Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

July 27, 2023 BCC Agenda Date/Item: _____

Board of County Commissioners
Clackamas County

Approval of amendment #18 updating program language to a revenue agreement with CareOregon, Inc. for Updates to the Shared Accountability Model. Estimated revenue Of the amendment is $500,000 for 2 years. Total anticipated revenue under this agreement is 4,068,430.00. Funding is through CareOregon, Inc. No County General Funds are involved.

Previous Board Action/Review	Amendment #15: Approved June 1, 2023; Amendment # 14: Approved November 22, 2022, 221123.I.d.1; Amendment # 13: Approved June 2, 2022, 220602IIID14; Amendment # 10: Approved May 13, 2021, 051321-A2; Amendment # 9: Approved February 25, 2021, 022521-A4; Amendment # 8: Approved November 25, 2020, 112520-A4; Amendment # 7: Approved January 9, 2020, 010920-A10; Amendment # 6: Approved August 8, 2019, 080819-A3; Amendment # 5: Approved December 4, 2018; Amendment # 4 Approved January 1, 2018; Amendment # 3 Approved October 23, 2017; Amendment # 2 Approved June 27, 2017; Amendment # 1 Approved May 10, 2016 Original Approved May 5, 2016, 050516-A1. Reviewed at Issues July 25, 2023		
Performance Clackamas	1. Ensure safe, healthy, and secure communities.		
Counsel Review	Yes	**Procurement Review**	No
Contact Person	Sarah Jacobson	**Contact Phone**	503-201-1890

EXECUTIVE SUMMARY: Clackamas Health Centers Division (CHCD) of the Health, Housing & Human Services Department requests the approval of Amendment #18 to

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agreement #7642 with CareOregon for updates to the Shared Accountability Model Program and associated Shared Accountability Model (SAM) Program Guide.

Clackamas Health Centers Division (CHCD) of the Health, Housing & Human Services Department and CareOregon have complementary objectives designed to promote the physical and mental health of the population and incentivize eligible clinical partners within the community to work together to improve health and reduce total cost in the service area over a multi-year period. CareOregon, Inc. shall distribute Shared Savings as defined in the SAM Program Guide by June 30 of each contract year from July 1, 2023, to December 31, 2025, p to $500,000.00.

RECOMMENDATION: Staff recommends approval of Amendment #18 to Provider Agreement #7642.

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

Amendment

between CAREOREGON, INC.

And

Clackamas County acting by and through its Health, Housing and Human Services Department, Health Centers Division

This eighteenth Amendment ("Amendment") to the CareOregon Provider Agreement ("Agreement") that was effective June 1, 2016 between CareOregon, Inc. ("CareOregon") and Clackamas County acting by and through its Health, Housing and Human Services Department, Health Centers Division ("Provider") (collectively, the "Parties"), is made and entered into as of July 1, 2023 (the "Amendment Effective Date").

WHEREAS, CareOregon and Provider agreed to enter into a Shared Accountability Model and

WHEREAS, CareOregon and Provider now desire to amend the terms of the Shared Accountability Model.

Now, therefore, in consideration of the mutual consideration, covenants and obligations set forth herein, the parties agree to amend the Agreement as follows:

1. This Amendment shall become effective on July 1, 2023 and remain in effect through December 31, 2025; and

2. All other terms and conditions of the Agreement shall remain in full force and effect.

3. Effective January 1, 2026, This Amendment will convert to a one-year amendment agreement with automatic annual renewals, subject to the terms referenced in **Section V. TERM, TERMINATION.**

IN WITNESS WHEREOF, the undersigned, with the intent to be legally bound, have caused this Amendment to be duly executed, July 1, 2023.

Agreed to on behalf of **Clackamas County Acting by and through its Health, Housing, And Human Services Department, Health Centers Division**

Signature:_____
Name:_____
Title:_____
Date:_____
Tax:_____
ID:_____

Agreed to on behalf of **CareOregon, Inc.**

Signature:_____
Name: Teresa K. Learn
Title: Chief Financial Officer
Date:_____

SHARED ACCOUNTABILITY MODEL PROGRAM

I. BACKGROUND

Provider is a party to a Provider Agreement ("Provider Agreement") whereby Provider has been providing and continues to provide services to members ("Members") enrolled in Oregon Health Plan ("OHP"). As stipulated in the Provider Agreement, Provider is subject to all the laws, rules, regulations, and contractual obligations including but not limited to those that apply to OHP.

Provider and CareOregon have complementary objectives designed to promote the physical and mental health of the population and incentivize eligible clinical partners within the community to work together to improve health and reduce total cost in the service area over a multi-year period.

II. PROVIDER RESPONSIBILITIES.

Provider agrees to:

A. Participate in the Safety Net Shared Accountability Model ("SAM") Program ("SAM Program") as outlined in this Shared Accountability Model Program Amendment ("Amendment"), the Shared Accountability Model Program Guide as amended from time to time ("SAM Guide"), including but not limited to provisions as approved by the Safety Net Shared Accountability Model Oversight Council ("SAM Council") per its Safety Net Shared Accountability Model Oversight Council Charter adopted October 7, 2021 ("SAM Council Charter"), which SAM Guide is incorporated herein by reference (with the same force and effect as though fully set forth herein) in collaboration with CareOregon.

B. Appoint staff personnel to act as a primary liaison between Provider and CareOregon who shall:

   i. Work with CareOregon to coordinate activities with CareOregon for each deliverable/task required in the SAM Guide.

   ii. Provide input on behalf of Provider on various work groups including any stakeholder committees, provider work groups, and others as may be created as part of the SAM Program.

   iii. Attend meetings as scheduled for the various work groups.

C. Engage in planning and development of utilization, quality, Member engagement, and community health improvement activities that seek to improve Members' overall health and address their changing needs, including Social Determinants of Health (SDOH).

D. Maintain any and all necessary licensure and perform all services by properly trained and licensed or certified staff.

E. Share with CareOregon agreed-upon Member-level information from its operational and analytical systems such as Electronic Health Record (EHR), data warehouses, operational stores and other agreed upon sources to support care management, quality improvement, access, Member experience, patient-reported outcomes, and cost efficiency efforts as related to this shared risk population in a mutually agreed upon format. Provider shall be responsible for maintaining, extracting and submitting all relevant data in support of CareOregon's efforts to monitor progress and track performance as to Provider's execution of the initiatives outlined in the SAM Guide. All data required by CareOregon shall be disclosed to CareOregon in compliance with Section VII, Data Sharing, of this Amendment.

F. Provider agrees to participate in the SAM Program in a manner consistent with all administrative guidelines provided by CareOregon through policies and procedures outlined in the CareOregon Policy and Procedure Manual and to comply with all applicable CareOregon policies that are applicable to the SAM Program (collectively, "Policies").

III. CAREOREGON RESPONSIBILITIES.

CareOregon agrees to:

A. Allocate funding for Shared Savings (as defined in the SAM Guide) distribution by June 30 of each contract year, following claims run out for the Measurement Period. The Measurement Period is defined as commencing on January 1 and ending on December 31.

B. Appoint a staff member as the primary liaison between CareOregon and Provider. In addition, CareOregon will appoint liaison personnel as needed to coordinate activities with Provider for each deliverable/task as required in the SAM Guide.

C. Provide data reports to Provider, as described in the SAM Guide under Currently Available Reports and Risk Share Reporting.

D. Support the SAM Program as described in the SAM Guide and comply with this Amendment, the SAM Guide, and Policies.

E. Provide access to current Health Resiliency Services staff through direct hire who are accountable and consistent with the Provider's high-risk patient need and care coordination needs of CareOregon.

F. Provide access to care coordination staff, assigned to members and clinic systems including hospitals and emergency departments to link high-risk patients to their primary care teams.

G. Update the SAM Guide from time to time to reflect changes in the Shared Accountability Model. Changes related to data-sharing, participating providers, new definitions or acronyms, updates to the FAQ, or other updates needed to keep the information in the Guide current will be identified in a Change Log and shared with Participating Providers. Changes to content that is within the scope of the SAM Oversight Council, such as updates to quality, access, or engagement measures, targets, or incentives, changes to shared savings allocation, changes to the total cost of care model or model implementation, or governance changes, will only be updated upon approval by the SAM Oversight Council.

IV. JOINT RESPONSIBILITIES.

A. The Parties agree to participate in the SAM Council that will meet at least quarterly to evaluate the performance of this Amendment The composition of the committee is defined by the SAM Council Charter. The SAM Council will develop, monitor and update the specifics for data sharing, reporting and analytics with clearly defined accountabilities and deliverables, and develop a methodology for the distribution of shared savings under the terms of the agreement amongst participating clinical partners as outlined in the SAM Council Charter.

B. The Parties understand that primary responsibility for producing population health analytics belongs to the party that maintains that data set. For example, CareOregon, using its population health analytics platform, will provide Member eligibility, claims and other medical expense data. Provider will continue to provide and support additional data needs related to Electronic Health Record (EHR) content and other provider-specific data. For the avoidance of doubt, CareOregon's obligation to share data related to fee or price information shall be limited to the State's standard fee schedule.

C. Both Parties agree to work cooperatively in developing a multi-year agreement to continue this shared risk arrangement with an intent to move from initial sharing of gains to sharing of both upside and downside risk, subject to the terms of Federal 330 funding if applicable. No downside risk arrangement between the Parties shall take effect without execution of a mutually agreed upon and fully executed Amendment.

D. Both Parties agree to continue working together 2023-2025 in good faith to evaluate annually and adjust the risk model and resulting payout amounts and to appropriately account for unexpected and material changes outside of the intent of the model that impact either the upside or downside shared risk amounts. Measures and targets will be decided jointly by both SAM participating providers and CareOregon. Quality metrics will be determined no later than January 31st of each program year, and improvement targets will be determined by April 15th of each program year. Any material changes to the risk model, quality requirements, and payout amounts must be approved via recorded vote by the Oversight Council, subject to the terms outlined in Section IV.A of this Amendment.

E. Both Parties agree transparency and open sharing of information and data are key to meeting the overall purpose and specific objectives of this arrangement. If CareOregon fails to provide an updated Dashboard within 60 days of the end of any performance month, then CareOregon will waive the quality gate to the shared savings calculation for the performance year in which such failure occurred.

V. TERM, TERMINATION.

A. TERM.

This Amendment shall be effective as of July 1, 2023 ("Effective Date") and shall continue until December 31, 2025, unless earlier terminated in accordance with this Section **V.** Notwithstanding the amendment provisions in the Provider Agreement, revisions to this Amendment will be made in writing by mutual agreement of both Parties.

B. TERMINATION.

i. This may be terminated immediately by CareOregon in the event:

(a) The Provider Agreement terminates for any reason;

(b) Provider defaults in the performance of any duties or obligations stated in this Amendment or upon reasonable belief that Provider is unable to perform its responsibilities in a competent manner; or

(c) Provider, its employee, agent, provider, or any other representative of Provider engages in fraud, dishonesty, or personal conduct that may harm the business and/or reputation of CareOregon, or if continuing this Amendment would violate state or federal law.

ii. In the event of termination under the terms of (b) or (c) above, Provider shall have no right to payment under this Amendment for any services not yet rendered, and any payment obligation by CareOregon as contemplated hereunder shall terminate except as to work performed through the date of termination.

iii. The Provider may terminate this agreement if: (a) CareOregon defaults in the performance of any of its material duties or obligations stated in this or upon reasonable belief that CareOregon is unable to perform its responsibilities in a competent manner; (b) Provider fails to receive funding appropriations or other expenditure authority as determined by Provider; or (c) CareOregon, its employee, agent, provider, or any other representative of CareOregon engages in fraud, dishonesty, or personal conduct that may harm the business and/or reputation of Provider, or if continuing this Agreement would violate state or federal law.

VI. CONFIDENTIALITY AND MARKETING.

A. Under HIPAA, CareOregon and Provider are considered Covered Entities ("CE") and each will comply with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (the "HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("HIPAA Regulations"), and other applicable federal and state privacy and security laws and regulations such as 42 CFR Part 2. The Parties agree to cooperate in accordance with the terms and intent of this for implementation of relevant law(s) and/or regulation(s) promulgated under HIPAA Regulations. The Parties further agree to be in compliance with the requirements of HIPAA Regulations and 42 CFR Part 2 and the laws and regulations promulgated subsequent hereto and as amended.

