OHA VBP PCPCH Data and CDA VBP data template - General Instructions

1. **Required:** Complete all yellow highlighted cells on the following worksheets:
"PCPCH"
"Model Descriptions"
"Hospital care CDA VBP Data"
"Maternity care CDA VBP Data"
"Behavioral care CDA VBP Data"

Voluntary for this reporting year:
"Childrens H.care CDA VBP Data"
"Oral H.care CDA VBP Data"

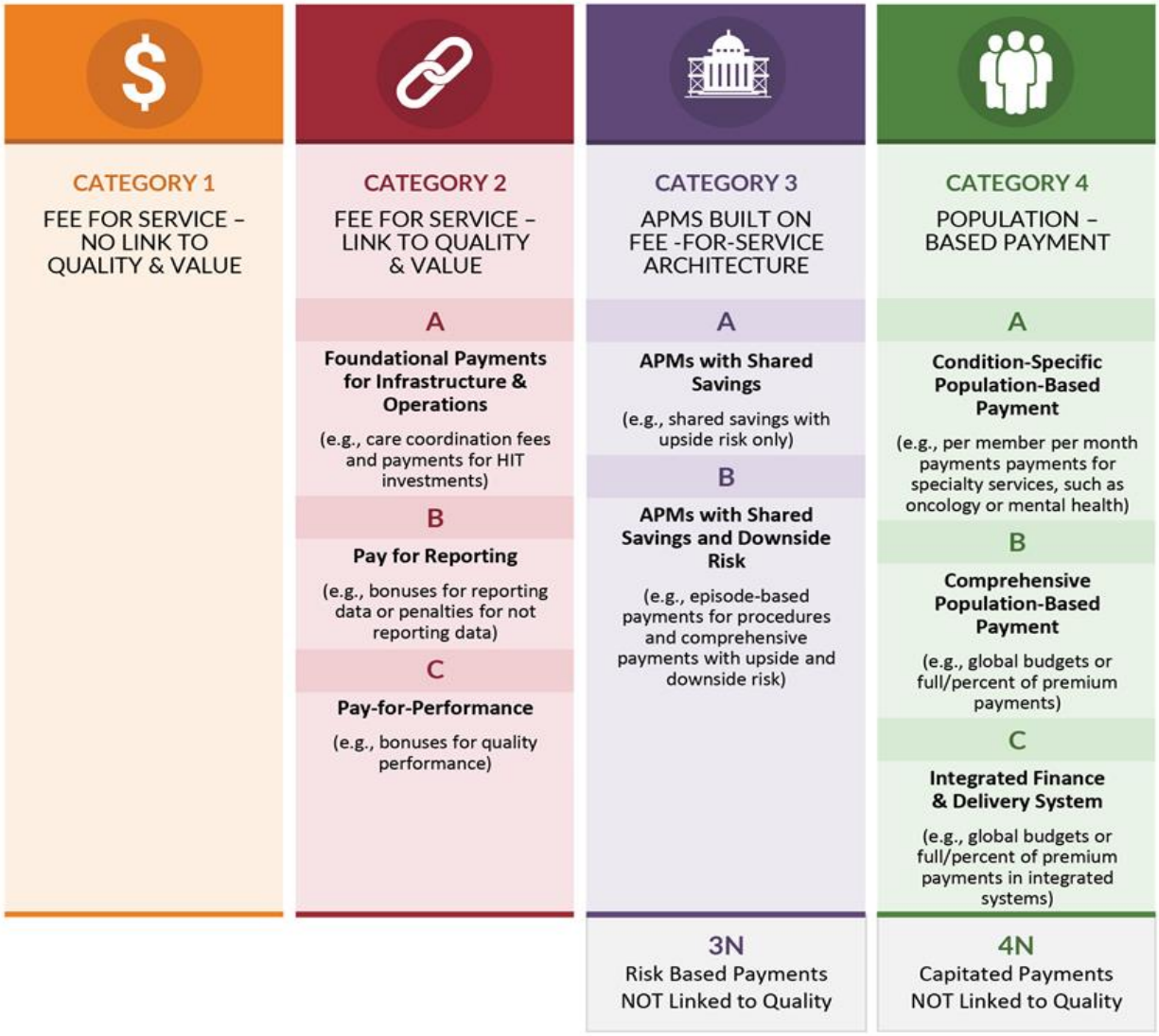
2. For payments that span multiple HCP-LAN categories, use the most advanced category. If for example you have a contract that includes a shared savings arrangement with a pay-for-performance component - such as a quality incentive pool - then you should put the total value of the annual contract in Category 3A for shared savings because 3A (shared savings) is more advanced than 2C (pay-for-performance).

