Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

June 9, 2022

Board of County Commissioners
Clackamas County

Approval of revenue agreement #10708 with CareOregon for the Primary Care Payment Model Program – Per Member Per Month Incentive Program. Anticipated value of the agreement is $1,626,235, however agreement has no maximum. Funding through CareOregon.
County General Funds are not involved.

Purpose/Outcomes	The purpose of this agreement is to provide Clackamas Health Centers Division (CHCD) funding for working towards improvement in patient's health outcomes.
Dollar Amount and Fiscal Impact	This is a no maximum revenue agreement. Based on number of clients reported and by what percentage the measure was increased during reporting period. Current budget is for projected $1,626,235 in revenue.
Funding Source	No County funds. This is a revenue agreement with CareOregon.
Duration	July 1, 2022 – June 30, 2023
Previous Board Action	Issues June 7, 2022
Strategic Plan Alignment	1. Individuals and families in need are healthy and safe. 2. Ensure safe, healthy and secure communities.
Counsel Review	1. May 23, 2022 2. KR
Procurement Review	1. Was the item processed through Procurement? yes ☐ no x 2. Revenue contract, no procurement needed.
Contact Person	Sarah Jacobson, Health Center Interim Director – 503-201-1890
Contract No.	10708

BACKGROUND:
Clackamas County Health Centers Division (CCHCD) of the Health, Housing & Human Services Department requests the approval of contract #10708, a revenue agreement with CareOregon for the Primary Care Payment Model Program – Per Member Per Month (PMPM) Incentive Program.

CareOregon offers payment incentives to organizations that have been qualified as a Patient Centered Primary Care Home and who have a Primary Care Payment Model letter of agreement with CareOregon. There is no way to determine the amount of revenue to be received as this is determined based on the number of members assigned to CCHCD and the amount of measured improvement reported per quarter. CCHCD is eligible for revenue generated per member per month depending on level of achievement at the Beavercreek, Sunnyside, Gladstone and Sandy clinics. Due to these factors we are processing this as a no maximum agreement.

This agreement is effective July 1, 2022 and expires on June 30, 2023.

RECOMMENDATION:
Staff recommends approval of this contract, and authorizes the Chair to sign on behalf of the County.

Respectfully submitted,

Rodney A. Cook

Rodney A. Cook, Director
Health, Housing & Human Services Department

#10708

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 Center Division Center (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 ("Health Share") is contracted with the Oregon Health Authority ("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 certified Coordinated Care Organization for the Oregon Health Plan ("OHP").

B. CareOregon, Inc is an Oregon nonprofit, public benefit corporation and is a subcontractor of Health Share whereby Health Share has delegated certain health plan functions, as contracted for in the CCO Contract, to CareOregon, Inc. Although CareOregon, Inc. is not a certified Coordinated Care Organization, for administrative simplicity, CareOregon will be referred to as "CCO" for purposes of this LOA.

C. Through this LOA, CareOregon 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.

D. 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.

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

AGREEMENT

I. Administration/Interpretation of Agreement.

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

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, 2022 ("Effective Date") and shall remain in effect through June 30, 2023 ("Termination Date") unless sooner terminated as stipulated for herein.

B. **Termination**. Other than as modified and expressly stated 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, any payments not yet made by CareOregon to Provider shall not be made and any remaining balance of payments disbursed to Provider under this Agreement that have not been used for, or committed to, the Program prior to termination must be refunded and repaid promptly to CareOregon. Provider understands and agrees that CareOregon will not be liable for, nor shall payments be made or used for, any services performed after the date of Termination.

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 ("Program") the description and obligations of which are further stipulated in Exhibits A through G 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 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 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, E, F and G 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: Sarah Jacobson
Phone: 503-201-1890
E-mail: SJacobson@clackamas.us

IV. Representations and Warranties.

A. **General Warranty**. Provider represents and warrants that Provider, its agents, or 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, or 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, based on the current information available concerning COVID-19.

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 safeguard all confidential information including the health information of Members as it applies to all activities related to this LOA.

   ii. Both Parties agree that 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 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. 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 LOA which result from the non-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, 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. 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 shall survive termination of this LOA.