B. The Parties agree that this Amendment and all negotiations and related documentation will remain confidential and that no press, news releases, other publicity release, or any other

external communication concerning this Amendment and the obligations contemplated herein will be issued without providing a copy of the communication to the other Party and receiving the other Party's prior written approval, unless applicable law requires such disclosure. If the Party is subject to the Oregon Public Records Law, CareOregon acknowledges that all negotiations and related documentation may be considered to be public information, with the exception of pricing data which will remain confidential. In addition, the Parties agree that they must obtain written permission prior to using another Party's name, trade name, image, symbol, design, or trademark in any marketing, advertising, or promotional campaign in any medium or manner. Email approval will suffice as written approval for purposes of this provision only.

VII. DATA SHARING.

A. In furtherance of the objectives of this Amendment Provider and CareOregon agree to share all necessary data for the treatment, processing of claims and proper care coordination of Members in compliance with applicable HIPAA Regulations, 42 CFR Part 2, and State law and regulation (collectively the "Privacy Laws"). The Member data outlined in the SAM Guide is information that may be disclosed between the Parties as authorized under the applicable Privacy Laws, but to the extent the Parties deem that Member consent is required under such Privacy Laws, Provider and CareOregon shall cooperate to procure properly executed consent forms. CareOregon certifies that any such data received from Provider will be kept secure and in compliance with applicable Privacy Laws. Provider acknowledges and agrees that any financial data received from CareOregon remains the sole property of CareOregon and Provider is not entitled to use, access, or disclose such data except as expressly permitted in the SAM Guide.

VIII. GENERAL PROVISIONS.

A. CONTINUING COOPERATION. Throughout the term of this Amendment the Parties shall cooperate in good faith and agree to perform any and all tasks which are reasonably necessary for the performance of this Amendment.

B. ADMINISTRATION/INTERPRETATION OF AGREEMENT. The Parties agree and understand that this Amendment is supplemental to the Provider Agreement. Nothing in this Amendment may be construed to waive any of the obligations or other commitments Provider or CareOregon have made pursuant to either the Provider Agreement, the CCO Contract, or any instruments executed pursuant to, or in connection with, the CCO Contract. Thus, the Parties acknowledge and agree that this Amendment 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 Amendment includes provisions that are applicable, all Policies shall be consistent with the Provider Agreement.

C. COMPLIANCE WITH LAW. The Parties shall observe and comply with all applicable local, state and federal laws, ordinances, rules and regulations now in effect or hereafter enacted, each of which is hereby made a part hereof and incorporated herein by reference.

D. AMENDMENT/ASSIGNMENT. No alteration and/or amendment of any terms or conditions of this Amendment shall be binding, unless reduced to writing and signed by the Parties hereto. The Parties agree to take such action as is necessary to amend this Amendment from time to time as is necessary for the Parties to comply with law, regulation, and directives from regulatory agencies. Provider may not assign, delegate or otherwise transfer this Amendment, in whole or in part, without the prior written consent of CareOregon. CareOregon may assign, delegate or otherwise transfer this Amendment, in whole or in part, to any of its affiliates or to the purchaser of the assets or successor to the operations of CareOregon or its affiliates.

E. REPRESENTATIONS AND WARRANTIES. By signing this Amendment, Provider expressly represents and warrants it is eligible to participate in, and receive payment pursuant to, this Amendment In so doing, Provider certifies neither it nor its employees, agents, or representatives are: (1) placed on the Tier Monitoring System by a Peer Review Committee; (2) have documented contract and/or compliance issues; or (3) are presently declared ineligible or voluntarily excluded from entering into this Amendment by any federal or state department or agency. Should it be determined that Provider was ineligible to receive payments pursuant to this Amendment, Provider expressly agrees to promptly repay all such payments disbursed to it under this Amendment and all funding associated with this Amendment will be discontinued until Provider is removed from the Tier Monitoring System or has resolved compliance issue(s) to CareOregon's satisfaction. Any discontinued funding that has been withheld will not be disbursed.

F. COUNTERPARTS/SIGNATURE. This Amendment may be executed in separate counterparts, each of which shall be deemed an original, and all of which shall be deemed one and the same instrument. The Parties' faxed signatures, and/or signatures scanned into PDF format, shall be effective to bind the Parties to this Amendment.

G. COMPLIANCE WITH OREGON LAW. This clause is applicable only to those Providers who are public entities. This Amendment is expressly subject to the debt limitation of Oregon Counties in Article XI, Section 10 of the Oregon Constitution, and contingent upon funds being appropriated thereto.

H. NOTICES. Unless expressly provided otherwise, all notices herein provided to be given, or which may be given, by any Party to the other, will be deemed to have been fully given when written and personally delivered or deposited in the United States mail, certified and postage prepaid and addressed as follows:

TO CareOregon:
Attention: Chief Financial Officer
CareOregon, Inc
315 SW Fifth Avenue
Portland, OR 97204

TO Clackamas County:
Attention: Administrator
Clackamas County
2051 Kaen Road
Oregon City, OR 97045

EXHIBIT A
CAREOREGON DATA SECURITY REQUIREMENTS

1. CareOregon Data. CareOregon Data is defined as all confidential and proprietary business information including but not limited to contract terms, business relationships, potential collaborations, trade secrets, payor lists, Personal Information (as defined in ORS 646A.602(12)), Protected Health Information (as defined in 45 C.F.R § 160.103), information considered confidential and restricted under other Oregon State and Federal laws, databases, strategic and financial information and other business information, the unauthorized disclosure or use of which will be highly injurious to CareOregon and its business and its relationships in amounts not readily ascertainable.

2. Security Program. With respect to information systems and networks under their respective ownership or control that are used to receive, process, store or transmit CareOregon data, Provider agrees to at all times maintain a well-documented security program that conforms to generally recognized industry standards, employ the use of at least one recognized security framework for its operations, and abide by all applicable laws or regulations. The security program shall include reasonable and appropriate administrative, technical, and physical measures to preserve the confidentiality, integrity, and accessibility of CareOregon Data or Provider data, as applicable. The security program must at a minimum include

a. Oversight and management of technologies used to protect CareOregon Data,
b. Proactive identification and addressing of vulnerabilities,
c. Periodic testing of security controls, and
d. Detection of and response to security events.

3. Backup and Retrieval. Provider shall be responsible for the commercially reasonable and prudent infrastructure and maintenance of the infrastructure to provide the herein described work. This includes, but is not limited to database backups, application backups, OS patches and upgrades, database patches and upgrades, power supply, network security, etc.

4. Audits. Each Party agrees to conduct third-party HIPAA audits every two years. A Party may elect to provide the other party with evidence of contemporaneous HITRUST certification in lieu of conducting a HIPAA audit. Upon a Party's request, the other Party shall provide an executive summary of its most recent HIPAA audit results together with a plan of action and milestones for remediation of identified deficiencies or vulnerabilities, if any.

Notwithstanding the foregoing, at any time during the term of the Amendment CareOregon may request that Provider perform an audit of the security of Provider's systems used to store, transmit and/or otherwise process CareOregon Data. The expense of any such audit made at the request of CareOregon when Provider has chosen to provide evidence of contemporaneous HITRUST certification in lieu of conducting a HIPAA audit, in accordance with the terms of this Section 4 or when such request by CareOregon falls within an interval less than two years from Provider's latest audit shall be borne by CareOregon. Any audit request by CareOregon must be completed by Provider in a timely manner not exceeding 45 calendar days from the date of such request. Provider may request an extension to the deadline of 45 calendar days, which request will not be unreasonably denied by CareOregon.

The Party subject to audit agrees to respond to all reasonable requests for documentation in the execution of that audit, such as security program documentation, system security plans (SSP), architectural or technical diagrams, security policies and procedures, internal risk assessments and, to the extent not subject to legal privilege, other security audits and/or assessments. The Party subject to audit shall be entitled to receive a copy of the auditor's draft report, including without limitation findings and recommended corrective actions, if any. The Party subject to audit agrees to review, respond and, where applicable, to remediate per the findings in the auditor's draft report in good faith, and the auditor shall take into account the audit subject's responses and any remediation efforts in its final report.

5. Data Security. Provider agrees to preserve the confidentiality, integrity, and accessibility of CareOregon Data with administrative, technical, and physical measures that conform to generally recognized industry standards and best practices. Maintenance of a secure processing environment includes but is not limited to the timely application of patches, fixes, and updates to operating systems and applications as provided by software vendor or open-source software support.

6. Data Storage. Provider agrees that any and all CareOregon Data will be stored, processed, and maintained solely on designated target servers in accordance with "Data Location" below. CareOregon Data must be encrypted while at rest, and in accordance with "Data Encryption Standard" below. Unless agreed to in writing, at no time will CareOregon Data be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with "Data Encryption Standard" below.

7. Data Location. Unless approved in advance by CareOregon, the Provider will limit the storage and transmission of CareOregon Data to data centers and network paths physically located in the continental United States. This includes the Provider's own data center assets and any third party or subcontracted "cloud" services used by the Provider to provide services to CareOregon.

8. Data Encryption Standard. Provider agrees to encrypt all CareOregon Data regardless of location using commercially supported encryption solutions. Provider agrees that all designated backup and recovery processes maintains data in encrypted form, including on recovery media. The Provider shall ensure physical storage encryption modules are consistent with FIPS 140-2 "Security Requirements for Cryptographic Modules". Encryption algorithms will meet or exceed the standards defined in NIST SP 800-57 Part 3 "Recommended Key Sizes and Algorithms" and at a minimum will be deployed with no less than a 256-bit key length for symmetric encryption and a 2048-bit key length for asymmetric encryption.

9. Data Transmission. Provider agrees that any and all electronic transmission of CareOregon Data, unless initiated by CareOregon, shall be transmitted in an encrypted state using encryption per Data Encryption Standard above, and take place solely in accordance with "Data Re-Use" below.

10. Data Re-Use. Provider agrees that data exchanged shall be used expressly and solely for the purposes enumerated in this Amendment. Data shall not be distributed, repurposed, or shared across other applications, environment, or business units of Provider, except as required by Provider to

support patient care and the SAM. Provider further agrees that no CareOregon Data of any kind shall be transmitted, exchanged, or otherwise passed to other providers or interested parties except on a case-by-case basis as specifically agreed to in writhing by CareOregon, unless the disclosure is related to compliance with the Interoperability and Patient Access final rule.

11. Non-disclosure and Separation of Duties. The Provider shall enforce separation of job duties, require commercially reasonable non-disclosure agreements, and limit staff knowledge of CareOregon Data to that which is absolutely necessary to perform job duties.

12. Data Breach. The Parties agree to shall provide notice, either orally or in writing, of any known, actual, or suspected compromise of the security, confidentiality, or integrity of CareOregon Data ("Data Breach"). Such notice shall be made as promptly as possible under the circumstances and without unreasonable delay, but in no event more than five (5) business days after the Party reasonably believes there has been a Data Breach. The Parties shall use commercially reasonable efforts to contain such Data Breach and provide the other Party with a detailed report that includes: (i) the nature of the unauthorized use or disclosure, (ii) the CareOregon Data used or disclosed, (iii) who made the unauthorized use ~~or~~ and who received the unauthorized disclosure, (iv) what the Party has done or shall do to mitigate any deleterious effect of the unauthorized use or disclosure, and (v) what corrective action the Party has taken or shall take to prevent future similar unauthorized use or disclosure. The Party shall provide the other Party with all reasonably available information regarding such Data Breach and provide supplemental information as it is discovered.

The Party may need to communicate with outside parties regarding a Data Breach, which may include contacting law enforcement, fielding media inquiries and seeking external expertise as mutually agreed upon, defined by law or contained in the Amendment. Discussing Data Breaches with the other Party should be handled on an urgent as-needed basis, and as part of the Party's communication and mitigation processes as mutually agreed upon, defined by law, or contained in the Amendment.