3. In addition to the LAN Framework, Contractor shall use the VBP Roadmap for Coordinated Care Organizations and the OHA VBP Technical Guide for Coordinated Care Organizations for the VBP specifications and the appropriate LAN VBP category for each payment model, located at https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx

5. The completed VBP PCPCH Data and CDA VBP data template must be submitted to the following email address: OHA.VBP@dhsoha.or.us no later than May 6, 2022. It may not be submitted as a PDF document and must remain a Microsoft Excel spreadsheet. Please use the following naming convention when submitting the template: CCO + reporting year + title of template (e.g. CCOABC 2020 VBP PCPCH Data and CDA Template).

version 02032022

https://hcp-lan.org/groups/apm-refresh-white-paper/



CONTRACTOR/CCO NAME: EOCCO
REPORTING PERIOD: **1/1/2021 - 12/31/2021**

Enter the per-member-per-month (PMPM) dollar amount you paid clinics participating in the Patient Centered Primary Care Home (PCPCH) program. If the PMPMs vary for a given tier, you may enter a range. Otherwise, enter a single dollar amount. In the "Average PMPM" column, enter the average PMPM payment for each tier, weighted by enrollment. If you paid one 'Tier 1' clinic $9.50 PMPM and another 'Tier 1' clinic $10.00 PMPM, and the first clinic had three times the number of members attributed as compared to the second clinic, then the average weighted PMPM would be $9.625. ($9.50 x 0.75 + $10.00 x 0.25 = $9.625). The weighting may be calculated using number of members or number of member months.

Evaluation Criteria for this worksheet: Response required for each highlighted cell, even if there are no current clinics in your service area at that tier level. Non response in a highlighted cell will not be approved.

PCPCH Tier	Number of contracted clinics	PMPM (or range) dollar amount	Average PMPM dollar amount	If applicable, note any deviations and rationale from required payment per tier (e.g. no payments to tier 1 clinics because there are none in CCO service area).
Tier 1 clinics	0			no payments to tier 1 clinics because there are none in CCO service area
Tier 2 clinics	0			no payments to tier 2 clinics because there are none in CCO service area
Tier 3 clinics	14			N/A
Tier 4 clinics	43			N/A
Tier 5 clinics	20			N/A

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Brief description of the five largest, defined by dollars spent, VBPs implemented (e.g. condition-specific (asthma) population-base payment)	**Most Advanced LAN Category in the VBP** (4 > 3 > 2C)	**Additional LAN categories within arrangement**	**Brief description of providers & services involved**	**Please describe if and how these models take into account:** **- racial and ethnic disparities; &** **- individuals with complex health care needs**
EOCCO Shared Savings Model- total cost of care risk sharing agreement and quality performance payment for primary care practices	3B	2A, 2C, 3N	Risk sharing agreement based on all incurred claims from all medical and pharmacy providers with upside and downside risk; hospitals (starting 2022) and PCPs are also subject to quality measures and can earn a bonus based on their performance meeting or exceeding select CCO incentive measure targets.	EOCCO has strategies in place for addressing health equity, which will help ensure that VBPs do not have adverse effects on any underserved population. These include strategies targeting both processes and outcomes. Examples of process strategies include the following: 1) EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data; 2) Disparity populations are evaluated and monitored through subcommittees of the EOCCO Quality Improvement Committee which has oversight of the TQS; 3) EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis. 4) EOCCO creates and shares cultural competence training programs that is available to its workforce, provider network, and community partners.
Primary Care Capitation and quality performance- Episode based payments with upside and downside risk and pay for performance with primary care practices	4A	2A, 2C, 3A	Full capitation for primary care services, based on assigned membership to each participating clinic. Primary Care practices are also eligible for quality incentive payments based on their performance meeting or exceeding select CCO incentive measure targets. These providers also participate in the EOCCO Shared Savings Model.	EOCCO has strategies in place for addressing health equity, which will help ensure that VBPs do not have adverse effects on any underserved population. These include strategies targeting both processes and outcomes. Examples of process strategies include the following: 1) EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data; 2) Disparity populations are evaluated and monitored through subcommittees of the EOCCO Quality Improvement Committee which has oversight of the TQS; 3) EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis. 4) EOCCO creates and shares cultural competence training programs that is available to its workforce, provider network, and community partners.
Primary care capitation, quality performance and total cost of care model with upside risk	4A	2A, 2C,3A	Full capitation for primary care services, based on assigned membership to each participating clinic. Primary Care practices are also eligible for quality incentive payments based on their performance meeting or exceeding select CCO incentive measure targets. Under this risk sharing model, participating clinics can earn an incentive bonus by managing the total cost of care trend. These providers do not participate in the EOCCO Shared Savings Model.	EOCCO has strategies in place for addressing health equity, which will help ensure that VBPs do not have adverse effects on any underserved population. These include strategies targeting both processes and outcomes. Examples of process strategies include the following: 1) EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data; 2) Disparity populations are evaluated and monitored through subcommittees of the EOCCO Quality Improvement Committee which has oversight of the TQS; 3) EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis. 4) EOCCO creates and shares cultural competence training programs that is available to its workforce, provider network, and community partners.
Behavioral Health (MH & SUD)	4A	4N	Outpatient Services for both Mental Health and SUD	Primary payment is Capitation. Incentive payments include Initiation and Engagement in SUD treatment, Increased engagement in MAT for members diagnosed with opioid use disorder and others.