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 all work pursuant 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 Clackamas County acting by and through its Health, Housing and Human Services Department, Health Center Division Center:

_____
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 Agreement, 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)
- Cost of Care Incentive Payment (COC)
- Behavioral Health Integration Incentive Payment (BHI)
- Oral Health Integration Incentive Payment (OHI)

All PMPM payments will be calculated using CareOregon 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 CareOregon Oregon Health Plan and members who are assigned secondary health plan coverage of CareOregon Oregon Health Plan with primary health plan coverage of CareOregon 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, 2022** and **February 28, 2023** utilizing the same data collection platform, Sharefile. Sharefile is a secure, HIPAA compliant file sharing system, and is the designated application CareOregon utilizes for data sharing in this program. CareOregon 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 CareOregon for establishing an alternative, approved data submission method.

Any resulting payment level adjustments will occur on the **December 2022** and **June 2023** 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:
        - At minimum five (5) quality measures with defined specifications
        - One (1) health equity element requiring a report submission

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 Agreement are:

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

**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 CareOregon members assigned to their clinic.*

a. The list of measurement(s) and measurement period for each participating clinic are presented in this Agreement in Exhibit C.

b. The initial clinic payment level determination for QIP and all other components are described in Exhibit B, Section C.

B. QUALITY INCENTIVE REPORTING TERMS

1. CareOregon 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. CareOregon agrees to provide clinics 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 CareOregon members that meet inclusion criteria.

3. If CareOregon 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 CareOregon are not required to submit a duplicate data set.

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

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

6. CareOregon 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 CareOregon 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 CareOregon during the Agreement if the following requirements are met:
   a. All QIP data including the Equity report 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 CareOregon 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 CareOregon, 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 CareOregon 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 CareOregon 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 CareOregon will provide performance using fee-for-service claims data for Provider review and information.

8. For each measure indicated as "Roster", CareOregon will timely 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. Submission of the Health Equity report for Improving Language Access is required. Additional information regarding the health equity Language Access questionnaire requirements and scoring are listed in Exhibits C and D.

10. 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 2021. Baseline data will be obtained from one of these sources, depending upon the specific measure:
    a. EHR/eCQM data submitted to CareOregon or as made available from OHA as part of the clinic's PCPM program participation for the period of June 2021 through July 2022
    b. Claims data provided by CCO for the calendar period January through December 2021
    c. The Electronic Health Record data (EHR/eCQM) data provided to and approved by CareOregon with the program application when requested by CareOregon.

11. 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 less than 50% of the clinical quality measures	Yes	Level 0
	No	Level 0

Meet program targets on 50% to less than 60% of the clinical quality measures	Yes	Level 1
	No	Level 0
Meet program targets on 60% to less than 80% of the clinical quality measures	Yes	Level 2
	No	Level 1
Meet program targets 80% or more of the clinical quality measures	Yes	Level 3
	No	Level 2

D. COST OF CARE INCENTIVE PAYMENTS:

1. All participating clinics deemed eligible will receive a Cost of Care (COC) Incentive PMPM Payment.

2. The Cost of Care 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:

Cost of Care Performance evaluation criteria on Family Practice Track Cost of Care Measure	Payment Level	COC PMPM
The Cost of Care narrative measure will be deemed as not met if any of the following occur: a) There are fewer than 500 members assigned to the Provider system b) The Cost of Care measure data is not timely submitted c) The Cost of Care Measure result does not meet the Target value d) The Pediatric Cost of Care narrative report was not timely submitted The Pediatric Cost of Care narrative report was not submitted through the required process e) The Pediatric Cost of Care narrative report does not contain responses to all three reporting components.	Level 0	$0.00
The Cost of Care will be deemed as met if all of the following occur: a) There are >=500 members assigned to total Provider system b) Data was timely submitted for the Cost of Care Measure c) The Pediatric narrative report was timely submitted through the required process and contains responses to all three reporting components	Level 1	$1.25

