brief Intervention and Referral to Treatment (SBIRT) Rate 1	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	73.7%	73.0%	73.0%	66.6%
Drug and Alcohol Misuse - Screening, Brief Intervention and Referral to Treatment (SBIRT) Rate 2	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	34.2%	33.7%	33.7%	28.7%
Screening for Depression and Follow-Up Plan	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	90.7%	87.7%	87.7%	61.0%
Behavioral Health Integration Focus Area							
CareOregon Population Reach	Clinic Reported	July 2022 – June 2023	Jan 2023 – Dec 2023	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Choice of Sub-Population:							
Patients with Diabetes: HbA1c	Clinic Reported	July 2022 - June 2023	Jan 2023 - Dec 2023	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Oral Health Integration Focus Area							
Fluoride Varnish Application, 1–10 year-olds	Claims	Jan 2023 - June 2023	Jan 2023 – Dec 2023	1.3%	2.2%	4.3%	6.4%
Equity							
Meaningful Language Access	Clinic Reported	Jan 2023 - June 2023	Jan 2023 – Dec 2023	N/A	40	40	N/A
Pediatric Narrative Report: Social Emotional Health	Clinic Reported	Jan 2023 – June 2023	Jan 2023 – Dec 2023	N/A	Successful Qualitative Submission	Successful Qualitative Submission	N/A

CareOregon Metro
Pediatric Track

CHC Gladstone Health Center

Measure	DataSource	Measurement Period 1	Measurement Period 2	Baseline Measurement	Target 1 (Measurement Period 1)	Target 2 (Measurement Period 2)	Benchmark
Clinical Quality Focus Area							
Well-Child Visits 3-6 yo	Claims	Jan 2023 - June 2023	Jan 2023 – Dec 2023	83.8%	41.1%	82.3%	68.6%
Immunizations for Adolescents (MCV4, Tdap, HPV)	Roster	Jan 2023 - June 2023	Jan 2023 – Dec 2023	51.0%	24.8%	49.6%	36.9%
Childhood Immunization Status (Combo 3)	Roster	Jan 2023 - June 2023	Jan 2023 – Dec 2023	63.6%	32.0%	64.0%	67.9%
Drug and Alcohol Misuse - Screening, Brief Intervention and Referral to Treatment (SBIRT) Rate 1	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	59.7%	60.4%	60.4%	66.6%
Drug and Alcohol Misuse - Screening, Brief Intervention and Referral to Treatment (SBIRT) Rate 2	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	36.4%	35.6%	35.6%	28.7%
Screening for Depression and Follow-Up Plan	EHR/ eCQM	July 2022 – June 2023	Jan 2023 – Dec 2023	77.7%	76.0%	76.0%	61.0%
Behavioral Health Integration Focus Area							
CareOregon Population Reach	Clinic Reported	July 2022 – June 2023	Jan 2023 – Dec 2023	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Choice of Sub-Population:							
Patients with Positive Depression Screen	Clinic Reported	July 2022 - June 2023	Jan 2023 - Dec 2023	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Oral Health Integration Focus Area							
Fluoride Varnish Application, 1–10 year-olds	Claims	Jan 2023 - June 2023	Jan 2023 – Dec 2023	8.2%	5.6%	11.2%	6.4%
Equity							
Meaningful Language Access	Clinic Reported	Jan 2023 - June 2023	Jan 2023 – Dec 2023	N/A	40 Successful Qualitative Submission	40 Successful Qualitative Submission	N/A N/A
Pediatric Narrative Report: Social Emotional Health	Clinic Reported	Jan 2023 – June 2023	Jan 2023 – Dec 2023	N/A			