Required implementation of care delivery areas by January 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. Refer to Value-based Payment Technical Guide for CCOs at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf for more information on requirements.

Evaluation Criteria for this worksheet: Response required for each highlighted cell. If question on row 19 and 20 are not applicable, include that as a response or it will not be approved.

CONTRACTOR/CCO NAME:	EOCCO
Describe Care Delivery Area (CDA) Note: a VBP may encompass two CDAs concurrently. If your CCO has take this approach, list both CDAs; no more than two CDAs can be combined to meet CDA requirement.	**The hospital CDA is specific to all cause in-patient re-admits. The accountability is primary with the hospitals and all hospitals who are participating in EOCCO's Shared Savings Model are included. The target is an improvement (reduction) from the prior year.**
LAN category (most advanced category)	**3B**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	**The quality incentive arrangement is effective for dates of service incurred from January 1, 2022 through December 31, 2022. Care delivery area payments will be calculated in alignment with the Risk Sharing Model calculations and payment will be incorporated into the settlement payments in third quarter 2023.**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**This VBP directly targets patients with complex care needs, as they are the ones most likely to experience readmits.**
Total dollars paid	**TBD- This was implemented as of 1/1/2022**
Total unduplicated members served by the providers	**TBD- This was implemented as of 1/1/2022**
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	**The measurement target for this measure will be based on the hospital's ability to control readmissions. Hospitals will receive an adjustment to the shared savings model surplus (or deficit), per the table below. [redacted] In the case of a shared saving deficit, the adjustments are reversed; for example a readmit rate greater than 8% increases the deficit owed by the amount indicated. However, any adjusted shared savings model deficit is still capped at the withhold amount.** **[redacted] This assumes all hospitals achieve max bonus based on a typical shared saving surplus amount.** [redacted]

If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	**The measurement target for this measure will be based on the hospital's ability to control readmissions. Hospitals will receive an adjustment to the shared savings model surplus (or deficit), per the table below. [redacted] In the case of a shared saving deficit, the adjustments are reversed; for example a readmit rate greater than 8% increases the deficit owed by the amount indicated. However, any adjusted shared savings model deficit is still capped at the withhold amount.** **[redacted] This assumes all hospitals achieve the lowest results based on a typical shared saving surplus amount. The** **[redacted]**
List the quality metrics used in this payment arrangement using the table provide in below. A least one quality component is needed to meet requirement:	

Metric	Metric Steward (e.g. HPQMC, NQF, etc.)	Briefly describe how CCO assesses quality (e.g. measure against national benchmark, compare to providers' previous performance, etc.)	Describe providers' performance (e.g. quality metric score increased from 8 to 10)
The number of acute inpatient stays for patients 18 and older during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, with risk adjustment for the predicted probability of an acute readmission.	**OHA technical Specifications**	**Percent reduction of readmit rates from the previous review period**	**TBD- This will be evaluated in late summer.**

Required implementation of care delivery areas by January 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. Refer to Value-based Payment Technical Guide for CCOs at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf for more information on requirements.

Evaluation Criteria for this worksheet: Response required for each highlighted cell. If question on row 19 and 20 are not applicable, include that as a response or it will not be approved.

CONTRACTOR/CCO NAME:	EOCCO
Describe Care Delivery Area (CDA) Note: a VBP may encompass two CDAs concurrently. If your CCO has take this approach, list both CDAs; no more than two CDAs can be combined to meet CDA requirement.	**The maternity care CDA is specific to postpartum care. The provider (or physician) group that performed the delivery is held accountable for this CDA. To be eligible for the CDA, the provider group must have at least 10 deliveries within the measurement year. Denominators will be attributed to provider groups based on the rendering provider for the delivery, as identified by codes 59400, 59409, 59510, 59610, 59612, 59618, rendered for births between January 1 – December 30 of the measurement year. EOCCO is using the target as specified by OHA.**
LAN category (most advanced category)	**3A**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	**The Metrics and Scoring Committee selects benchmark and improvement targets for each quality measure for the CCOs. Provider groups will receive a bonus payment based on their performance meeting or exceeding EOCCO's 2022 measure target. EOCCO will publish this rate within 30 days of notification from the Oregon Health Authority. In subsequent years, calculations will be based on a provider group's ability to meet the EOCCO measure target published by OHA and show improvement from the prior year's performance to receive the highest level of bonus percentage calculation. The bonus will be calculated based on the provider group's total reimbursement for professional delivery services as identified by the list of codes above. [redacted]** **See cells D13:G16 for the rate schedule**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**Inadequate postpartum care can contribute to persistent racial and ethnic disparities in maternal and infant health outcomes.**
Total dollars paid	**TBD- This was implemented as of 1/1/2022**
Total unduplicated members served by the providers	**TBD- This was implemented as of 1/1/2022**
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	[redacted]
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	**There is no downside risk in this model**
List the quality metrics used in this payment arrangement using the table provide in below. A least one quality component is needed to meet requirement:	

