Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

June 20, 2024 BCC Agenda Date/Item: _____

Board of County Commissioners
Clackamas County

Approval of a Revenue Agreement with CareOregon, Inc. for the Primary Care Payment Model Program. Agreement Value estimated at $1,950,000 for 1 year. Funding through CareOregon, Inc. No County General Funds are involved.

Previous Board Action/Review	June 9, 2022, II.D.11 July 20, 2023, II.C.5 Briefed at Issues June 18, 2024		
Performance Clackamas	1. Individuals and families in need are healthy and safe. 2. Ensure safe, healthy and secure communities.		
Counsel Review	Yes	**Procurement Review**	No
Contact Person	Sarah Jacobson	**Contact Phone**	503-201-1890

EXECUTIVE SUMMARY: This agreement provides revenue to the Health Centers Division through the Primary Care Payment Model Program. The Health Centers Division is eligible to receive a per member per month (PMPM) value based payment comprised of up to four (4) focus area components based on level of achievement in these areas: Clinical Quality Incentive Payment, Equity Focus Area Payment, Behavioral Health Integration Incentive Payment, and Oral Health Integration Incentive Payment. The clinics participating in this program are Beavercreek, Gladstone, Sunnyside, and Sandy.

RECOMMENDATION: The staff respectfully recommends that the Board of County Commissioners approve this agreement and authorize Chair Smith to sign on behalf of Clackamas County.

Respectfully submitted,

Rodney A. Cook

For Filing Use Only

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

Health, Housing & Human Services

CareOregon, Inc.

Healthcare Services Contract

Primary Care Payment Model

This Healthcare Services Contract (HSC) is between CareOregon, Inc. (CareOregon) and Clackamas Health Centers (Provider), to enable Provider's participation in the Primary Care Payment Model (PCPM) Program (PCPM Program). For purposes of this HSC, 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 Authority (OHA) to operate as a Coordinated Care Organization under a series of Contracts, including but not limited to, Medicaid and Non-Medicaid Contracts, herein intentionally referred to in the singular as the "CCO Contract."

B. CCO and Provider entered into a Provider Agreement (Provider Agreement) whereby Provider has been providing and continues to provide services to CCO Members. As stipulated in the Provider Agreement, Provider is subject to all the laws, rules, regulations, and contractual obligations governing the provision of care to CCO Members.

C. Through this Agreement, 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 HSC.

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

The Parties agree and understand that this HSC is supplemental to the Provider Agreement and that the applicable provisions of the Provider Agreement are incorporated by reference into this HSC. Nothing in this HSC 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 HSC 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 HSC includes provisions that are applicable, all Policies shall be consistent with the Provider Agreement.

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

II. Term and Termination

A. **Term.** This HSC is effective as of **July 1, 2024** (Effective Date) and shall remain in effect through **June 30, 2025** (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 HSC with or without cause upon providing 30 days written notice to the other Party.

   ii. CCO, in its sole discretion, may terminate this HSC 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 HSC; 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 HSC 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 HSC.

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 HSC.

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 HSC.

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

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

this HSC, 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 HSC. 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 HSC.

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

Provider Contact: Angie Amundson
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 HSC 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 HSC. In so doing, Provider certifies by entering into this HSC 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 HSC 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 HSC, 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 HSC, Provider expressly agrees to promptly repay all such payments disbursed to it under this HSC and all funding associated with this HSC 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 HSC 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 HSC 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 HSC 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 HSC 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 HSC, and specifically to safeguard all confidential information including the health information of Members as it applies to all activities related to this HSC.
   ii. Both Parties agree that this HSC 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, unless applicable law requires such disclosure. 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 HSC 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. If the Oregon Tort Claims Act is applicable to either CCO or the Provider, this section is modified by its terms.

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 HSC 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 HSC, or (b) any breach or default in performance of any such Party's obligations in this HSC 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 HSC 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 HSC shall be at all times limited by the tort claim limits provided in the Oregon Tort Claims Act and the Oregon Constitution. This indemnity shall not be limited by reason of any insurance coverage required under this HSC and shall survive termination of this HSC.