d) Either the Cost of Care Measure Target was met -OR- the Pediatric Narrative Report is evaluated as meeting the reporting requirement.		
Cost of Care Performance on Pediatric Track Cost of Care Measure	**Payment Level**	**COC PMPM**
The Cost of Care narrative measure will be deemed as not met if any of the following occur: a) There are less than 500 members assigned to the system b) The Pediatric narrative report is not timely submitted c) The Pediatric narrative report was not submitted through the required process d) The Pediatric narrative report does not contain responses to all three reporting components.	Level 0	$0.00
The Cost of Care narrative measure will be deemed as met if the narrative: a) There are >=500 members assigned to total Provider system b) The Pediatric narrative report is timely submitted using the required process c) The Pediatric narrative report contains responses to all three reporting components and is evaluated as meeting the reporting requirement	Level 1	$1.25

3. Additional information on the Cost of Care 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 Tier 1 or Tier 2 designation are eligible to receive a Behavioral Health Integration (BHI) Incentive PMPM Payment. Tier designation criteria is listed in the table below:

Behavioral Health Integration Criteria

Behavioral Health Integration Criteria	Tier 1	Tier 2
Staffing: ✓ A 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; or is offsite delivering telehealth services provided the BHC staff is dedicated to the practice site as part of the required BHC to PCP clinic FTE ratio.	✓ ✓ ✓	✓ ✓ ✓

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

2. 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 Tier designation as shown below. Only clinics that meet all Tier 2 requirements of CareOregon's BHI Model of Care are eligible to receive BHI payment level two (2).

Performance on BHI Measures	Payment Level	BHI PMPM

Less than 5.0% reach on either measure	Level 0	$0.00
One of the following conditions is met: • Both measures attain a minimum of 5% and both are less than 12.0% • Both measures attain a minimum of 5% with one measure at 12% or higher. • Clinic has **Tier 1** designation and attains 12.0% or greater reach on **both** measures.	Level 1	$2.00
Clinic has **Tier 2** designation and attains 12.0% 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 CareOregon 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 CareOregon, 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 Agreement.

6. Clinics will provide narrative responses during the data submission events to questions about the services and methods employed in the delivery of behavioral healthcare.

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

8. 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.

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

10. CareOregon 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 this Agreement, all participating clinics that applied to participate in the Oral Health Incentive and were deemed eligible will receive a $1.25 PMPM Oral Health Integration (OHI) Incentive Payment.

2. Each participating clinic must submit the reporting due at each data submission event.

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

Oral Health Integration Performance evaluation criteria criteria for each Report Submission	Payment Level	COC PMPM
The Oral Health Integration Measure will be deemed as not met if any of the following occur: a) Responses are missing for any of the questions in the narrative reports b) The report is not timely submitted	Level 0	$0.00

c) The report was not submitted through the required process		
The Oral Health Integration Measure will be deemed as met if all of the following occur: a) The narrative report is submitted as scheduled b) The narrative report is complete and demonstrates processes are in place for providing preventive Oral Health services and treatment, Oral Health assessments, and Oral Health referrals c) The narrative report receives the minimum passing quantitative score when evaluated.	Level 1	$1.25

3. The Oral Health Integration Measure scoring rubric is presented in Exhibit F.

Exhibit B
Payment Terms and Other Conditions of Participation

A. Conditions of Payment:

1. CareOregon agrees to pay participating clinics a monthly PMPM incentive payment, provided this Agreement is fully executed, according to the following timelines:
    a. If this Agreement is executed prior to June 1st, 2022, PMPM will commence on the Agreement effective date.
    b. If this Agreement is executed between the 1st and the 15th of June 2022, PMPM will commence in August 2022.
    c. If this Agreement is executed after June 15, 2022 CareOregon 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 Agreement execution.
    e. Measure improvement targets will not be adjusted based on timing of Agreement execution.

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

3. EFT/Remittance Advice. If Provider is able to accept payments and remittance advice electronically CareOregon 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 CareOregon for receiving payments via electronic funds transfer.