The Party shall (1) cooperate with the other Party as reasonably requested to investigate and resolve the Data Breach, (2) promptly implement necessary remedial measures, if necessary, and (3) document responsive actions taken related to the Data Breach, including any post-incident review of events and actions taken to make changes in business practices in providing the work, if necessary.

Unless otherwise stipulated, if a Data Breach is a direct result of the other Party's breach of its contractual obligation to encrypt personal data or otherwise prevent its release as reasonably determined by the other Party, the Party shall bear the costs associated with (1) the investigation and resolution of the Data Breach; (2) notifications to individuals, regulators or others required by federal and state laws or as otherwise agreed to; (3) a credit monitoring service required by state (or federal) law or as otherwise agreed to; (4) a website or a toll-free number and call center for affected individuals required by federal and state laws - all not to exceed the average per record per person cost calculated for data breaches in the United States in the most recent Cost of Data Breach Study: Global Analysis (published by the Ponemon Institute) at the time of the Data Breach; and (5) complete all corrective actions as reasonably determined based on root cause.

13. Damages. Notwithstanding any other provision in this Amendment Provider shall indemnify, hold harmless, and defend CareOregon from and against any and all costs (including, without limitation, mailing, labor, administrative costs, and vendor charges), fines, liabilities, and corrective action (including, without limitation, notification costs, forensics, credit monitoring services, call center services, identity theft protection services, and crisis management/public relations services) arising out of a Data Breach that is caused by the Provider.

14. Rights to Data. Provider and CareOregon agree that as between them, all rights, including all intellectual property rights, in and to CareOregon Data shall remain the exclusive property of CareOregon, and Provider has a limited, non-exclusive license to access and use CareOregon Data as provided to Provider solely for performing its obligations under the Amendment. Nothing herein shall be construed to confer any license or rights.

15. End of Amendment Data Handling. Provider agrees that upon termination of the Amendment, it shall erase, destroy, and render unrecoverable all CareOregon Data, and certify in writing that these actions have been completed within thirty (30) days of the termination of the Amendment or within seven (7) days of the request of the CareOregon contract administrator, whichever comes first. At a minimum, a "Clear" media sanitation is to be performed according to the standards enumerated by the National Institute of Standards, Guidelines for Media Sanitation, SP800-88, Appendix A (csrc.nist.gov). For those Providers who are a public entity, all end- of-Amendment data handling is subject to record retention requirements.

16. Subcontractors. Provider shall require that all subcontractors and other service providers with access to CareOregon Data comply with the CareOregon Data Security Requirements herein. Upon request by CareOregon, Provider shall disclose to CareOregon the identities of all subcontractors and other service providers that have access to CareOregon Data.

17. Legally Required Disclosures. If Provider is required to disclose CareOregon Data pursuant to the order of a court or administrative body of competent jurisdiction or a government agency, Provider shall: (i) if practicable and permitted by law, notify CareOregon prior to such disclosure, and as soon as possible after such order; (ii) cooperate with CareOregon (at CareOregon's costs and expense) in the event that CareOregon elects to legally contest, request confidential treatment, or otherwise attempt to avoid or limit such disclosure; and (iii) limit such disclosure to the extent legally permissible.

18. Provider shall provide to CareOregon relevant contact information for a Provider's employee who CareOregon may contact any time should any security related questions, or concerns arise.

CareOregon

Shared Accountability Model Program Guide

A resource guide for providers

Table of Contents

ABOUT THIS GUIDE

CareOregon is committed to ensuring providers have the tools and resources necessary to help best serve our Members.

We created this Guide to help our partners understand the Shared Accountability Model (SAM) and ensure successful delivery of health care services to Members.

CareOregon will update this guide from time to time to reflect changes in the Shared Accountability Model. Changes related to data-sharing, participating providers, new definitions or acronyms, updates to the FAQ, or other updates needed to keep the information in the Guide current will be identified in a Change Log and shared with Participating Providers. Changes to content that is within the scope of the SAM Oversight Council, such as updates to quality, access, or engagement measures, targets, or incentives, changes to shared savings allocation, changes to the total cost of care model or model implementation, or governance changes, will only be updated upon approval by the SAM Oversight Council.

Guide Components

- Vision / Goals / Commitments
- SAM governance structure
- Oversight council roles and responsibilities
- Definitions
- Model Overview
- Assignment
- Payments Grid
- Key Data
- Calculation Methodology

Shared Accountability Model Participating Providers – 2022-2025

- Cascadia Behavioral Healthcare
- Central City Concern
- Clackamas County Health Department
- La Clinica del Valle (non-financial participant)
- Multnomah County Health Department
- Native American Rehabilitation Association
- Neighborhood Health Center
- Outside In
- Rogue Community Health (non-financial participant)
- Virginia Garcia Memorial Health Center
- Wallace
- Yakima Valley Farm Workers (non-financial participant)

SAM VISION, GOALS AND COMMITMENTS

Shared Goals

- Build shared ownership and accountability among partners and CareOregon for member health at the provider and community level
- Encourage service redesign and practice transformation to reduce health disparities, promote health equity, support integration, and meet the needs of the whole population
- Increase partners' clinical, technical, and administrative ability to perform well under the Total Cost of Care (TCOC) model and share in the savings generated
- Align partners' financial incentives around cost, access, utilization, quality, and member experience
- Incent and support provider organizations and community partner organizations in working together to improve quality care and reduce avoidable costs and utilization
- Supports CCOs' commitments to implement value-based payment arrangements and further the goals of CCO 2.0
- Share meaningful data that will support providers' successful participation in the Total Cost of Care model
- Create a learning collaborative.

Provider Commitments

- Engage in planning and development of utilization, quality, member engagement, and community health improvement activities that seek to improve members overall health and address their changing needs, including Social Determinants of Health (SDOH).
- Agrees to share with CareOregon member-level information from its operational and analytic systems such as Electronic Health Record (EHR), data warehouses, operational stores and other agreed upon sources to support care management, quality improvement, access, member experience, patient reported outcomes, and cost efficiency efforts as related to this shared risk population in a mutually agreed upon format.
- Demonstrate a commitment to Health Equity.
- Demonstrate commitment to meeting state and national quality and member experience benchmarks and improving health indicators for all populations of interest.
- Provide reasonable and timely access to members and openness to new members.
- Where clinically appropriate, refer members within participating providers and services.
- Participate in shared rewards or penalties on shared goals.
- Commit to operational efficiency and sustainability.
- Provide timely and accurate documentation and coding of member diagnoses to inform treatment.
- Disclose conflicts of interests.

CareOregon and Providers will work to develop mutually agreeable metrics for these commitments through the SAM Oversight Council.

CareOregon Commitments

- CareOregon agrees to calculate the annual PMPM cost based on claims history and off lag medical expenses for comparison to the target PMPM as outlined in the SAM Shared Savings Calculation Methodology section.
- CareOregon agrees that payment made pursuant to the Shared Accountability Model described herein will not be lower than the payment amount Provider would have received under a Prospective Payment System (PPS Amount). As such, any downside risk assumed by the Provider pursuant to the Shared Accountability Model will not result in a payment amount that is lower than the PPS Amount.
- CareOregon agrees to work collaboratively with provider partners when data sharing is necessary to assist in the assessment of model performance or during evaluation of potential model changes. Details of data sharing are outlined in the Key data/reporting that will be shared section.
- CareOregon agrees to allocate funding for Shared Savings distribution by June 30th of each year following claims run out for the previous Calendar Year.

SAM GOVERNANCE STRUCTURE

The Shared Accountability Model is governed by an Oversight Council. The membership structure and role/responsibilities of the Oversight Council are outlined below. The SAM Charter is included in the Appendix to this Guide.

Membership

- Committee chair – CareOregon appointed staff for Year 1, then open to other members
- One representative (or proxy) from each participating provider group – 12 invited
- One CareOregon leader
- No compensation for Oversight Council members or chair
- Attendance by representative or proxy is an expectation of participation
- CareOregon's Chief Financial Officer is the executive sponsor from CareOregon
- Support for the SAM Oversight Council will be provided by CareOregon teams including provider contracting, regional leadership, legal counsel, compliance, quality, financial, medical directors, and information services
- Community Health Center Network of Oregon (CHCNO) will also support the SAM Oversight Council

Role and Responsibilities

- Goal is consensus decisions, majority vote decides, proxy voting is acceptable with prior notice
- All contractually participating members have voting rights, the chair only votes in the event of a tie
- Committee's work is confidential and only discussed among and within participating organizations

Oversight Council Scope

Area	Role	Frequency
Quality, Access and Engagement Measures, Targets, and Incentive Structure: Using health equity lens - • Review and recommend proposed measures • Review and recommend the method for setting performance thresholds • Recommend performance targets for suggested measures • Review and recommend proposed measurement incentive structure (e.g., regional level, clinic level, individual level, specialty level, etc.)	Approve	Annually
Total Cost of Care Measures, Targets, and Incentive Structure: • Review proposed measures and shared savings methods and targets	Approve	Annually
Shared Savings Distribution: • Evaluate and define how the gain/loss is distributed across participants using quality and engagement performance, member service measures, and Total Cost of Care performance.	Approve	Annually

• Define member service measures for Shared Savings Distribution (e.g., total panel size, engaged panel size, risk-adjusted membership, etc.)		
Structural Changes to Total Cost of Care Model: • Evaluate and recommend structural changes to model • Evaluate and recommend structural changes by practice	Recommends	Annually
Model Implementation: • Consults on the implementation of the payment model across all participating clinics • Consults on model parameters (e.g., risk adjustment, member mix adjustment, large claims adjustment, etc.) • Advises data and reporting package from CareOregon • Provides ongoing feedback about enhancements	Consults	Ongoing
Governance Changes: • Recommends changes to membership, roles and responsibilities of the committee, and other relevant governance considerations. Due to the financial considerations involved, CareOregon must agree to all changes in roles and responsibilities.	Recommends	Ongoing

Out of Scope

- Payment methods within the clinics and/or medical groups participating in the model
- Payment methods under payer contracts where CareOregon doesn't contract for risk
- Clinician performance management
- Boundaries of the geographies that define the regions and attribution methods for members selected into those regions
- Determining total eligible budget for shared savings

DEFINITIONS OF KEY TERMINOLOGY

We understand initiatives like the Shared Accountability Model mean new acronyms and terminology. This definitions section is a reference for some of those terms you will find throughout this Guide.

Key Terms

CCO 2.0: the second round of Oregon's managed care contracting program for Medicaid. CCO 2.0 contracts run from January 1, 2020 through December 31, 2024.

Downside Risk: the risk event applicable when the actual cost PMPM rate exceeds the target cost PMPM.

Incurred but Not Reported (IBNR): IBNR is a type of reserve account used in the insurance industry as the provision for claims that have transpired but have not yet been reported to an insurance company.

Off-lag: Off-Lag expenses represent medical expenses that are not paid through the claims system. The name off-lag comes from the fact that they are not "lagged" costs when calculating lag factors for Incurred but Not Reported (IBNR) estimates. IBNR estimates are required by health plans to estimate expenses for claims where the service has been rendered by a provider, but the claim has not yet been received or processed by the health plan.

Upside Risk: the risk event applicable when the actual cost Per Member Per Month (PMPM) is less than the target cost PMPM.