H. **Compliance and Licensure**. Provider and CCO shall, at all times during the term of this HSC 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 HSC; 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 HSC. The Parties shall have the right to immediately unilaterally terminate this HSC 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 HSC 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 HSC shall not create any rights in any third parties who have not entered into this HSC, nor shall this HSC 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 HSC without the prior written consent of the other Party.

<signature page to follow>

Agreed to on behalf of Clackamas Health Centers:

_____

Signature

Name: _____

Title: _____

Date: _____

Agreed to on behalf of CareOregon, Inc.:

_____

Signature

Name: Teresa Learn

Title: Chief Financial Officer

Date: _____

Exhibit A

Description of PCPM Program Components

For the period of this HSC, 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 CareOregon Medicare 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, 2024** and **February 28, 2025** 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 2024** and **June 2025** 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 clinical track 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 HSC 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 Clinic	Family Medicine	$0.00	$3.60	$5.85	$9.55
2. Gladstone Clinic	Pediatrics	$0.00	$3.40	$4.95	$8.10
3. Sunnyside Clinic	Family Medicine	$0.00	$3.60	$5.85	$9.55
4. Sandy Clinic	Family Medicine	$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 HSC 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 (AIIS), 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 HSC will not be granted.

5. Participating clinics agree to submit reporting information for all the Measures as defined in the HSC 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 HSC 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 data from the other clinics within the same track 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. Payment level will be determined based on equivalent percentages.

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 2023. 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 2023 through July 2024,
    b. Claims data provided by CCO for the calendar period January through December 2023,
    c. The Electronic Health Record (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*	**Payment Level**

Meet improvement target or benchmark on 1 or less clinical quality measures	Level 0
Meet improvement target or benchmark on 2 of the clinical quality measures	Level 1
Meet improvement target or benchmark on 3 of the clinical quality measures	Level 2
Meet improvement target or benchmark on 4 or more of the clinical quality measures	Level 3

*For clinics that have had measures removed due to low denominator equivalent percentage of quality measures met will be used.

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 clinical tracks however measure performance is calculated using aggregated Provider system data within the same track and is determined as follows:

Equity Focus Area performance evaluation criteria	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 Social Needs Screening report was not timely submitted e. The Social Needs Screening was not submitted through the required process f. The Social Needs Screening report does not contain responses to all reporting components	Level 0	$0.00
The EFA measure will be deemed as met if all the following occur: a. Data was timely submitted for the MLA EFA measure and target value was met b. All components of the Social Needs Screening were submitted timely.	Level 1	$1.25

*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 are eligible to receive a Behavioral Health Integration (BHI) Incentive PMPM Payment. Behavioral Health Integration 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 the reported BHI program measure values as defined in Exhibit E for the measurement period.

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.	Level 1	$2.00
Clinic 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, professional counselor associate, or marriage and family therapist associate ✓ Psychologist resident

*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.

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

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

3. 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.

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

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

6. 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.

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

8. 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 HSC, 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 HSC, 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	OHI PMPM
OHI Subpopulation measure improvement target is not met and clinic attests they do not refer patients to dental services	Level 0	$0.00
OHI Subpopulation measure improvement target is met and clinic attests they do not refer patients to dental services		
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 HSC is fully executed, according to the following timelines:
    a. If this HSC is executed prior to June 5th, 2024, PMPM will commence on the HSC effective date.
    b. If this HSC is executed between the 6th and the 15th of June 2024, PMPM will commence in August 2024.
    c. If this HSC is executed after June 15, 2024, 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 HSC execution.
    e. Measure improvement targets will not be adjusted based on timing of HSC 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 EFT.