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

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

6. CareOregon may suspend payments for one or more program PMPM components to participating clinics that cease to meet eligibility requirements. CareOregon

may subsequently resume payments upon notification of eligibility fulfillment during the Agreement period. Provider is encouraged to contact CareOregon 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 Agreement 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 Agreement 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 CareOregon BHI with payment level 0 at time of LOA effective date. ✓ Clinics that do not attest to CareOregon BHI Model of Care.	✓ Clinics currently participating in CareOregon 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 CareOregon BHI with payment level 2 at time of LOA effective date.	
Oral Health Integration	**$ 0.00**	**$ 1.25**		
	✓ Clinics not participating in this program component.	✓ All clinics approved to participate in the Oral Health Component of Program.		
Cost of Care	**$ 0.00**	**$ 1.25**		
	✓ Clinics currently participating in PCPM with Cost of Care payment level 0 at time of LOA effective date.	✓ Clinics currently participating in PCPM with Cost of Care 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 Agreement effective date will initially receive QIP payment level one (1).
b. Clinics participating in a CCO PCPM program as of June 1, 2022, will continue to receive the same June 2022 QIP and COC payment levels assigned.
c. Clinics that are participating in the CCO IBH program as of June 1, 2022 with payment level 0 will initially receive the same IBH 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 IBH 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 Agreement, 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 Agreement will be re-evaluated.

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

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

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

Exhibit C

Detailed Measure Sets for Clinical Tracks

See 2022 Program Description for complete measure description and information

CareOregon Metro

Family Practice Track

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 2022 - Jun 2022	Jan 2022 – Dec 2022	51.6%	26.4%	52.9%	64.1%
Diabetes: HbA1c Poor Control	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	27.9%	27.9%	27.9%	27.5%
Immunizations for Adolescents (MCV4, Tdap, HPV)	Roster	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	40.7%	20.2%	40.3%	36.9%
Drug and Alcohol Misuse - Screening, Brief Intervention and F	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	74.8%	74.1%	74.1%	68.2%
Drug and Alcohol Misuse - Screening, Brief Intervention and F	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	7.3%	11.9%	11.9%	53.5%
Screening for Depression and Follow-Up Plan	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	90.4%	87.8%	87.8%	64.6%
Third Next Available	Clinic Specific	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	26	20	20	N/A
Improving Language Access	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	40 points	40 points	N/A
Behavioral Health integration Focus Area							
CareOregon Population Reach	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
Choice of Sub-Population:							
Patients with Diabetes: HbA1c > 9	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
Oral Health Integration Focus Area							
Oral Health Assessment, Preventative Care, Referral, and Education - Pediatric Prevention	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Narrative Submission	Successful Qualitative Submission	N/A
Oral Health Assessment, Preventative Care, Referral, and Education - Oral Evaluation for Adults with Diabetes	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Narrative Submission	Successful Qualitative Submission	N/A
Cost of Care Focus Area							
Inpatient and Emergency Department Utilization for	Claims	May 2021 - Apr 2022	Nov 2021 – Oct 2022	6.6	6.5	6.4	N/A
Pediatric Cost of Care Narrative Report	Narrative Report	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Narrative Submission	Narrative Submission	N/A

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

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

CareOregon Metro

Family Practice Track

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 2022 - Jun 2022	Jan 2022 – Dec 2022	26.9%	15.3%	30.6%	64.1%
Diabetes: HbA1c Poor Control	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	34.4%	33.7%	33.7%	27.5%
Immunizations for Adolescents (MCV4, Tdap, HPV)	Roster	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	39.0%	19.4%	38.8%	36.9%
Drug and Alcohol Misuse - Screening, Brief Intervention and F	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	88.6%	86.6%	86.6%	68.2%
Drug and Alcohol Misuse - Screening, Brief Intervention and F	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	0.0%	5.4%	5.4%	53.5%
Screening for Depression and Follow-Up Plan	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	92.3%	89.5%	89.5%	64.6%
Third Next Available	Clinic Specific	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	26	20	20	N/A
Improving Language Access	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	40 points	40 points	N/A
Behavioral Health integration Focus Area							
CareOregon Population Reach	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
Choice of Sub-Population:							
Patients with Diabetes: HbA1c > 9	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
Oral Health Integration Focus Area							
Oral Health Assessment, Preventative Care, Referral, and Education - Pediatric Prevention	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Narrative Submission	Successful Qualitative Submission	N/A
Oral Health Assessment, Preventative Care, Referral, and Education - Oral Evaluation for Adults with Diabetes	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Narrative Submission	Successful Qualitative Submission	N/A
Cost of Care Focus Area							
Inpatient and Emergency Department Utilization for	Claims	May 2021 - Apr 2022	Nov 2021 – Oct 2022	6.6	6.5	6.4	N/A
Pediatric Cost of Care Narrative Report	Narrative Report	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Narrative Submission	Narrative Submission	N/A