Exhibit D
Quality Measure Reporting Specifications

Clinical Quality Measurement Specifications

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

Measure	Sponsor (link to technical specifications)
Kindergarten Readiness: Well-Child Visits 3-6 yo	Oregon Health Authority
Immunizations for Adolescents (MCV4, Tdap, HPV)	Oregon Health Authority
Alcohol and Drug Misuse: SBIRT Rate 1 &2	Oregon Health Authority
Screening for Depression and Follow-Up Plan	Oregon Health Authority
Childhood Immunization Status (Combo 3)	Oregon Health Authority
Diabetes: HbA1c Poor Control	Oregon Health Authority
Controlling High Blood Pressure	Oregon Health Authority
Colorectal Cancer Screening	CMS - Stars – Page 28
Breast Cancer Screening	CMS – Stars – Page 26

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

Equity: Diabetes Measure & Narrative

This Equity Diabetes Measure is scored based on both meeting the improvement target for EHR/eCQM measure HbA1c poor control and a narrative report. The diabetes narrative report is focused on describing your clinic's process and/or policy for disaggregating diabetes control data by REALD to identify disparities and opportunities for action. Clinics will submit the narrative reporting using the template provided by the CCO below.

Diabetes Equity Narrative Report

Building an-equity centered data system for clinical quality improvement

Data are the building blocks for how we describe the health of people and the communities where they live – stories that emerge from data help us to understand and contextualize what drives or impedes health and how structural factors like racism and other forms of discrimination influence a person's opportunity to live a healthy life (RWJF, 2021)

Drivers for building an equity-centered data system:

- Changing how we tell stories about the health of people and communities, so equity informs meaningful narrative change
- Prioritizing governance of data infrastructure to put equity at the center
- Ensuring quality improvement measurement captures and addresses structural racism and other inequities

Clinic Name:	
Name of Person Completing:	
Date Submitted:	
Does your clinic have a standard process or policy for disaggregating measure data by Race, Ethnicity, Preferred Language, Disability status, or Sexual Orientation and Gender Identity (SOGI)?	☐ Yes ☐ No
If you answered "No" above, do you have a plan for developing a process or policy for disaggregated performance data?	☐ Yes ☐ No
If you answered "Yes" above, has your process or policy been reviewed and/or received input from patients via a patient advisory council or similar group?	☐ Yes ☐ No
Are you interested in technical assistance to support developing standard processes for	☐ Yes ☐ No

disaggregating data and identifying actionable opportunities?	
Please describe any barriers you have experienced in disaggregating data by Race, Ethnicity, Preferred Language, Disability status, or Sexual Orientation and Gender Identity.	
Please describe any disparities identified while analyzing your disaggregated diabetes A1c performance data.	
How are the results from disaggregated data analysis shared with your patient population?	
Please describe how your clinic is building an equity-centered data system to drive clinical quality improvement.	

Equity: Improving Language Access Report Questions and Scoring

The Equity Report will be scored by the total number of points earned from clinics providing affirmative responses to the questions listed below. The Equity Report has a total of 50 possible points. Part 1 has 12 points, Part 2 has 20 points and Part 3 has 18 points. In order to pass, the clinic must receive the minimum number of points listed in the detailed measure set tables in Exhibit C for the respective data submission due date.

Part 1: Identification and assessment for communication needs

Question 1: Maximum 6 points

Please answer yes or no for each of the following statements on how your clinic identifies patients needing communication access (e.g. LEP, sign language users)

	Yes or No
The clinic has a **process to respond to individual requests** for language assistance services (including sign language)	
The clinic has a **process for self-identification** by the Deaf or hard of hearing person, non-English speaker or LEP individual.	
The clinic has a **process for using open-ended questions** to determine language proficiency on the telephone or in person	
The clinic's front desk and scheduling staff are **trained to use video relay or** TTY for patient services	
The clinic uses **"I Speak" language identification cards or posters**	
The clinic has a **process for responding to patients' complaints about** language access and clearly communicates this process to all patients.	

Question 2: Maximum 3 points

Please answer yes or no for each of the following statements about collecting data.

	Yes or No
The clinic collects data on the **number of patients served who are Limited English Proficient (LEP)**	
The clinic collects data on the **number of patients served who are Deaf and hard of hearing**	
The clinic collects data on the **number of and prevalence of languages spoken by their patients**	

Question 3: Maximum 3 points

Please answer yes or no for each of the following statements about members that refused, did not need or needed interpretation services but were not identified as such.