Year	Improved from last year	Met target	Did not meet target
1	N/A	15%	0%
2+	Yes	20%	10%
	No	15%	0%

Metric	Metric Steward (e.g. HPQMC, NQF, etc.)	Briefly describe how CCO assesses quality (e.g. measure against national benchmark, compare to providers' previous performance, etc.)	Describe providers' performance (e.g. quality metric score increased from 8 to 10)
The percentage of deliveries of live births between January 1 – December 30 of the measurement year that had a postpartum visit on or between 7-84 days after delivery.	**OHA technical Specifications**	**See above for year one and year two assessment. The "met target" is meeting the EOCCO improvement target or benchmark, whichever is less.**	**TBD**

Required implementation of care delivery areas by January 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. Refer to Value-based Payment Technical Guide for CCOs at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf for more information on requirements. **Evaluation Criteria for this worksheet:** Response required for each highlighted cell. If question on row 19 and 20 are not applicable, include that as a response or it will not be approved.	
CONTRACTOR/CCO NAME:	EOCCO
Describe Care Delivery Area (CDA) Note: a VBP may encompass two CDAs concurrently. If your CCO has take this approach, list both CDAs; no more than two CDAs can be combined to meet CDA requirement.	**Outpatient Behavioral Health (both Mental Health and SUD)**
LAN category (most advanced category)	**4A**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	**CMHP responsible for all Outpatient Behavioral Health (Mental Health & SUD)**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	Primary payment is Capitation. Incentive payments include Initiation and Engagement in SUD treatment, Increased engagement in MAT for members diagnosed with opioid use disorder and others (see attached).
Total dollars paid	[redacted]
Total unduplicated members served by the providers	**65,800 potential (based on 12/2021 membership)**
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	[redacted]
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	**There is no downside risk in this model**
List the quality metrics used in this payment arrangement using the table provide in below. A least one quality component is needed to meet requirement:	

Metric	Metric Steward (e.g. HPQMC, NQF, etc.)	Briefly describe how CCO assesses quality (e.g. measure against national benchmark, compare to providers' previous performance, etc.)	Describe providers' performance (e.g. quality metric score increased from 8 to 10)
Meeting 2022 EOCCO targets for Initiation and Engagement in SUD Treatment	**NCQA**	**2022 measures**	**2022 measures**
Increased engagement in MAT for members diagnosed with an opioid use disorder	**GOBHI / EOCCO Internal Utilization Review**	[redacted]	[redacted]
Reduced readmissions to emergency departments for BH reasons	**GOBHI / EOCCO Internal Utilization Review**	[redacted]	
Reduce readmissions of BH acute care hospitalizations	**GOBHI / EOCCO Internal Utilization Review**	[redacted]	
Increased number of peer delivered BH services provided to Members	**GOBHI / EOCCO Internal Utilization Review**	[redacted]	[redacted]

Required implementation of care delivery areas by January 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. Refer to Value-based Payment Technical Guide for CCOs at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf for more information on requirements.

This worksheet is voluntary for this reporting year.

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Describe Care Delivery Area (CDA) Note: a VBP may encompass two CDAs concurrently. If your CCO has take this approach, list both CDAs; no more than two CDAs can be combined to meet CDA requirement.	
LAN category (most advanced category)	
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	
Total dollars paid	
Total unduplicated members served by the providers	
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	
List the quality metrics used in this payment arrangement using the table provide in below. A least one quality component is needed to meet requirement:	

Metric	Metric Steward (e.g. HPQMC, NQF, etc.)	Briefly describe how CCO assesses quality (e.g. measure against national benchmark, compare to providers' previous performance, etc.)	Describe providers' performance (e.g. quality metric score increased from 8 to 10)

Required implementation of care delivery areas by January 2022: Hospital care, Maternity care and Behavioral health care; Children's health care and Oral health care CDAs are required by 2024. Refer to Value-based Payment Technical Guide for CCOs at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf for more information on requirements.

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LAN category (most advanced category)	
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