Measures using the Minnesota Method are denoted with "MM."
*Measure is aggregated to the system/organization-level instead of clinic-level.

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 2022 - Jun 2022	Jan 2022 – Dec 2022	50.0%	25.7%	51.4%	64.1%
Diabetes: HbA1c Poor Control	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	33.0%	32.5%	32.5%	27.5%
Immunizations for Adolescents (MCV4, Tdap, HPV)	Roster	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	37.1%	18.5%	37.1%	36.9%
Drug and Alcohol Misuse - Screening, Brief Intervention and F	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	61.2%	61.9%	61.9%	68.2%
Drug and Alcohol Misuse - Screening, Brief Intervention and F	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	4.5%	9.4%	9.4%	53.5%
Screening for Depression and Follow-Up Plan	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	87.2%	84.9%	84.9%	64.6%
Third Next Available	Clinic Specific	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	26	20	20	N/A
Improving Language Access	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	40 points	40 points	N/A
Behavioral Health integration Focus Area							
CareOregon Population Reach	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
Choice of Sub-Population:							
Patients with Diabetes: HbA1c > 9	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
Oral Health Integration Focus Area							
Oral Health Assessment, Preventative Care, Referral, and Education - Pediatric Prevention	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Narrative Submission	Successful Qualitative Submission	N/A
Oral Health Assessment, Preventative Care, Referral, and Education - Oral Evaluation for Adults with Diabetes	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Narrative Submission	Successful Qualitative Submission	N/A
Cost of Care Focus Area							
Inpatient and Emergency Department Utilization for	Claims	May 2021 - Apr 2022	Nov 2021 – Oct 2022	6.6	6.5	6.4	N/A
Pediatric Cost of Care Narrative Report	Narrative Report	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Narrative Submission	Narrative Submission	N/A

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

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

CareOregon Metro

Pediatric Track

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 2022 - Jun 2022	Jan 2022 – Dec 2022	71.7%	35.5%	70.9%	64.1%
Childhood Immunization Status (Combo 3)	Roster	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	64.5%	32.6%	65.2%	71.1%
Immunizations for Adolescents (MCV4, Tdap, HPV)	Roster	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	52.9%	25.7%	51.3%	36.9%
Drug and Alcohol Misuse - Screening, Brief Intervention and F	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	63.9%	64.3%	64.3%	68.2%
Drug and Alcohol Misuse - Screening, Brief Intervention and F	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	0.0%	5.4%	5.4%	53.5%
Screening for Depression and Follow-Up Plan	EHR/ eCQM	Jul 2021 - Jun 2022	Jan 2022 – Dec 2022	71.4%	70.7%	70.7%	64.6%
Third Next Available	Clinic Specific	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	26	20	20	N/A
Improving Language Access	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	40 points	40 points	N/A
Behavioral Health integration Focus Area							
CareOregon Population Reach	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
Choice of Sub-Population:							
Patients with Positive Depression Screen	Clinic Reported	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
Oral Health Integration Focus Area							
Oral Health Assessment, Preventative Care, Referral, and Education - Pediatric Prevention	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Narrative Submission	Successful Qualitative Submission	N/A
Cost of Care Focus Area							
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pediatric Cost of Care Narrative Report	Narrative Report	Jan 2022 - Jun 2022	Jan 2022 – Dec 2022	N/A	Narrative Submission	Narrative Submission	N/A