	Yes or No
The clinic collects data on the number of patients served **who self-identified as LEP but refused interpretation services**	
The clinic collects data on the number of patients served **who are Deaf and hard of hearing but refused interpretation services.**	
The clinic collects data on the number of **patients served who were not identified in the chart as LEP or Deaf and hard of hearing, but who requested interpretation services**	

Part 2: Provision of Language Assistance Services

Question 4: Maximum 4 points

Please answer yes or no to each of the following statements about tracking language access services at your clinic.

	Yes or No
The clinic tracks **the primary language** of person encountered or served.	
The clinic tracks **the use of language assistance services such as interpreters and translators**	
The clinic tracks **bilingual and sign language staff time spent** on language assistance services	
The clinic tracks **the use of spoken and sign language assistance services by modality** (e.g. in person; telephonic, video, other)	

Question 5: Maximum 7 points

Which types of language assistance services are used by your clinic in providing care to CCO members?

-Select Yes – CO vendor only, if your only source of contracted interpretation services is one of the CO provided vendors. -Select Yes if you have other interpretation contracts outside of CO.

Both responses will count as “yes”.

	Yes, Yes – CCO vendor only or No
Bilingual staff and providers	
In-house interpreters (spoken and sign)	
In-house translators (for documents)	
Contracted in-person interpreters	
Contracted translators (for documents)	
Contracted telephonic interpretation services	
Contracted video interpretation services	

Question 6: Maximum 7 points

Please select yes or no to the language assistance services that your clinic can provide detailed member level information on, such as member ID, date of service and interpreters' credential.

	Yes or No
Bilingual staff and providers	
In-house interpreters (spoken and sign)	
In-house translators (for documents)	
Contracted in-person interpreters	
Contracted translators (for documents)	
Contracted telephonic interpretation services	
Contracted video interpretation services	

Question 7: Maximum 1 point

	Yes or No
Does your clinic have policies on the use of family members or friends to provide interpretation services?	

Question 8: Maximum 1 point

If yes to the previous question, please briefly describe or attach your policies on when or how family members can provide interpretation services.

Part 3: Data Reporting

Percent of member visits with interpreter need in which interpreter services were provided: 18 points possible

Numerator: Denominator visits that were provided with interpreter services

Denominator: Visits at the practice site during the measurement period with a CCO member who self-identified as having interpreter needs

Exclusions: Visits for which the member was offered and refused interpreter services

> **Measuring Performance:** To achieve points, the clinic is required to report the data provided from the CCO on the population identifying as needing an interpreter. Member level data by visit will be used for 2023. The required data to be reported for each member visits to be counted towards the point total are:
>
> 1. *The Interpreter Type, Certification status, and OHA Registry Number is complete. Or*
> 2. *Interpreter was a Bilingual Staff is complete Or*
> 3. *Member refused interpreter service and the service refusal reason is complete*

Reporting Format: The CCO will provide visit data for those members assigned to clinic and self-identified as needing an interpreter to the OHA. Please fill out the fields using the drop downs in the data set. Follow the data dictionary below for allowed answers.

Column Name	*Valid Input Value*	*Additional Instructions for Completing the Reporting Template*
Member ID	Member's Medicaid ID	
Visit Type/Care Setting	Office Outpatient Telehealth Other	**Please report only one visit per member per day**. If multiple types of visits occurred on the same day, then please select one type of visit **using the order of selections as a hierarchy**. If an office outpatient visit and telehealth occurred on the same day, report the office outpatient visit, etc.