Acronyms

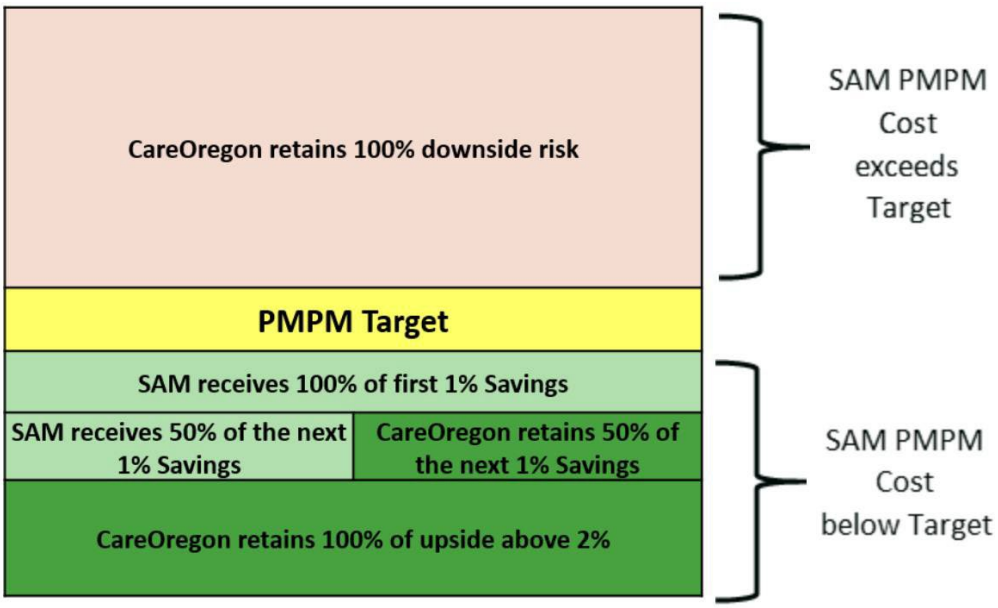
- **CCO:** Coordinated Care Organization
- **CDPS:** Chronic Illness & Disability Payment System
- **CHCNO:** Community Health Center Network of Oregon
- **EHR:** Electronic Health Record
- **FFS:** Fee for Service
- **HSO:** Health Share of Oregon
- **IBNR:** Incurred but Not Reported
- **NDC:** National Drug Code
- **OHA:** Oregon Health Authority
- **PCP:** Primary Care Provider
- **PCPCH:** Patient-Centered Primary Care Home
- **PCPM:** Primary Care Payment Model
- **PMPM:** Per Member Per Month
- **SAM:** Shared Accountability Model
- **SDOH:** Social Determinants of Health
- **TCOC:** Total Cost of Care
- **YTD:** Year-to-Date

MODEL OVERVIEW

The Shared Accountability Model (SAM) is a Total Cost of Care (TCOC) arrangement. The goal of the model is to measure all costs for a population compared to a specified target.

- The measurement and target are set on a Per Member Per Month (PMPM) basis, meaning that they scale to the size of the population.
- The model specifies which benefits, members, and costs are included in the model and which are excluded, this is outlined in the SAM Shared Savings Calculation Methodology section. This section also lays out the methodology for developing the cost target for a given year.
- Each region participating in the model has a single shared cost target for all participating clinics. Participating clinics and regions are outlined in the Shared Accountability Model Participating Providers section.
- If costs in a year are below the cost target this results in an Upside Risk event and participating clinics are entitled to shared savings as described in the Risk Sharing Model Illustration. If costs in a year are above the target this results in a Downside Risk event and participating clinics participate in shared losses. In 2022 and 2023 there is no Downside Risk for participating clinics.

Risk Sharing Model Illustration—2022 and 2023



Notes:

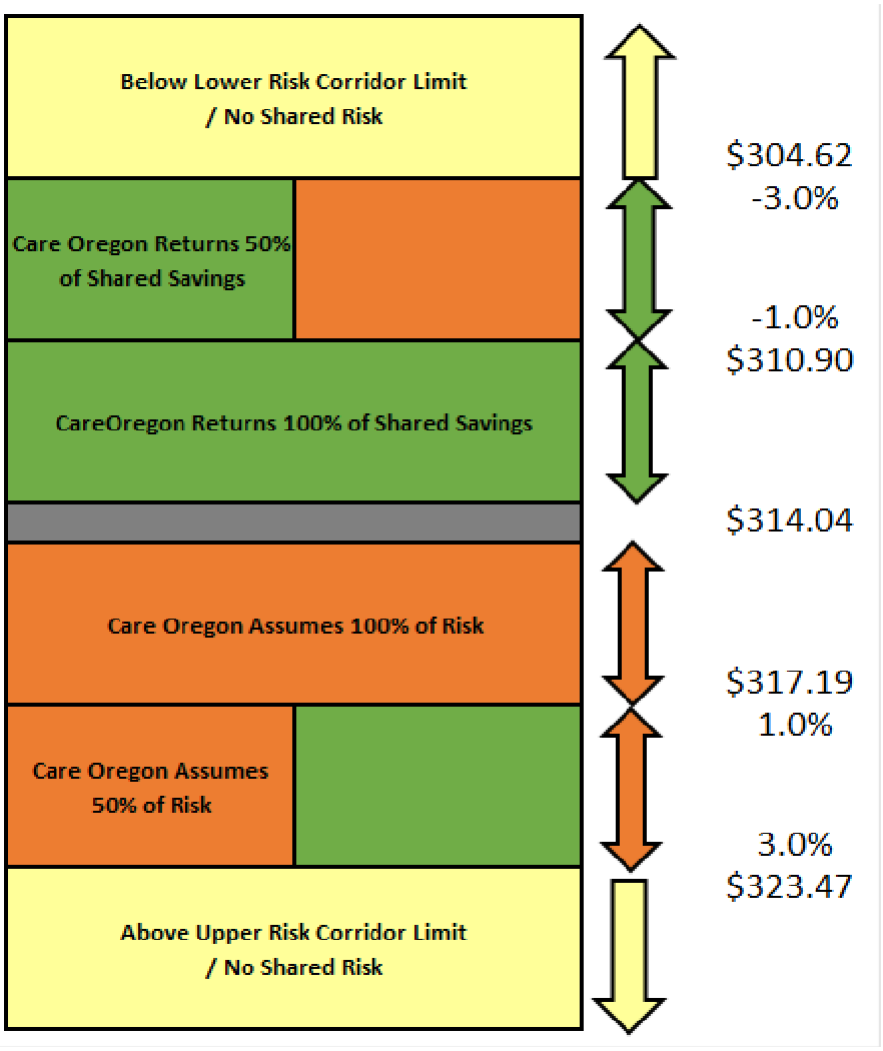
- Upside Only savings for 2022 and 2023
- Providers receive 100% of 1st 1% of Savings and 50% of 2nd 1% of Savings
- For FQHCs this would be considered a Bonus/Incentive payment

Financial Impact Illustration-2023

Item	Quality Metric Met	Quality Metric Not Met
Shared Savings [a]	$5,000,000	$5,000,000
Quality Gate Percent [b]	25%	25%
Guaranteed Amount [c] = [a] * (1- [b])	$3,750,000	$3,750,000
Quality Score [d]	Met	Not Met
Quality Adjusted Shared Savings [e] = [c] + [d] * ([a] - [c])	**$5,000,000**	**$3,750,000**

- A negotiated portion of the savings would be held to a 25% quality gate
- The updated shared savings in the example above would be $5.0m or $3.75m depending on quality
- Quality metric(s) to be voted on by SAM oversight council

Risk Sharing Model Illustration—2024



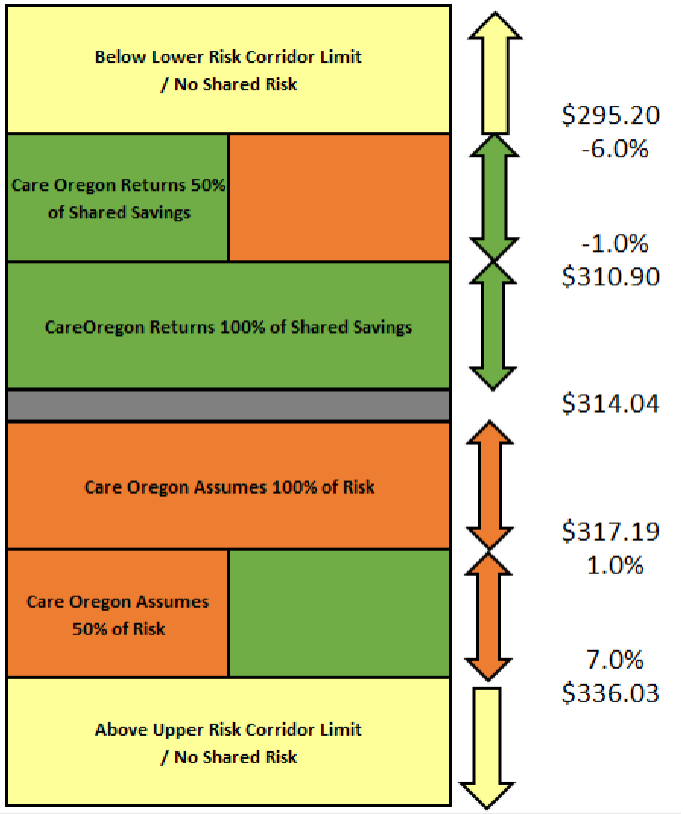
Financial Impact Illustration-2024

Item	Upside	Downside	Upside	Downside
Shared Savings (Loss) [a]	$6,800,000	($3,400,000)	$6,800,000	($3,400,000)
Quality Gate Percent [b]	25%	25%	25%	25%
Guaranteed Amount [c] = [a] * (1 - [b])	$5,100,000	($2,550,000)	$5,100,000	($2,550,000)
Quality Score [d]	**Met**	**Met**	**Not Met**	**Not Met**
Quality Adjusted Shared Savings [e] = [c] + [d] * ([a] - [c])	**$6,800,000**		**$5,100,000**	
Quality Adjusted Shared Deficit [f] = [c] + (1 - [d]) * ([a] - [c])		**($2,550,000)**		**($3,400,000)**

- A negotiated portion of the savings would be held to a 25% quality gate
- The updated shared savings in the example above would be $6.8m or $5.1m depending on quality
- The updated shared loss in the example above would be $2.55m or $3.4m depending on quality

- Quality metric(s) to be voted on by SAM oversight council

Risk Model Illustration-2025



Financial Impact Illustration-2025

Item	Upside	Downside	Upside	Downside
Shared Savings (Loss) [a]	$11,900,000	($10,200,000)	$11,900,000	($10,200,000)
Quality Gate Percent [b]	25%	25%	25%	25%
Guaranteed Amount [c] = [a] * (1 - [b])	$8,925,000	($7,650,000)	$8,925,000	($7,650,000)
Quality Score [d]	**Met**	**Met**	**Not Met**	**Not Met**
Quality Adjusted Shared Savings [e] = [c] + [d] * ([a] - [c])	**$11,900,000**		**$8,925,000**	
Quality Adjusted Shared Deficit [e] = [c] + (1 - [d]) * ([a] - [c])		**($7,650,000)**		**($10,200,000)**

- A negotiated portion of the savings would be held to a quality gate
- The updated shared savings in the example above would be $11.9m or $8.925m depending on quality

- The updated shared loss in the example above would be $7.65m or $10.2m depending on quality
- Quality metric(s) to be voted on by SAM oversight council

DETAILS OF ASSIGNMENT METHODOLOGY

CareOregon has specific processes to ensure that members have access to a designated Primary Care Provider/Clinic (PCP). PCPs are automatically assigned when the member enrolls with CareOregon. CareOregon members are assigned to PCP clinics or offices. Members are not assigned to individual practitioners unless the practitioner has a solo practice.