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

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

Exhibit D
Quality Measure Reporting Specifications

Clinical Quality Measurement Specifications

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

a. Kindergarten Readiness: Well-Child Visits 3-6 yo
b. Immunizations for Adolescents (MCV4, Tdap, HPV)
c. Alcohol and Drug Misuse: SBIRT Rate 1 &2
d. Screening for Depression and Follow-Up Plan
e. Childhood Immunization Status (Combo 3)
f. Diabetes: HbA1c Poor Control
g. Cigarette Smoking Prevalence

Measure specifications can be found at the Oregon Health Authority's website:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx
The most current specifications provided by the OHA will be used at the time of the performance evaluation. Participants shall be responsible for monitoring specification updates.

Equity Report Questions and Scoring: Improving Language Access

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 CareOregon 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 CareOregon member who self-identified as having interpreter needs

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

Measuring Performance: This measure is reporting only. In order to achieve points, the clinic is only required to report the data. There will be no targets or benchmarks for this program year. In future program years, this measure will have an improvement target or benchmark.

Reporting Format: For this reporting year, data will only be required in aggregate format: numerator and denominator for each practice site. If your clinic is able to track and report exclusions, they will be accepted, however, not all clinics may be able to report exclusions. Ability to report exclusions is not a requirement.

Clinics are encouraged to submit in the encounter level format if they have the capabilities, but it is not a requirement at this time. *In future program years*, this measure will change from aggregate to encounter level reporting.

A sample format for encounter level reporting is provided below for reference.

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	
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.

CCO Cost of Care Measure

1) FAMILY PRACTICE TRACK - INPATIENT AND EMERGENCY DEPARTMENT MEASURE

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

Numerator

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

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

More information about the PQIs can be found here:
https://qualityindicators.ahrq.gov/Modules/pqi_resources.aspx#techspecs

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Each visit to an ED for one of the above PQIs is included in the numerator. Multiple ED visits on the same date of service are counted as one visit. Emergency Department visits are specified by the codes identified in the OHA ED Utilization specifications:

https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Ambulatory-Care-Avoidable-ED-visits-2018.pdf

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

Denominator
Member months for all CCO assigned population aged 19 and older.

Data elements required denominator: 1,000 Member Months.

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

2) PEDIATRIC COST OF CARE NARRATIVE REPORT SPECIFICATIONS

Provider is to submit written narrative responses to questions within a template that will be provided by CareOregon. The template will be in Word 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/IBH)
2. Social Emotional Health Assessments and Services Process
3. Community partnerships and educational opportunities

Reporting Component 1: Behavioral Health/Integrated Behavioral Health Staffing
Submit a roster of Behavioral Health providers with the following:

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

Pediatric Cost of Care Narrative Report Grading Rubric/Evaluation Worksheet
The following worksheet will be utilized by CCO to evaluate the Pediatric Cost of Care narrative reports.

Please fill out the fields below	
Narrative:	Pediatric Cost of Care
Program:	Primary Care Payment Model
Evaluator Name:	
Date Evaluated:	
LOB:	
Provider:	

Evaluation Elements	Scoring	Comments
Narrative described clinic's capability to risk stratify, interventions to address needs including both social & physical health	☐Met ☐Partially Met ☐Not Met ☐NA	
Narrative described train plans, policies, and practices to support TIC. Plans include orientation and training of both new and existing staff.	☐Met ☐Partially Met ☐Not Met ☐NA	
Narrative described processes for	☐Met ☐Partially Met	

screening and addressing social-emotional health for 0-5 yos	☐Not Met ☐NA	
Narrative described how the clinic identifies patients with special healthcare needs including process for referral to specialist or resources.	☐Met ☐Partially Met ☐Not Met ☐NA	
Clinic described or provided a policy or procedure to ensuring pediatric patients receive psychotropic medication for medically accepted indications. Response identifies population of focus	☐Met ☐Partially Met ☐Not Met ☐NA	

Narrative Grading Scoring					
	Total Possible Evaluation Elements	Total Met	Total Partially Met	Total Not Met	Total N/A
Totals	5				