Visit Date	Visit Date YYYY/MM/DD	**Please report only one visit per member per day**.
In-person Interpreter Service	Yes No	Report all that apply during the visit date
Telephonic Interpreter Service	Yes No	
Video Remote Interpreter Service	Yes No	
Was the Interpreter OHA Certified or Qualified	OHA Certified OHA Qualified Not Certified or Qualified by OHA Unknown	
Interpreter's OHA Registry Number	OHA Registry number	
Was the Interpreter a Bilingual Staff	Yes No	
Did the member refuse Interpreter Service	Yes No Enter reason code 1-4: 1. Member refusal because in-language visit is provided, 2. Member confirms interpreter needs flag in MMIS is inaccurate, 3. Member unsatisfied with the interpreter services available, 4. Other reasons for patient refusal	Scenario 1: The member confirms the provider for the visit can perform in-language service and therefore no interpreter service is needed. To note, if the in-language service provider is OHA certified or qualified, it could be a numerator hit for the metric. Scenario 2: OHA recommends initiating correction of the interpreter flag in MMIS. Visits with refusal reasons 1 or 2 can be excluded IF the CCO attests collecting corresponding information in the CCO self-assessment survey question #11. Scenarios 3 and 4 do not qualify for denominator exclusion.

2) Equity: Pediatric Social Emotional Health Narrative Report Specifications

Provider is to submit written narrative responses to SEH assessment questions within a template that will be provided by CCO. The template will be in Excel Format and uploaded to the reporting location with other data submissions.

Narrative reports are evaluated based on completeness of the submission. A template will be provided for providers to fill out during data submission events. 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 three reporting components.

1. Behavioral Health/Integrated Behavioral Health Staffing (BH
2. Social Emotional Health Assessments and Services Process
3. Community partnerships and educational opportunities

Reporting Component 1: Behavioral Health Staffing

Submit a roster of Behavioral Health providers with the following:

1. BH Providers with the applicable skill set to serve 0-5 year olds
2. Weekly capacity of BH providers who serve 0-5 year-olds for new referrals (respond for each provider identified)
3. Each BH Provider's race/ethnicity
4. Each BH Provider's spoken language
5. Confirm if dyadic therapy modalities are offered by each BH provider

If your staffing model excludes behavioral health staff, you will be asked to provide a narrative addressing:

1. How social emotional assessments are incorporated within your practice
2. Provide a response advising if your practice is expecting to hire new BH staff or implement new BH programs, accompanied by an estimated timeline
3. Program description.

Reporting Component 2: Social Emotional Health Assessments and Services Process

Provide descriptions of how the clinic assesses social emotional health that may include:

- Emotional assessments
- Neurobehavioral statutes exams
- Health & Behavior assessments

Reporting Component 3: Community Partnerships and education opportunities

Consider community-based organizations, advocacy groups, and early learning providers that represent children and families in your community on the components listed below:

1. List name of organization and primary contact (Excel format will be accepted)
2. What social-emotional services are provided by the organization?
3. What gaps does the organization address?
4. For clinics not having a social worker(s), track current barriers & opportunities for improvement to access services

Exhibit E
CCO Behavioral Health Integration Measure Specifications

1. BHI Population Reach Measure Specifications

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

2. 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 CCO members with a positive depression screen as indicated by the measurement tool during measurement period.
Diabetes: HbA1c > 9 (Family Practiceand Internal Medicine)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique CCO 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 CCO 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 (e.g. 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).

List is not all inclusive, the intent is that any service providing a clinical intervention or insight to the patient or on the patient's behalf including telehealth appointments can be included.

Provider is accountable for submitting data for the BHI Population Reach Measures to specifications.

Exhibit F

Reporting Requirements by Data Source

Claims Measures

Performance on claims-based measures is calculated using CCO 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.

EHR/eCQM Measures

Clinics that do not already provide CCO with data, or have data provided to CCO 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 CCO are not required to submit separately for PCPM.

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/YearNine2021GuidanceDocumentation-final.pdf

OHA is expected to publish Year 10 guidance documentation during the fourth quarter of 2022, and these specifications are to be used and applied to the measure reporting and evaluation of data due for the February 2023 data submission event.

Roster Measures

The Family Practice and Pediatric clinical tracks may include at least 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, CCO will provide clinics with a roster twice annually at least 30 days prior to data submission deadline, of all assigned CCO members that meet inclusion criteria.