The auto-assignment process runs daily and only attempts to assign a PCP clinic for those members that are currently unassigned. This process assigns members to PCPs based on a variety of factors including:

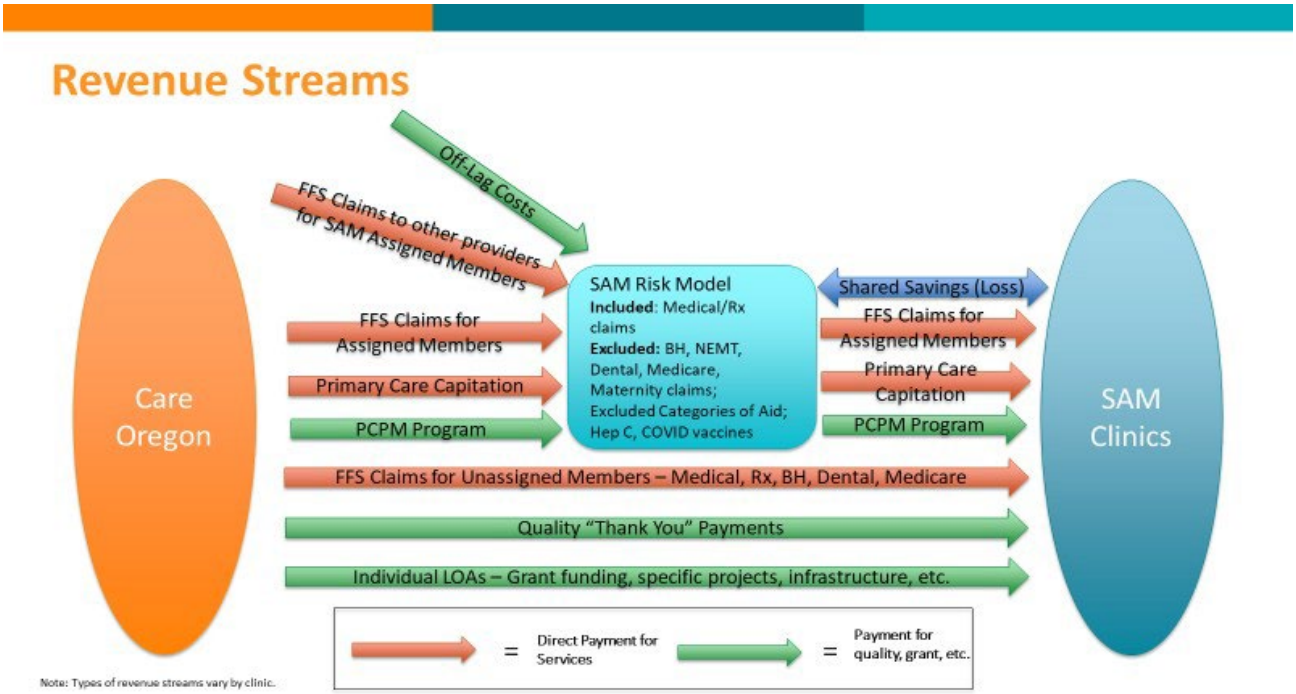
- Member address/region
- Gender
- Age
- Family assignments (based on Guardian ID)
- PCP clinic capacity
- Member discharge history

Members that were not previously assigned to a PCP clinic under the Oregon Health Plan and that do not currently have family members assigned to a nearby clinic, are randomly assigned to a clinic within their geographic area that meet their demographic needs and are accepting new members. CareOregon applies Preferential Assignment to assign a larger proportion of members to preferred clinics that demonstrate positive health outcomes.

PAYMENT PATHWAYS: CONTINUING PAYMENT STREAMS; FFS, PCPM, QUALITY POOL

The illustration below highlights current revenue streams and how they will interact or not interact with the Shared Savings calculation.

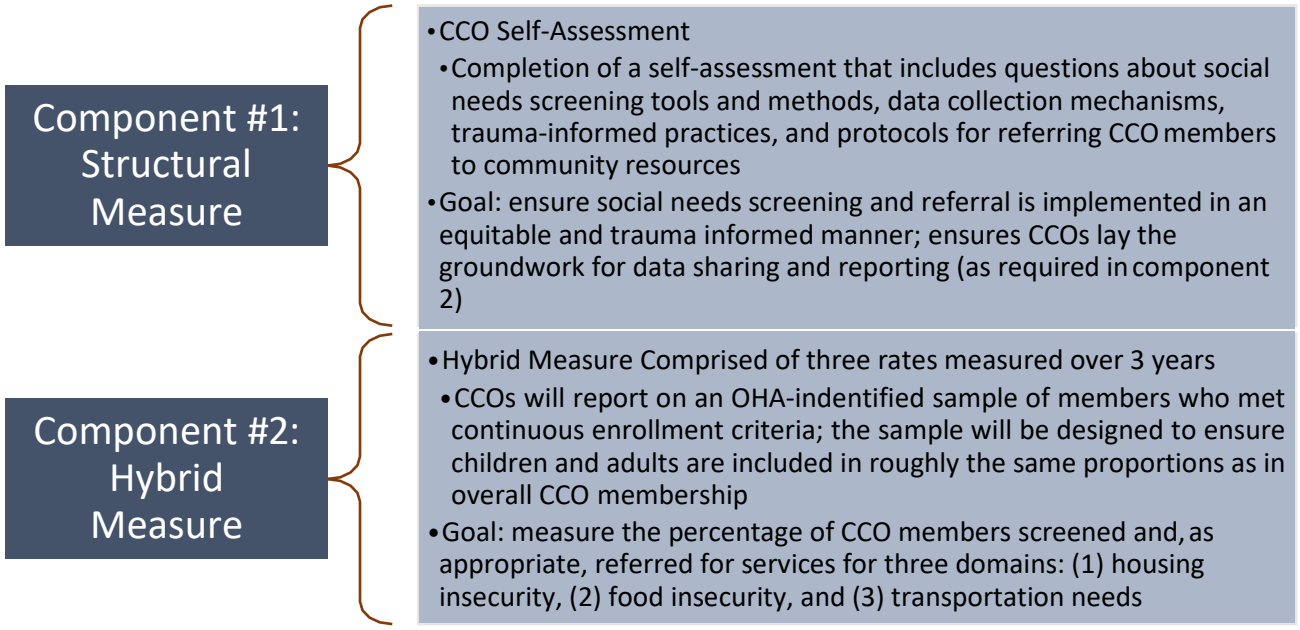
All current revenue streams will continue for 2023. In addition to current payments, clinics will also be eligible to earn Shared Savings for 2023.



QUALITY METRIC OVERVIEW

For contract year 2023, the SAM model will introduce a quality gate. A quality gate is a *threshold level on one or more quality measures that a clinician must meet in order to receive a supplemental payment, such as a Shared Savings Payment*[1]. The SAM program will be introducing a quality gate to access the potential upside shared savings in 2023. The gate described above will be operationalized through a single quality measure that is aligned with the OHA Social Needs Screening and Referral Measure. This new upstream measure was developed in recognition of the *profound impact social factors like income, environmental conditions, and racism have on a person's health. The goal of the Social Needs Screening and Referral Measure is that CCO members have their social needs acknowledged and addressed*[2].

The Social Needs Screening and Referral Measure is comprised of two components:



The measure is set up as a glide path that builds upon itself year over year. The yearly requirements are outlined in the table 1 and 2 below.

Table 1. Must-Pass Elements for Component 1, by Measurement Year (MY)

	Elements of work to be accomplished	MY1 (2023)	MY 2 (2024)	MY 3 (2025)
A. Screening Practices				
1.	Collaborate with CCO members on processes and policies	Must pass	Must Pass	Must Pass
2.	Establish written policies on training	Must pass	Must Pass	Must Pass
3.	Assess whether/where members are screened	Must pass	Must Pass	Must Pass
4.	Assess training of staff who conduct screening		Must Pass	Must Pass
5.	Establish written policies to use REALD data to inform appropriate screening and referrals	Must pass	Must Pass	Must Pass
6.	Identify screening tools or screening questions in use	Must pass	Must Pass	Must Pass
7.	Assess whether OHA-approved screening tools are used		Must Pass	Must Pass
8.	Establish written protocols to prevent over-screening	Must pass	Must Pass	Must Pass
B. Referral Practices and Resources				
9.	Assess capacity of referral resources and gap areas	Must pass	Must Pass	Must Pass
10.	Establish written procedures to refer members to services		Must Pass	Must Pass

11.	Develop written plan to help increase community-based organization (CBO) capacity in service area		Must Pass	Must Pass
12.	Enter into agreement with at least one CBO that provides services in each of the 3 domains	Must pass	Must Pass	Must Pass
C. Data Collection and Sharing				
13.	Conduct environmental scan of data systems used in your service area	Must pass	Must Pass	Must Pass
14.	Set up data systems to clean and use REALD data		Must Pass	Must Pass
15.	Support a data-sharing approach within the CCO service area		Must Pass	Must Pass

Table 2. Must-Pass Elements for Component 2, by Measurement Year (MY)

Rate #	Description	Applicable MY	Notes
1	Percentage of CCO members from OHA-identified sample who were screened for each of the three required domains at least once during the measurement year	MY 2 (2024)	
2	Of the sample population screened, the percentage of CCO members with a positive screen for any of the three required domains	MY 2 (2024)	Performance on rate 2 will not be benchmarked, it's intended to capture prevalence in the CCO
3	Of the sample population with an identified need, those who received at least one referral	MY 3 (2025)	Measures referrals made, not closed loop referrals

SAM Quality Measure Details

For SAM contract year 2023, the quality gate metric will be a process measure focused on collectingthe information required in the self-assessment for year 1 of the social needs screening metric. The metric will be score on a pass/fail basis.

Measure	Data Source	Performance Period	Baseline	2023 Performance Target	2023 Eligible Upside Percentage
Social Needs Screening Environmental Assessment	Narrative and Attestation	1/1/2023 – 12/31/2023	N/A	Completion of Narrative and Attestation	100%

Each SAM Clinic will submit a completed assessment by October 31, 2023 using the assessment template provided by CareOregon. CareOregon will develop a draft assessment template and bring to the SAM Oversight Council and Data Subcommittee meetings in May 2023 for review and feedback. The assessment template will be finalized by CareOregon and sent out to clinics by June 5, 2023. See detailed timeline below:

- Draft Social Needs Screening Assessment Template Completed — April 28, 2023
- Draft Assessment Template Reviewed by SAM Oversight Council — May 17, 2023
- Draft Assessment Template Reviewed by SAM Data Subcommittee — May 18, 2023
- Social Needs Screening Assessment Template Finalized — May 31, 2023
- Social Needs Screening Assessment Template Sent to Clinics — June 5, 2023
- Completed Assessment Template Submitted to CareOregon — October 31, 2023

Each SAM clinic system partner should complete the assessment based on current state at the time of completion. The goal is to understand current state in each clinic system. One assessment may be submitted per clinic system. The successful completion and submission of the Social Needs Screening Assessment by October 31, 2023 will result in meeting the performance target for 2023. Clinics who submit incomplete assessments or fail to submit an assessment all together will not meet the performance target. Quality metric performance impact on access to potential shared savings earnings is still being determined. This program guide will be updated once a decision has been reached.

Section References:

1. Center for Healthcare Quality and Payment Reform. (2018). *Healthcare Payment Glossary.* Retrieved from https://glossary.chqpr.org/index.html
2. Oregon Health Authority. (2022). *Social Determinants of Health: Social Needs Screening and Referral Measure – MY2023*. Retrieved from DRAFT-2023-specs-(SDOH)-2022.11.22.pdf (oregon.gov)

KEY DATA: REPORTING THAT WILL BE SHARED

CareOregon will support and assist with additional data needs when or if they arise. CareOregon will strive to develop for delivery to Provider the appropriate data extract reporting with Provider-specific information for physical and behavioral health that will facilitate comparison efforts between Provider and CareOregon provider network.