Overall Score	
Score*	
Narrative status	

Evaluation of Narrative Questions – Definitions
The grading rubric definitions of how to evaluate the narrative questions
Met: The response addressed each requirement listed in the element. Policies or procedures described comprehensively address the element. Met = Full credit: 1 out of 1
Partially Met: The response addressed some but not all of the listed requirements in the element. Or a response was provided to all listed requirements, but policies or procedures have significant room for improvement. Partially Met = Half credit: .5 out of 1
Not Met: Section was unanswered, response did not address the requirements of the element or policies and procedures are inadequate to address the element. Not Met = No credit: 0 out of 1
N/A: Not applicable for program

*80% of evaluation elements are required to pass

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 Practice only)	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 and the Access & Engagement Measure according to specifications.

Exhibit F

CCO Oral Health Integration Measure– Scoring Rubric for Clinical Workflows

CareOregon

CareOregon 2022 PCPM Oral Health Measures: Scoring Rubric for Clinical Workflows

Pediatric Required Elements: Fluoride Varnish, Patient Education, Screening OR Assessment, Referral Option 1, 2 or 3

Diabetes Required Elements: Patient Education, Screening, Referral Option 1, 2 or 3

Partner/Clinic/Provider:				
Pediatric Population Participant:	No	Oral Health Screening	Referral Option 1	
Diabetes Population Participant:	No	Oral Health Screening	Referral Option 1	

Required Workflow	Population	Competency	Excellent – Pass	Good - Pass	Needs Improvement
Fluoride Varnish Application	Pediatric (Ages 1-10 only)	Provider/Staff/Clinic have the workflows and clinical skills to place fluoride varnish; clinical orders, chart documentation and billing mechanisms are/will be implemented	• Patient selection criteria including mechanisms such as scrubbing, standard at all visits, risk-based decision-making tools • Training plan for fluoride varnish application includes training materials, tools and hands on practice • Staff person to apply fluoride varnish identified (MA, RN, Provider) • Documentation/chart entry automated/templated in EHR • Order entry and associated ICD-10 Z code can be entered • Ability to submit claim with CPT 99188 or D1206 codes with engagement from billing team • Post varnish instructions reviewed verbally AND provided as printed resource/added to AVS • Clinic orders supplies ☐	• Patient selection criteria is clear • Training plan for fluoride varnish application • Staff person to apply fluoride varnish identified (MA, RN, Provider) • Chart note documentation process outlined • Order entry and associated ICD-10 Z code can be entered • Ability to submit claim with CPT 99188 or D1206 codes • Post varnish instructions plan for patient • Clinic orders supplies ☐	☐
Patient Education	Pediatric ages 1-14 Diabetic population	Provider/Staff/Clinic have the basic skills to discuss the importance of oral health with their patient and provide guidance as needed	• Oral health education materials reviewed verbally AND provided as printed resource/added to AVS; they are age appropriate • Adopt oral health materials from CareOregon or professionally endorsed organization (*CareOregon diabetes materials available on website, pediatric materials coming soon) • Materials are available in multiple languages ☐	• Established talking points are clear and age appropriate • Identify team member to provide patient/family education • Patient education materials are available ☐	☐
Oral Health Screening	Diabetic patients Can be used for pediatrics ages 1-14 if not providing assessment	Provider/Staff/Clinic provide a very brief oral health screening to patients. *This screening may be conducted by any trained staff member	• Screening questions are added to the EHR • Staff person to capture screening questions identified and oriented • Patient selection criteria is clear • Frequency of screening service identified • Chart note documentation outlined and readily available or built into EHR • Order entry and associated ICD-10 Z code entry entered • Ability to submit claim with D0190 code ☐	• Adopt and implement screening questions or screening tool • Staff person to capture screening questions identified and oriented • Patient selection criteria is clear • Frequency of screening service identified • Chart note documentation outlined • Order entry and associated ICD-10 Z code entry ☐	☐

CareOregon

CareOregon 2022 PCPM Oral Health Measures: Scoring Rubric for Clinical Workflows

Pediatric Required Elements: Fluoride Varnish, Patient Education, Screening OR Assessment, Referral Option 1, 2 or 3