4. Providers participating in an APM program at time of HSC 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 HSC 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 HSC 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 HSC 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 $11.00 (Unique to Each Clinic)**
	✓ Clinics currently participating in PCPM with Quality payment level 0 at time of HSC effective date.	✓ Clinics currently participating in PCPM with Quality payment level 1 at time of HSC effective date. ✓ All clinics new to participating in PCPM.	✓ Clinics currently participating in PCPM with Quality payment level 2 at time of HSC effective date.	✓ Clinics currently participating in PCPM Track 2 with Quality payment level 3 at time of HSC effective date.
BHI	**$ 0.00**	**$ 2.00**	**$ 4.00**	
	✓ Clinics currently participating in CCO BHI with payment level 0 at time of HSC 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 HSC 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 HSC effective date.	
Oral Health Integration	**$0.00**	**$ 1.25**		
	✓ Clinics currently participating in PCPM with OHI payment level 0 at time of HSC effective date.	✓ Clinics currently participating in PCPM with OHI payment level 1 at time of HSC effective date. ✓ All clinics new to participating in PCPM.		
Equity Focus Area	**$ 0.00**	**$ 1.25**		
	✓ Clinics currently participating in PCPM with Equity payment level 0 at time of HSC effective date.	✓ Clinics currently participating in PCPM with Equity payment level 1 at time of HSC effective date. ✓ All clinics new to participating in PCPM.		

a. Clinics that are not participating in a CCO PCPM program prior to the HSC effective date will initially receive QIP payment level one (1).
b. Clinics participating in a CCO PCPM program as of June 1, 2024, will continue to receive the same June 2024 QIP and EFA payment levels assigned.
c. Clinics that are participating in the CCO BHI program as of June 1, 2024 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. All participating clinics must be recognized by CareOregon as a primary care provider in order to qualify for payment under the PCPM Program. In the event that a clinic is pending recognition, no payment will be due until such recognition is finalized, at the sole discretion of CareOregon.

2. To ensure appropriate payment of funds under this HSC, 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).

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

4. 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.

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

6. This HSC may be amended by CCO upon written notice to Provider to reflect immaterial programmatic changes to the CCO PCPM. Any other changes to this HSC can only be amended by a written agreement signed by the parties hereto.

Exhibit C
Detailed Measure Sets for Clinical Tracks

CLACKAMAS COUNTY BEAVERCREEK

CareOregon Metro
Family Practice Track

Area of Focus	Measure	Data Source	Measurement Period 1	Measurement Period 2	Baseline	Target 1	Target 2	Benchmark
Clinical Quality	Kindergarten Readiness: Well- Child Visits 3-6 yo	Claims	Jan 2024-June 2024	Jan 2024-Dec 2024	45.5%	24.0%	47.9%	70.2%
	Postpartum Care	Roster	Deliveries Oct 8 2023 - Apr 7 2024	Deliveries Oct 8 2023- Oct 7 2024	80.9%	83.9%	83.9%	85.9%
	Diabetes: HbA1c Poor Control	EHR/eCQM	July 2023-June 2024	Jan 2024-Dec 2024	27.0%	25.0%	25.0%	21.1%
	Childhood Immunizations (Combo 3)	ALERT IIS	Jan 2024-June 2024	Jan 2024-Dec 2024	44.4%	34.0%	67.9%	67.9%
	Screening for Depression and Follow-up Plan	EHR/eCQM	July 2023-June 2024	Jan 2024-Dec 2024	84.5%	82.9%	82.9%	68.2%
Oral Health Integration	Oral Evaluation for Adults with Diabetes	Claims	Jan 2024-June 2024	Jan 2024-Dec 2024	38.2%	18.8%	37.6%	31.9%
Behavioral Health Integration	Population Reach	Clinic Reported	July 2023-June 2024	Jan 2024-Dec 2024	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
	Patients with Diabetes: HbA1c > 9	Clinic Reported	July 2023-June 2024	Jan 2024-Dec 2024	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Equity	Meaningful Language Access	Roster and Clinic Reported	Jan 2024-June 2024	Jan 2024-Dec 2024	N/A	40 Points	40 points	N/A
	Social Needs Screening	Roster and Clinic Reported	Jan 2024-June 2024	Jan 2024-Dec 2024	N/A	Reporting Only	Reporting Only	N/A