Currently Available Reports

Medicaid Overall Cost and Utilization Dashboard

What the Medicaid Cost & Utilization Dashboard Provides:

- Allows PCP clinic users to track cost trends for their assigned member population enrolled in CareOregon's Medicaid physical health plan and gain insight to how variation in use and price drive overall cost. The dashboard provides the following claims-based analysis:
    - Medicaid physical health per member per month (PMPM) cost trend
    - Use and price drivers of Medicaid physical health PMPM cost trend
    - Inpatient cost trend with use and price drivers by admit type
    - Inpatient admission counts by admit type and facility
    - Member enrollment trends by coverage type and age
    - Monthly PMPM cost, use and unit price summary tables for download to Excel

Quality Metrics Dashboard

What the CareOregon Quality Metrics Dashboard Provides:

- Allows primary care clinics to monitor performance on CCO Quality Metrics and Medicare Stars Measures for their assigned CareOregon physical health plan members. The dashboard provides the following:
    - Current performance on claims-based and ALERT-based CCO incentive metrics and non-incentivized quality metrics
    - Current performance on clinical Medicare Stars Measures (not including pharmacy measures)
    - Actionable member lists that show metrics-related gaps in care for currently assigned members and can be downloaded as an Excel file
    - Interactive Equity Explorer tool to analyze metric populations by race/ethnicity, age, sex, and language
    - Clinic Comparison tools that allow a clinic to see their metric performance and engagement rates compared to the overall CareOregon primary care network

Risk Share Reporting

Contract Performance Reporting

What the Contract Performance Reporting Provides:

- Financial report on YTD risk share costs compared to target and estimated savings. The report includes:
    - Risk Share methodology overview
    - Summary of Base Period claims PMPM by Eligibility Category
    - Calculation of Measurement Period Cost Target
    - Summary of Measurement Period claims PMPM by Eligibility Category
    - Calculation of Measurement Period YTD Experience
    - Illustration of Measurement Period YTD Experience compared to Target

Raw Data Files – Medical Claims, Pharmacy Claims, Eligibility, Risk

What the Raw Data Files Provide:

- Detailed flat files for members included in the Risk Share. The data files include:
    - Medical Claims
        - Includes claim-level detail for assigned members in the measurement period and previous periods.
        - Includes Behavioral Health claims data that is not restricted by CFR 42 Part 2
    - Pharmacy Claims
        - Includes claim-level detail for assigned members in the measurement period and previous periods.
        - Includes claims managed by OHA that appear on the Mental Health Drug Carve Out list.
    - Eligibility
        - Includes demographic, eligibility category, and risk data for assigned members in the measurement period and previous periods.
    - Risk
        - Includes member-level risk data indicating which CDPS+Rx condition categories a member qualifies for in the measurement period and previous periods.

Develop Together – Future State

These are reports that CareOregon has not yet developed. Our goal is to work with the SAM partners to identify and develop these and/or other reports that meet the needs of the clinics to achieve success in the Shared Accountability Model. The specific reports that will be developed may change over time based on future collaboration and discussion between CareOregon and participating clinics.

- Cost and Utilization Opportunity Report
- Enhanced Member-Level Reporting
- Comparison Reporting – Cross-clinic comparison of costs, coding, and quality

SAM SHARED SAVINGS CALCULATION METHODOLOGY

Claim Cost PMPM Calculation – 2022-2025

CareOregon will calculate the Calendar Year PMPM for the Shared Accountability Model as follows:

All model calculations and targets are on a shared basis for all participating clinics within a given region. There will be a single shared cost target and a single shared model outcome for each participating region. Model will allow 3 months claim "runout" with the final data set to be run no earlier than April 1st of the following year. A final annual payment settlement date is no later than June 30, for the prior calendar year. Each calendar year of the agreement, except 2022, will use the previous calendar year's data as the base period for calculating the PMPM target. Due to the impact of COVID-19, 2022 will use 2019 as the base period for calculating the PMPM target. The PMPM target will be calculated based on steps 1 – 11 listed below.

If new sites are added to the Agreement as mutually agreed upon by both parties, the enrollment file will be inclusive of new members assigned to said practices provided:

a) both parties have collectively reviewed available claims history
b) an effective date is specified for inclusion in performance calculations

Step 1: Member months – Current Year member months will be summed for the following eligibility categories:

Included Eligibility Categories	
PCR	Parents & Other Caretaker Relatives Adults
PWO	Pregnant Women
CHILD0105	Children age 1 to 5
CHILD0618	Children age 6 to 18
FOSTER	Children in Adoptive, Substitute, or Foster Care
ABAD	Aged, Blind and Disabled w/o Medicare
OAA	Old Age Assistance w/o Medicare
ACA 19 - 44	ACA Expansion Adults ages 19 to 44
ACA 45 - 54	ACA Expansion Adults ages 45 to 54
ACA 55 - 64	ACA Expansion Adults ages 55 to 64

Step 2: Total (medical and pharmacy) Claim costs will be summed for each of the above eligibility categories

- Claims cost categories excluded from the calculation include:
    a) Mental/Behavioral Health (including Behavioral Health in Primary Care)

b) Hepatitis C
c) Maternity Health
d) Medicare
e) Dental
f) All COVID-19 vaccination costs
g) Unforeseen or unknown high costs that may arise as agreed upon by Agreement
h) Participants (e.g., a new cancer drug)
i) Additional costs listed in the table below

Excluded Eligibility Categories*	
ABAD (Duals)	Aged, Blind and Disabled with Medicare
OAA (Duals)	Old Age Assistance with Medicare
CHILD0001	Children age 0 to 1
BCCP	Breast and Cervical Cancer Program
All HOP categories	Healthier Oregon Program

**Cover All Kids eligibility categories will also be excluded from 2022 risk share calculations.*

Step 3: "Off Lag" medical expenses per member month will be agreed upon between CareOregon and Provider based on CareOregon documentation. Off lag costs will include the reinsurance costs for the actual large claim attachment point agreed to in Step 6 below.

Step 4: A "completion factor" will be included to reflect incomplete claims runout. The completion factor will gross up total claim costs by a percentage.

Step 5: Total Member months (1) * Off Lag Medical Expenses (3) + Total Claim Costs (2) * Completion Factor (4) will yield Total Claims Costs adjusted for off-lag medical expenses and claim runout (completion).

Step 6: A claim cost limit has been set for each of the applicable Calendar Year settlement calculations. A defined “Large Claim Costs” amount exceeding this threshold will be removed from the adjusted total claims costs element of the claim cost PMPM final calculation.

Large Claim Costs are defined to be:

- Attributable to a single member for service dates during a calendar year
- The accumulated member claims costs from the claims cost categories included in the model
- All cases where the total of the above claims exceed $150,000.00 per member per calendar year

Step 7: Base period claim costs will be adjusted to reflect OHA program changes (including DRG hospital inpatient and outpatient rates updates) in the measurement period as estimated by OHA.

Step 8: Adjusted Total Claims Costs less large claims (6) will be divided by member months (1) for each eligibility category to arrive at Claim Costs per member per month (PMPM).

Step 9: Model will utilize a modified OHA risk adjustment methodology:

- Model CDPS+Rx version 6.5
  - Captures diagnosis codes and Rx NDC codes from claim data
  - Maps diagnosis and NDC codes into condition categories (e.g., Diabetes)
  - Each condition category has an assigned cost weight
  - Model weights differ between "active" and "disabled" children/adults
- Filtering Logic (OHA modification)
  - Months of eligibility requirement
  - Diagnostic services excluded
- Member Level Risk Score
  - For each member in each time period (typically, 12 months), condition categories are identified
  - Cost weights are aggregated into a composite score (additive)
- CareOregon Risk Model Application
  - Measure base and measurement period risk scores

Step 10: Claim costs will be adjusted by a target trend rate based on OHA Best Estimate Claim Cost Trend applied on a Category of Service and Category of Aid basis. The trend will be applied to update the base period claim costs to the measurement period. For example, in 2022, since the base period will be 2019, three years of OHA trend (2020, 2021, and 2022) were applied to the claim costs.

Step 11: Claim costs or Target Claim Costs can be averaged proportionally (according to distribution of member months) to arrive at a single PMPM measurement amount and target amount for each year of the agreement.

APPENDIX

FAQ

1. PCPM and SAM Model:

a. We understand from our meeting that PCPM will not be subsumed by SAM. In this first year of SAM, we will benefit from both the PCPM quality payments and the SAM shared savings, correct?
The short answer is – yes, there will be no change to the current revenues you receive through PCPM as part of the SAM Model.

While PCPM dollars are not affected by SAM, PCPM payments (i.e., costs) are included in development of the cost target and thus in the SAM Shared Savings calculation. See my simplified example below. They will be included in the off-lag costs for the model.

Cost Category	PMPM Expense
Primary Care Cost	$40 PMPM
Specialist/Hospital/Rx.	$200 PMPM
PCPM Funding	$10 PMPM
Total Cost	**$250 PMPM**

2. Program Details:

a. Please confirm the start date for each SAM program year performance period.

While contracts must be signed by March 31st, 2022, the performance period start-date is retrospective to January 1st, 2022 and runs through December 31st, 2022.

3. Large Claim Costs:

a. Claims over $150K will be excluded from the cost target calculation, correct?
To clarify, the exclusion is for amounts accrued above the 150k threshold by any member over a calendar year. So, a member with three $60,000 claims would be affected by this provision, even though no individual claim exceeded $150,000. Only the amount in excess of $150,000 is removed from the model, so in the example above the $180,000 expense for this member would be reduced to $150,000 in the model calculation.

b. Will FQHCs know how many members' accrued claims costs exceed the 150k threshold in the base period?
Yes. This data is available in the raw claims data, we would need to setup additional reporting to identify these members in a separate report outside of the claims data.

c. Will FQHC know how many members' accrued claims costs exceed the 150k threshold in the program period? Can we get details on these instances?
Yes. You will have full claims detail on all claims.

d. Will FQHC know how many members' annual accrued claims in the $50K - $149K range exist in the program period? Can we get details on these instances?
You would be able to identify these members in the raw claims detail, we would need to develop additional reporting to report on these in a separate report outside of the claims data.

e. Do you have model to potentially flag members who will have high-cost claims?
We do have some internal modeling from the John Hopkins ACG risk model that identifies the likelihood of a member having a high-cost claim. This data is not currently built into the raw claims data that we share with our risk partners but could be built into future reporting.

4. PMPM Cost Targets:

a. Will each FQHC have a defined PMPM cost target based on historic data?
No – all the FQHCs are held to a single shared target. The PMPM cost historic baseline and PMPM cost target will be based on the experience for the shared group of FQHCs that decide to participate. FQHCs will meet the target and earn shared savings as a group.

b. For each FQHC, will a distinct PMPM cost target be calculated for specific member segments?
No, see above.

c. How is member segmentation used to determine PMPM costs targets and performance?

i. Eligibility criteria
Each Category of Aid that is included in the risk share model has its baseline experience, target, and measurement experience calculated on an individual Category of Aid basis. The Category of Aid costs are then blended across all Categories of Aid to produce the aggregate PMPM target and measurement experience. This is to ensure that a change in member mix (e.g., % of children) is accounted for when setting the cost target.

ii. Diagnostic coding
Diagnostic codes are included in the CDPS+Rx risk model that is used to risk adjust the cost target between the baseline period and the measurement period. An increase in the risk level of the population from the baseline period to the measurement period will result in an additional increase in the cost target, and vice versa.

iii. OHA guidelines
For OHA guidelines that affect payments (e.g., new covered benefits, changes to payment guidelines – 80% to 85% DRG) these adjustments are incorporated into the cost model. This is outlined in Step 7 of the calculation methodology. As an example, due to the change in DRG payment rate from 80% to 85% of CMS DRG

rates between 2022 and 2023, we are applying an upward adjustment to the cost target to reflect the increase in expected cost resulting from the contracting change.

Please see "CDPS + Rx FAQ" for further details on risk adjustment; pages 28-34 of the Program Guide Appendix.

5. **Social Determinants of Health:**

    a. If SDoH is excluded from the cost calculation in year 1, how does CareOregon account for complexity that may driving care utilization? Neither the risk score nor the historic PMPM costs seem to reflect this.
    By using the FQHCs' own experience to develop the baseline data, we are accounting for the extent to which Social Determinants of Health (SDOH) affected utilization in 2019, though we are not able to directly measure SDOH need.

    We are unable to adjust for changes in the SDOH-level that may affect utilization between the baseline period (2019) and the measurement period (2022) because it is not currently captured in the risk score. This limitation is currently also present in OHA's approach to allocating funding between CCOs. Their calculations currently consider the risk profile of the membership, but not the SDOH characteristics of members assigned to each CCO.

    b. If we cannot use SDoH for risk profiling now, how probable is it that it will be incorporated in SAM in the near future (i.e., 2-3 yrs.)?
    I think it is very likely that we will have an approach to incorporate SDOH risk profiling into cost projections in two to three years. That likelihood increases to near-certainty if OHA adopts a model that incorporates SDOH in their rate-setting approach. Even without OHA leading efforts, we are committed to collaborating with you to collect data and develop the expertise to include SDOH in the SAM risk adjustment methodology.

6. **"Clinics" vs. "Health Centers":**

    a. Is there specific intention in using the term "clinics" (versus Center) to refer to the FQHC participants in the SAM contract? What is it?
    There is no specific intention on our part between using clinics vs. Centers. We've used "clinics" as a more generic term in our standard contract language for use across a variety of contract types.

    b. Does this have an implication on how the program cost and quality metrics will be defined?
    No, see above.