Diabetes Required Elements: Patient Education, Screening, Referral Option 1, 2 or 3

Required Workflow	Population	Competency	Excellent – Pass	Good - Pass	Needs Improvement
Oral Health Assessment	Pediatrics ages 1-14 only Oral health screening is not needed for pediatric practices who choose this option	Provider (MD, NP, DO, PA) can conduct an oral health assessment using an approved risk assessment tool; required provider training has been completed	• Training plan for assessment completed for providers • Adopt and implement approved Caries Risk Assessment Tool (CRA) that is integrated into the EHR • Patient selection criteria including mechanisms such as scrubbing, standard at all visits, risk-based decision-making tools • Frequency of screening service identified • Documentation/chart entry automated in EHR • Ability for order entry and associated ICD-10 Z code to be entered • Ability to submit claim with D0191 code ☐	• Training plan for assessment completed for providers • Identify responsible provider • Adopt and implement approved Caries Risk Assessment Tool (CRA) • Patient selection criteria is clear • Frequency of screening service identified • Documentation/chart entry in EHR • Ability for order entry and associated ICD-10 Z code to be entered ☐	☐
Referral Option 1	Pediatric ages 1-14 Diabetic Population All referrals use the Referral Portal	Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care using the Referral Portal	• Creation of dental referral in EHR referral system by provider or team • Staff person identified to process EHR referral and submit referral into the portal • Train staff to access and use portal • Chart documentation • Communicate referral expectation to patient/family and include in AVS or other patient communication ☐	• Creation of dental referral process for provider team • Workflow and staff person identified to submit referrals into the portal • Train staff to access and use portal • Chart documentation • Communicate referral expectations to patient/family ☐	☐
Referral Option 2	Pediatric ages 1-14 Diabetic Population Referrals completed using the Referral Portal **and** an alternate method(s)	Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care using the Referral Portal and other pathways; a workflow submission for each workflow is required	• For Portal: Completes requirements in option 1 • For Alternative to Portal • Does the process need to identify patient's dental plan? If so, workflow is established to identify dental plan. • Define and document the criteria for portal use vs the alternative • Creation of EHR referral by provider or team • Staff person identified to process referral using documented process guide or similar • Chart documentation • Communicate referral expectation to patient/family and include in AVS or other patient communication • Develops and documents a process to report monthly referral volume ☐	• For Portal: Completes requirements in option 1 • For Alternative to Portal • Does the process need to identify patient's dental plan? If so, workflow is established to identify dental plan. • Define and document the criteria for portal use vs the alternative • Creation of referral by provider or team • Staff person identified to process referral using documented process guide or similar • Chart documentation • Communicate referral expectation to patient/family Develops and documents a process to report monthly referral volume ☐	☐
Referral Option 3	Pediatric ages 1-14 Diabetic population Referrals completed without using the Referral Portal; provide separate workflows if using multiple methods	Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care	• Does the process need to identify patient's dental plan? If so, workflow is established to identify dental plan. • Creation of EHR referral by provider or team • Staff person identified to process referral using documented process guide or similar • Chart documentation • Communicate referral expectation to patient/family and include in AVS or other patient communication • Develops and documents a process to self-report monthly referral volume ☐	• Does the process need to identify patient's dental plan? If so, workflow is established to identify dental plan. • Creation of referral by provider or team • Staff person identified to process referral using documented process guide or similar • Chart documentation • Communicate referral expectation to patient/family • Develops and documents a process to self-report monthly refe volume ☐	☐
Comments:					

Exhibit G

Reporting Requirements by Data Source

Claims Measures

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

EHR/eCQM Measures

Clinics that do not already provide CareOregon with data, or have data provided to CareOregon by another entity on the clinic's behalf, for CCO EHR/eCQM measures, must submit member-level or aggregate performance data on all EHR/eCQM measures. Clinics for which this data is already provided to CareOregon are not required to submit separately for PCPM.

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, CareOregon will provide clinics with a roster twice annually at least 30 days prior to data submission deadline, of all assigned CareOregon members that meet inclusion criteria.