CLACKAMAS COUNTY HEALTH - SUNNYSIDE CLINIC

CareOregon Metro

Family Practice Track

Area of Focus	Measure	Data Source	Measurement Period 1	Measurement Period 2	Baseline	Target 1	Target 2	Benchmark
Clinical Quality	Kindergarten Readiness: Well- Child Visits 3-6 yo	Claims	Jan 2024-June 2024	Jan 2024-Dec 2024	50.0%	26.0%	52.0%	70.2%
	Postpartum Care	Roster	Deliveries Oct 8 2023 - Apr 7 2024	Deliveries Oct 8 2023- Oct 7 2024	81.7%	84.7%	84.7%	85.9%
	Diabetes: HbA1c Poor Control	EHR/eCQM	July 2023-June 2024	Jan 2024-Dec 2024	24.9%	22.9%	22.9%	21.1%
	Childhood Immunizations (Combo 3)	ALERT IIS	Jan 2024-June 2024	Jan 2024-Dec 2024	44.4%	34.0%	67.9%	67.9%
	Screening for Depression and Follow-up Plan	EHR/eCQM	July 2023-June 2024	Jan 2024-Dec 2024	91.7%	89.4%	89.4%	68.2%
Oral Health Integration	Oral Evaluation for Adults with Diabetes	Claims	Jan 2024-June 2024	Jan 2024-Dec 2024	35.2%	17.5%	34.9%	31.9%
Behavioral Health Integration	Population Reach	Clinic Reported	July 2023-June 2024	Jan 2024-Dec 2024	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
	Patients with Diabetes: HbA1c > 9	Clinic Reported	July 2023-June 2024	Jan 2024-Dec 2024	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Equity	Meaningful Language Access	Roster and Clinic Reported	Jan 2024-June 2024	Jan 2024-Dec 2024	N/A	40 Points	40 points	N/A
	Social Needs Screening	Roster and Clinic Reported	Jan 2024-June 2024	Jan 2024-Dec 2024	N/A	Reporting Only	Reporting Only	N/A

Sandy Health Clinic

CareOregon Metro

Family Practice Track

Area of Focus	Measure	Data Source	Measurement Period 1	Measurement Period 2	Baseline	Target 1	Target 2	Benchmark
Clinical Quality	Kindergarten Readiness: Well- Child Visits 3-6 yo	Claims	Jan 2024-June 2024	Jan 2024-Dec 2024	41.5%	22.2%	44.3%	70.2%
	Postpartum Care	Roster	Deliveries Oct 8 2023 - Apr 7 2024	Deliveries Oct 8 2023- Oct 7 2024	80.0%	83.0%	83.0%	85.9%
	Diabetes: HbA1c Poor Control	EHR/eCQM	July 2023-June 2024	Jan 2024-Dec 2024	17.6%	18.0%	18.0%	21.1%
	Childhood Immunizations (Combo 3)	ALERT IIS	Jan 2024-June 2024	Jan 2024-Dec 2024	44.4%	34.0%	67.9%	67.9%
	Screening for Depression and Follow-up Plan	EHR/eCQM	July 2023-June 2024	Jan 2024-Dec 2024	90.6%	88.4%	88.4%	68.2%
Oral Health Integration	Oral Evaluation for Adults with Diabetes	Claims	Jan 2024-June 2024	Jan 2024-Dec 2024	25.6%	13.3%	26.6%	31.9%
Behavioral Health Integration	Population Reach	Clinic Reported	July 2023-June 2024	Jan 2024-Dec 2024	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
	Patients with Diabetes: HbA1c > 9	Clinic Reported	July 2023-June 2024	Jan 2024-Dec 2024	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Equity	Meaningful Language Access	Roster and Clinic Reported	Jan 2024-June 2024	Jan 2024-Dec 2024	N/A	40 Points	40 points	N/A
	Social Needs Screening	Roster and Clinic Reported	Jan 2024-June 2024	Jan 2024-Dec 2024	N/A	Reporting Only	Reporting Only	N/A