7. **CareOregon has expressed intention to sign a single contract with the Community of Health Center Network of Oregon (CHCNO) on behalf of the FQHC participants it represents that decide to engage with SAM. How will this impact calculation of:**

    a. Target Cost PMPM?
    There will not be any impact on the Target PMPM calculation, except based on which FQHCs that are part of CHCNO agree to join SAM.
    So for instance, if three of the four Metro FQHCs that are part of CHCNO chose to sign the

SAM agreement through CHCNO, but the fourth decided not to participate, CareOregon members assigned to the fourth FQHC would not be included in the baseline data, which would change the Target Cost PMPM. This is the same change that would result if an FQHC who is not a member of CHCNO decided not to participate. In both cases the only impact on the Target Cost PMPM would be based on who is/is not in the base data and the measurement period.

b. Distribution of shared savings?
The impact of CHCNO FQHCs signing a shared contract will only affect the distribution of shared savings ***for CHCNO*** *FQHCs.*

Please see the example below outlining a distribution scenario in which FQHC C and D are participating through CHCNO and FQHC A and B are not. For the sake of example simplicity, assume only these four FQHCs are part of the Shared Accountability Model. In this example there are $1,000,000 of shared savings to distribute and the chosen distribution method is based on member months.

	FQHC A	**FQHC B**	**FQHC C**	**FQHC D**	**Total**
Participating in CHCNO	No	No	Yes	Yes	
Member Months	500	6,000	2,000	1,500	10,000
Shared Savings Distribution (Direct to FQHCs)	500 / 10,000 * $1,000,000 = $50,000	$600,000	$0	$0	$650,000
Shared Savings Distribution (To CHCNO)	$0	$0	$200,000	$150,000	$350,000
Total Shared Savings Distribution	$50,000	$600,000	$200,000	$150,000	$1,000,000

In this example the CHCNO-member FQHCs will determine together how to invest and distribute amongst themselves the $350,000 shared savings distribution payment sent to CHCNO.

SAM Oversight Council Charter

Safety Net Shared Accountability Model – Oversight Council Charter

10/7/2021

Background

Consistent with our vision of creating healthy communities, we are committed to changing the nature of our partnership and agreements to share in the accountability of our members health through a partnership that improves member engagement, health outcomes, and makes good use of the resources which we are entrusted. We will work together from common principles to advance the following common goals**:**

- **Build shared ownership and accountability among partners and CareOregon** for member health at the provider and community level
- **Encourage service redesign and practice transformation** to reduce health disparities, promote health equity, support integration, and meet the needs of the whole population
- **Increase partners' clinical, technical, and administrative ability** to perform well under the Total Cost of Care (TCOC) model and share in the savings generated
- **Align partners' financial incentives** around cost, access, utilization, quality, and member experience
- Incent and **support provider organizations and community partner organizations in working together** to improve quality care and reduce avoidable costs and utilization
- Supports CCOs' commitments **to implement value-based payment arrangements and further the goals of CCO 2.0**
- **Share meaningful data** that will support providers' successful participation in the Total Cost of Care model

Objectives

The objective of this committee is to assist CareOregon's contracted providers in reaching our shared population and community health improvement objectives by (1) recommending the structure and parameters of a Community Based Total Cost of Care model, (2) recommending and approving the performance metrics used to allocate funds among the participants, and (3) consulting with CareOregon on expansion of the model (i.e., benefits and providers) and tools needed to enhance performance.

Scope

Includes:

- The Safety Net Shared Accountability Total Cost of Care Model contracts between CareOregon and its contracted providers in identified regions (JCC, Metro, CPCCO)
- Medicaid and Medicare lines of business
- Determining the allocation of shared savings to participating entities in the Safety Net Shared Accountability Total Cost of Care Model contracts

Area	Role	Frequency
Quality, Access and Engagement Measures, Targets, and Incentive Structure: Using health equity lens - • Review and recommend proposed measures • Review and recommend the method for setting performance thresholds • Recommend performance targets for suggested measures • Review and recommend proposed measurement incentive structure (e.g., regional level, clinic level, individual level, specialty level, etc.)	Approve	Annually
Total Cost of Care Measures, Targets, and Incentive Structure: • Review proposed measures and shared savings methods and targets	Approve	Annually
Shared Savings Distribution: • Evaluate and define how the gain/loss is distributed across participants using quality and engagement performance, member service measures, and Total Cost of Care performance. • Define member service measures for Shared Savings distributed (e.g., total panel size, engaged panel size, risk-adjusted membership, etc.)	Approve	Annually
Structural Changes to Total Cost of Care Model: • Evaluate and recommend structural changes to model • Evaluate and recommend structural changes by practice	Recommends	Annually
Model Implementation: • Consults on the implementation of the payment model across all participating clinics • Consults on model parameters (e.g., risk adjustment, member mix adjustment, large claims adjustment, etc.) • Advises data and reporting package from CareOregon • Provides ongoing feedback about enhancements	Consults	Ongoing
Governance Changes: • Recommends changes to membership, roles and responsibilities of the committee, and other relevant governance considerations. Due to the financial considerations involved, CareOregon must agree to all changes in roles and responsibilities.	Recommends	Ongoing

Out of Scope

- Payment methods within the clinics and/or medical groups participating in the model
- Payment methods under payer contracts where CareOregon doesn't contract for risk
- Clinician performance management
- Boundaries of the geographies that define the regions and attribution methods for members selected into those regions
- Determining total eligible budget for shared savings

Membership and Roles

Committee Leadership Structure:

- The Oversight Committee will be chaired by the CareOregon appointed staff the first year then open up the role to others who may be interested in being the Chair.

Committee Membership:

1. The Committee shall have 14 members, including the Committee Chair
    a. 12 representatives from Community Health Centers who are participating in the model (unless they designate a proxy)
    b. 1 CareOregon leader:
        i. CareOregon Regional Representative from a participating region (possibly Regional Medical Director, Clinical Integration Director, or Regional VP)

2. Committee members will aim to have balanced representation between clinicians and administrators as practicable
3. Committee members will not be compensated for the time they serve on the Committee
4. Committee members can be removed from the Committee at the discretion of the Chair should they fail to attend meetings and participate constructively in committee activities, with the option to appoint a new representative of their organization
5. CareOregon's Chief Financial Officer is the executive sponsor of the Committee
6. The Committee shall develop its own recruitment process after the initial appointment
7. The Committee will be supported by:
   CareOregon Provider and VBP Contracting, Regional leadership, Counsel, Compliance, Network Relations/QI, Finance, CareOregon Medical Director Representative, CareOregon Information Services, and Community Health Center Network of Oregon (CHCNO).

Responsibilities of Committee Members:

1. All contractually participating members of the Committee have voting rights and the Chair will only vote in the event of a tie
2. Committee members are responsible for assuring the group faithfully executes on the areas of responsibility listed above being mindful of agreed upon design principles

3. The Committee may establish sub-committees, as needed, to organize and develop recommendations that the Oversight Committee will evaluate and determine action upon more effectively
4. Committee members work toward collective success, and are not to represent the interests of a particular constituency
5. Committee members are to work with collegiality, with recommendations being made by consensus as much as possible; decisions will be made by majority vote of the entire Committee (seven represents a majority out of thirteen); decisions will only be voted upon when there is a quorum of at least 11 attendees. Voting by proxy and sending a proxy representative is acceptable with prior reasonable notification to the Committee Chair
6. Members agree to keep the Committee's work confidential and will be required to sign a non-disclosure agreement with respect to external organizations not participating in the Shared Accountability Model.
7. Members agree to disclose any real or perceived conflicts of interest involved in any voting matter

Design Principles:

- Shared governance and decision making between partners
- Engage partners in an active learning experience
- Promote teamwork and encourages collaboration while preserving local autonomy
- Bias toward simplicity (support CHCs' move into contract model without additional infrastructure and simple to manage)
- Transparency of performance and shared savings between participants
- Stage path to accepting risk based on organizational readiness
- Scalable and adaptable
- Aim to add value (cost, quality, experience) and promote health equity
- Reward based on achieving performance targets rather than percentiles

Meeting Guidelines

1. Committee will meet as often as deemed necessary to achieve their objectives, but shall meet at least quarterly
2. Committee will be supported by CareOregon and may request assistance to fulfill its responsibilities from supporting functions and organization (e.g., CHCNO)

CareOregon Responsibilities

1. Management and oversight of the Total Cost of Care methodology and calculations
2. Preparing and sharing reporting on Total Cost of Care performance, quality and engagement performance, and productivity performance on an agreed-upon basis with committee members

Anti-trust Compliance

Committee Members agree to abide by all federal and state anti-trust laws

Program Guide Change Log

Date	Section Updated	Description of Change	SAM OC Approval Status/Date
2/14/22	Appendix	Addition of FAQ, SAM Oversight Council Charter and Change Log	N/A
2/14/22	SAM Governance Structure	Added note that SAM Oversight Council Charter was added to the Appendix	N/A
2/14/22	About this Guide	Added language regarding how the Program Guide will be updated, how SAM providers will be informed of updates and which updates require SAM Oversight Council Approval	Approved
2/14/22	Provider Commitments	Added commitment around timely and accurate documentation and coding. Also added language around development of metrics that align with commitments.	Approved
12/8/22	CareOregon Commitments	Language added ensuring that any downside risk assumed by a Provider will not result in payment lower than the PPS Amount.	Pending Approval
12/8/22	Risk Model and Financial Impact Illustrations	Risk Model Illustrations and Financial Impact Illustrations updated throughout for the additional contract years.	Pending Approval
12/8/22	Quality Metric Overview	Added to Page 15, 2023 Quality Metric Overview: Social Needs Screening and Referral information	Pending Approval
12/8/22	Eligibility Categories	Updated the included eligibility categories for the claim cost PMPM calculation on Page 18.	Pending Approval
12/8/22	Appendix	Added the CDPS + Rx FAQ guide to the Program Guide Appendix for reference	Pending Approval
3/15/23	Appendix	Added the following to the CDPS +Rx FAQ guide: SAM will work to explore incorporating social needs and zip codes into the risk model as soon as a method to do so is approved by the SAM Oversight Council.	Pending Approval

CareOregon Shared Accountability Model
CDPS+Rx FAQ

Background

The Chronic Illness and Disability Payment System (CDPS), Medicaid Rx (MRX), and Chronic Illness and Disability Payment System plus Medicaid Rx (CDPS+Rx) are diagnostic-based risk adjustment models that were developed and are maintained by the University of California San Diego (UCSD). States and other entities (e.g., HSO) use risk scores generated by these models to adjust capitated payments to Medicaid health plans.

The three models are updated periodically to include new diagnosis or national drug codes (NDC) and weights. Minor revisions usually only update condition mappings (described below). Major revisions change the structure of the model.

For more information, please see USCD's website:

https://hwsph.ucsd.edu/research/programs-groups/cdps.html#Relevant-Papers-and-Additional-

Algorithm and Model Descriptions

CDPS

CDPS conditions for a member are determined using a member's diagnostic history (ICD-10 codes). These conditions indicate illness burden related to major body systems (e.g., Cardiovascular, Skeletal and Connective, Nervous System) or chronic disease (e.g., Diabetes, Cancer). There are 19 disease grouping categories that generalize CDPS conditions. Each CDPS condition is hierarchical within a disease grouping. The hierarchy reflects the clinical severity of the condition. Since a member can have diagnosis codes that map to two different severities, the most severe condition within a disease group is selected for the given disease grouping. For example, a member may have a diagnosis code that identifies the member with a *Cardiovascular, Very High* (*CARVH*) condition and a Cardiovascular, Low (*CARL*) condition. The CDPS model assigns *CARVH* condition to the member and ignores the *CARL* condition. This is done to avoid double counting conditions. Each of the hierarchical CDPS conditions is assigned a CDPS weight and CDPS weights are additive across major body system and chronic disease categories. Generally, the higher the weight, the higher the expected costs are during the time period being evaluated or predicted.

The 19 categories are:

• Cardiovascular	• Psychiatric
• Skeletal and Connective	• Nervous System
• Pulmonary	• Gastrointestinal
• Diabetes	• Skin
• Renal	• Substance Abuse
• Cancer	• Developmental Disability
• Genital	• Metabolic
• Pregnancy	• Eye
• Cerebrovascular	• Infectious

• Hematological	

See Appendix A for Common Diagnosis Codes for CDPS Conditions

MRX

Similar to CDPS, the Medicaid Rx (MRX) is a pharmacy-based model developed by UCSD. The MRX model uses National Drug Classification (NDC) codes to assign MRX categories to a member based on types of pharmacological therapy. Each of these categories is assigned a MRX weight. Similar to the CDPS model, there is a hierarchy associated with the MRX conditions.

CDPS+Rx

The CPDS+RX model combines diagnosis codes (ICD-10) and NDC codes into a third model. The diagnosis code mapping is the same as the CDPS mapping; however, the NDC mapping used by the CDPS+RX model is different than the MRX model.

Claim Exclusions

Laboratory and Radiology claims are generally excluded from condition identification. This is because these types of encounters can be used to rule out a possible condition for a member. By including them, a member's risk may be overstated. States and entities calculating risk conditions maintain their own laboratory / radiology definitions and are usually based on common procedural terminology (CPT) or revenue codes. Similarly, maternity claims are occasionally excluded from risk adjustment since maternity claims fall under kick payments that are not risk adjusted.

Prospective vs Concurrent (Weight Type)

The three models outlined above have two different risk weights: Prospective and Concurrent. Prospective weights are used to predict relative costs in the future while concurrent weights are used to describe historical cost relativities. A member's conditions are identified independent of the prospective or concurrent method. Said differently, the condition algorithm does not change between concurrent and prospective methods. For example, if a member is identified as having diabetes in the concurrent model, then they also have diabetes in the prospective model.

Building a Member-Level Risk Score

The three models model build a risk score for each member using the following steps:

1. **Aid Category Type** – Each member is assigned to one of four aid category types (AidCatType) based on his or her disability status and age. Generally, SSI and disabled populations are assigned to the disabled category. Parents, children, and ACA Expansion populations are assigned to the active category. Each active and disabled category is further divided into two cohorts: Children and Adults. Children are determined based on age (e.g., members less than 18 as of July 1st). Adults are members not classified as children. The four AidCatTypes in the UCSD models are disabled adults (DA), disabled children (DC), active adults (AA), and active children (AC).
2. **Intercept Weight** – Every member is assigned the intercept weight. This weight varies by the AidCatType of the member.

3. **Demographic Weight** - The member's demographic weight is determined based on the AidCatType and the age and gender of the member. The source for this information typically comes from enrollment records.
4. **Condition Weight** – A member's conditions are identified using medical and/or pharmaceutical encounter data (e.g., ICD-10 and NDC). Each condition a member has is mapped to a risk weight according to the AidCatType and weight type (prospective versus concurrent). The weights for a member are additive. That is, if a member has conditions in two diagnostic category groups, the member will receive credit for both conditions. This results in a member with multiple conditions receiving a higher weight.

Aggregation & Financial Impact

Once the risk score has been developed for each risk adjusted member,[1] risk scores are aggregated to the Category of Aid (COA). The averaging uses a member month weighting technique where each member's weight depends on their membership during the experience period. At this stage, states and payer entities normalize the weights so risk adjusted capitation payments are budget neutral. This is done by dividing the plan's raw risk score for the cohort by the overall average risk score for that cohort.[2] The normalized risk score is multiplied by the base capitation rate for the COA to determine the Per Member Per Month (PMPM) funding for each category.

OREGON HEALTH AUTHORITY

The Oregon Health Authority (OHA) and its actuarial firm Optumas employ a modified version of the CDPS+Rx model in calculating the capitation rates for each CCO within the state in a budget-neutral manner. For contract year 2022, some COAs are excluded from risk adjustment, including PLMA, CHILD 00-01, DUAL-MEDS and CAF. Reasons for exclusion vary by population, but generally these eligibility categories are not suitable for risk adjustment. For example, Oregon may not have complete encounter data for dual eligible populations since Medicare is the primary payer.

Further criteria employed by OHA to build the member-level risk scores include: nine diagnosis codes from encounter claims; national weights are applied while state-specific weights are being developed using recent historical data; concurrent (explaining the past) and prospective (predicting the future) models were employed; and a minimum of 3-month enrollment duration is required.

CAREOREGON SHARED ACCOUNTABILITY MODEL

The CareOregon Shared Accountability Model (SAM) will work with its actuarial firm Wakely to apply a modified version of the OHA CDPS+Rx model methodology for participating providers. SAM will use CDPS+Rx model version 6.4; will require three months of eligibility for inclusion; and will exclude laboratory and radiology services.

SAM will work to explore incorporating social needs and zip codes into the risk model, as soon as a method to do so is approved by the SAM Oversight Council.

Impact of risk adjustment under the CDPS+Rx model & SAM: accuracy of diagnosis coding is highly relevant

Risk Adjustment is driven by demographic and diagnostic information. It estimates differences in the health risk of members based on their age, gender, and the diagnoses they received from medical claims.

Accurate and complete diagnosis coding directly feeds into the CDPS+Rx risk adjustment model and how the state calculates the rates to CCOs. The more accurate and complete the diagnosis coding, the more accurately risk adjustment will reflect the health and expected cost of the populations of which CCOs are assigned. Subsequently that money is incorporated into the VBP models we develop. Particularly in relation to SAM, the greater the accuracy of diagnosis coding, the better the risk adjustment will be in correctly reflecting the health and expected cost of the SAM population. This is what we use to calculate the cost growth target and the total potential shared savings in the SAM model.

Primary Care Providers have influence on this factor in the adjustment model. The work you do to support and improve accuracy in coding of diagnostic complexity impacts and directly connects to development of the SAM financial model and associated potential shared savings total. For example, if the actual claim cost for the performance period is $200 per member per month (PMPM) and the risk score changes from 1.0 to 1.05, the adjusted claim cost PMPM will be $200 / 1.05 = $190 PMPM. The change in adjusted actual costs would yield more shared savings for the SAM providers.

Currently CDPS+Rx doesn't take into account REALD or social determinants of health. What is needed to include social health into risk adjustment? What is the process to achieve this?

Key Elements to Enable Social Health Risk Adjustment:

1. **Consistent and accurate data for the population**

In a Historical Experience model, such as SAM, we need consistent and accurate data for the SAM population related to social health for the Base Period and the Measurement Period.

2. **A model that relates social risk factors to Total Cost of Care**

A model would allow us to connect social risk factors with the expected impact on the Total Cost of Care. For instance, someone with these "X" social risk factors tends to have X% higher Total Cost of Care compared to someone with no social risk factors.

3. **Sufficient confidence and testing that the Social Risk Adjustment process improves accuracy**

This is the testing portion of the process. It would require us to make an estimate based on observed data. We would look at the actual Social Risk Adjustment factors we had estimated across different subsets of the population and determine if it corresponds to observed differences in their Total Cost of Care.

Social Risk Adjustment & SAM Roadmap—Steps for Moving to Social Risk Adjustment in the Financial Model

Year 1 (2023): Data Collection

Year 2 (2024): Tracking

Year 3 (2025): Incorporation into the model

APPENDIX A – COMMON DX CODES FOR CDPS CONDITIONS

- *Top 5 most common ICD-10 codes were selected for each condition from a representative dataset*
- *Some conditions may have fewer than 5 diagnosis codes listed if the top few codes accounted for the overwhelming majority of observations for that condition*
- *Codes are listed left-to-right in order of frequency in representative dataset, with Code 1 representing higher frequency than Code 5*

CDPS Label	Description	Code 1	Code 2	Code 3	Code 4	Code 5
CARVH	Cardiovascular, very high	T82868A	Z941	T82898A	T82858A	T826XXA
CARM	Cardiovascular, medium	I110	I5032	I509	I5022	I130
CARL	Cardiovascular, low	I2510	I4891	I480	I739	I214
CAREL	Cardiovascular, extra low	I10	I129	I160		
PSYH	Psychiatric, high	F209	F250	F251	F259	F200
PSYM	Psychiatric, medium	F840	F319	F29	F3181	F603
PSYML	Psychiatric, medium low	F4310	F331	F4312	F332	F902
PSYL	Psychiatric, low	F438	F4323	F4322	F4325	F5001
SKCM	Skeletal, medium	M069	M0579	M419	M869	M329
SKCL	Skeletal, low	M810	M5136	M5126	M8580	M4316
SKCVL	Skeletal, very low	M47816	M47812	M5010	M5030	M461
CNSH	CNS, high	G8250	G800	G931	G1221	G8254
CNSM	CNS, medium	G35	G809	G8220	G808	G801
CNSL	CNS, low	G40909	R569	F0390	G629	G20
PULVH	Pulmonary, very high	Z930	Z9981	Z430	Z9911	E840
PULH	Pulmonary, high	J479	J151	J14	J471	R092
PULM	Pulmonary, medium	J9601	J9621	J9611	J690	J9602
PULL	Pulmonary, low	J449	J45909	J441	J189	J4520
GIH	Gastro, high	Z931	Z933	K912	Z932	Z431
GIM	Gastro, medium	K7460	K760	K7030	K7031	K766
GIL	Gastro, low	K219	K921	K449	K922	K429
DIA1H	Diabetes, type 1 high	E1022	E1021	E1029	E1011	
DIA1M	Diabetes, type 1 medium	E109	E1065	E1010	E1042	E108
DIA2M	Diabetes, type 2 medium	E1142	E1122	E1140	E1151	E1129
DIA2L	Diabetes, type 2 low	E119	E1165	E11621	E1169	E118
SKNH	Skin, high	L89154	L89314	L89893	L89309	L89153
SKNL	Skin, low	L97512	L97522	L97812	L97822	L97412
SKNVL	Skin, very low	L03116	L03115	L84	L089	L03113
RENEH	Renal, extra high	Z992	Z4901			

RENVH	Renal, very high	N186	N184	N189	N182	N185
RENM	Renal, medium	I120	I132	Z940	Z936	N250
RENL	Renal, low	N3946	R32	N393	R339	N3941
SUBL	Substance abuse, low	F1120	F1520	F1121	F1510	F1521
SUBVL	Substance abuse, very low	F1020	F1010	F1021	F1011	F10239
CANVH	Cancer, very high	C7951	C787	C9000	C7931	C7989
CANH	Cancer, high	Z5111	Z510	Z5112	C3490	C220
CANM	Cancer, medium	C20	C773	C189	C187	C801
CANL	Cancer, low	C61	C50919	C50411	C50412	C541
DDM	DD, medium	F72	F73			
DDL	DD, low	Q909	F79	F70	F71	Q999
GENEL	Genital, extra low	N401	N400	N83201	N83202	N809
METH	Metabolic, high	E8881	E230	E806	E83110	E222
METM	Metabolic, medium	E43	E875	E291	E46	E440
METVL	Metabolic, very low	E876	M109	M1A9XX0	M1A09X0	M10071
PRGCMP	Pregnancy, complete	Z370	Z391	O76	O80	Z392
PRGINC	Pregnancy, incomplete	Z3480	Z3483	Z3689	O26893	Z3482
EYEL	Eye, low	H4311	H4312	Z947	H3562	H3561
EYEVL	Eye, very low	Z961	H25813	H2513	H25812	H25811
CERL	Cerebrovascular, low	I69354	I69351	I69391	I69320	I69398
AIDSH	AIDS, high	B20				
INFH	Infectious, high	B259	A429	A481	A480	A4152
HIVM	HIV, medium	Z21	Z1612	Z1624	Z1611	Z1629
INFM	Infectious, medium	A419	B370	A4189	A4151	A4102
INFL	Infectious, low	B182	B1920	B181	B029	B1910
HEMEH	Hematological, extra high	D66	D67			
HEMVH	Hematological, very high	D5700	D571	D5701		
HEMM	Hematological, medium	D61818	D709	D701	D619	D61810
HEML	Hematological, low	D696	D689	D693	D6959	D684