CLACKAMAS COUNTY HEALTH - GLADSTONE CLINIC

CareOregon Metro

Pediatric Track

Area of Focus	Measure	Data Source	Measurement Period 1	Measurement Period 2	Baseline	Target 1	Target 2	Benchmark
Clinical Quality	Kindergarten Readiness: Well- Child Visits 3-6 yo	Claims	Jan 2024-June 2024	Jan 2024-Dec 2024	74.3%	37.0%	73.9%	70.2%
	Immunizations for Adolescents (MCV4, Tdap, HPV)	ALERT IIS	Jan 2024-June 2024	Jan 2024-Dec 2024	48.3%	23.6%	47.1%	36.9%
	Childhood Immunizations (Combo 3)	ALERT IIS	Jan 2024-June 2024	Jan 2024-Dec 2024	73.0%	36.3%	72.5%	67.9%
	Screening for Depression and Follow-up Plan	EHR/eCQM	July 2023-June 2024	Jan 2024-Dec 2024	71.4%	71.1%	71.1%	68.2%
	Alcohol and Drug Misuse: SBIRT Rate 1	EHR/eCQM	July 2023-June 2024	Jan 2024-Dec 2024	62.7%	64.7%	64.7%	66.6%
	SBIRT Rate 2 (must pass both rate 1&2)	EHR/eCQM	July 2023-June 2024	Jan 2024-Dec 2024	33.3%	46.7%	46.7%	46.7%
Oral Health Integration	Fluoride Varnish Application, 1-5 yo	Claims	Jan 2024-June 2024	Jan 2024-Dec 2024	24.8%	13.0%	26.0%	37.1%
Behavioral Health Integration	Population Reach	Clinic Reported	July 2023-June 2024	Jan 2024-Dec 2024	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
	Patients 0 to 5 years	Clinic Reported	July 2023-June 2024	Jan 2024-Dec 2024	N/A	Tier 1: 6.0% Tier 2: 14.0%	Tier 1: 6.0% Tier 2: 14.0%	N/A
Equity	Meaningful Language Access	Roster and Clinic Reported	Jan 2024-June 2024	Jan 2024-Dec 2024	N/A	40 Points	40 points	N/A
	Social Needs Screening	Roster and Clinic Reported	Jan 2024-June 2024	Jan 2024-Dec 2024	N/A	Reporting Only	Reporting Only	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	Oregon Health Authority
Breast Cancer Screening	HEDIS (CMS Stars)
Postpartum Care	Oregon Health Authority

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.

*HOP and Basic Health Plan members will not be excluded from data.

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 2024. 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.

Social needs screening will be reporting only for 2024 to establish baseline for targets in 2025 (year 2).

Component 1-Self Assessment

CCOs will complete a self-assessment that includes questions about social needs screening tools and methods, data collection mechanisms, trauma-informed practices, and protocols for referring CCO members to community resources. Component 1 will be a survey format to be completed one time per year.

Component 2 – Population Sample
A random sample of clinic population will be selected for this roster measure.
Sample size parameters:

- Number of assigned Members who meet the denominator criteria determines sample size.
- Sample will never be more than 500 annually (250 per reporting period) or less than 100 annually (50 per reporting period).
- Larger samples available at provider request.

Rate 1: The percentage of CCO members from the OHA-identified sample who were screened for each of the three required domains at least once during the measurement year

Rate 2: Of the sample population screened, the percentage of CCO members with a positive screen for any of the three required domains.

Oral Health Integration

Part 1: Referral to Dental Services

As part of the PCPM application, each clinic will be asked about processes for referring patients to dental services. These questions must be answered completely to the best of your ability to pass the OHI measure. The questions will be included in the reporting workbook, under the OHI sheet.

Specifically, the questions in the reporting workbook include:

Referral to Dental Services	
Do you refer patients to dental services?	
If yes, describe your referral to dental mechanism(s).	
Would you like support or technical assistance to learn more, implement or refine documented referral pathways to dental care/providers?	

Part 2: Quantitative Measure Performance

The reporting for the oral health integration performance metric will be determined based on track and/or population assigned to the PCP clinic.

Measure	Measure Sponsor
Oral Evaluation for Adults with Diabetes	Fluoride varnish (population limited to 1-5 year olds, no high risk criteria is applied, and only **one**

	application necessary, physical health claims using D1206 or 99188)
Fluoride Varnish Application, 1–5-year-olds	Oregon Health Authority

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	
Patients between 0-5 years old (Pediatric and Family Medicine)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique CCO members who are between ages 0-5 years old seen by clinic during measurement period.
Diabetes: HbA1c > 9 (Family Practice and Internal Medicine)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique CCO members with a Diabetes: HbA1c > 9 seen by clinic 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 seen by clinic 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
- ✓ Non-CO members

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

- ✓ Any service received in primary care during the measurement period

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

Roster Measures

Some measures 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 (AIIS). 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.