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

Required: Complete all yellow highlighted cells on one of the following worksheets. The other worksheet is optional:
"Children's Health CDA VBP Data"
"Oral Health CDA VBP Data"

2. For payments that span multiple HCP-LAN categories, use the most advanced category. For example, if 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 HCP-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@odhsoha.oregon.gov** no later than May 5, 2023. 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).

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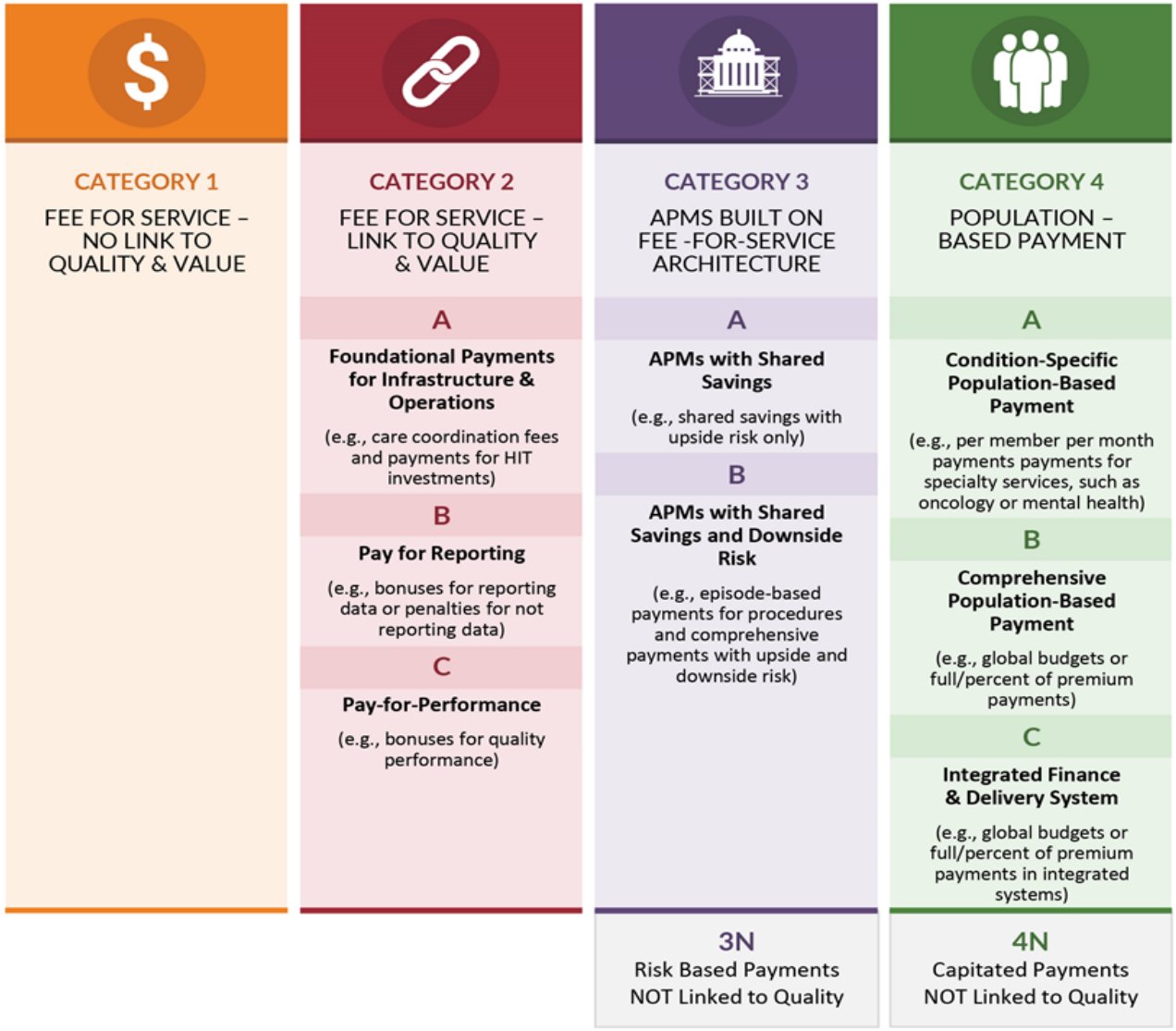
https://hcp-lan.org/groups/apm-refresh-white-paper/



CONTRACTOR/CCO NAME: Health Share of Oregon (CareOregon ICN)
REPORTING PERIOD: **1/1/2022 - 12/31/2022**

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 dollar amount or range**	**Average PMPM dollar amount**	**If a PMPM range (rather than a fixed dollar amount) is provided in column C, please explain.**	**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					No Tier 1 clinics currently participate in the program
Tier 2 clinics					No Tier 2 clinics currently participate in the program
Tier 3 clinics	17	$6.47-$16.80	$ 12.94	Clinic payment rates vary throughout the year based on quality levels.	
Tier 4 clinics	74	$3.40-$16.05	$ 11.92	Clinic payment rates vary throughout the year based on quality levels.	
Tier 5 clinics	33	$10.00-$16.05	$ 14.33	Clinic payment rates vary throughout the year based on quality levels.	

CONTRACTOR/CCO NAME: Health Share of Oregon (CareOregon ICN)
REPORTING PERIOD: **1/1/2022 - 12/31/2022**

Evaluation criteria for this worksheet: Response required for each highlighted cell. Non-response in a highlighted cell will not be approved.

Brief description of the five largest models, defined by dollars spent and VBPs implemented (e.g. condition-specific (asthma) population-based payment)	**Most advanced LAN category in the VBP model** (4 > 3 > 2C) *Note: For models listed at a LAN category 3B or higher, please list the risk sharing rate.*	**Percentage of payments made through this model at the highest indicated LAN category**	**Additional LAN categories within arrangement**	**Total dollars involved in this arrangement**	**Quality metric(s)**	**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**
PCPCH PMPM Payment Program	2C	100%	N/A	$31,385,508	Numerically described in the PCPCH tab. Incorporates providers that achieve PCPCH tier recognition, and provides payments based on quality, behavioral health and oral health integration, and cost of care performance.	The PCPCH payments for quality are risk-adjusted into low-, medium-, and high-risk clinics to provide additional funding for providers serving members with complex health care needs.	The PCPCH payments for quality are risk-adjusted into low-, medium-, and high-risk clinics to provide additional funding for providers serving members with complex health care needs.
Capitation	4A	100%	N/A	$6,795,760	Primary Care providers receiving a fixed payment monthly based on assigned membership in place of fee for service payments for an identified population of CPT codes.	Our providers receiving primary care capitation serve some of our highest need members. The groups we currently have capitation arrangements with include: Providence	Provider receivign primary care capitation serve some of our highest needs members. The groups we currently have capitation arrangements with include: Yakima Valley Farm Workers (FQHC), Virginia Garcia (FQHC); North by Northeast (Small community-clinic serving primarily Black or African-American members in NE Portland); Housecall Providers (A clinic serving very high needs members who require home-based care.)
Behavioral Health Quality Program	2C	100%	N/A	$ 2,917,218	Includes key Behavioral health providers that are providing Mental Health and/or Substance Use Disorder treatment. Providers must serve Health Share members and meet a minimum threshold of members served/services provided on an annual basis. Providers receive additional payments based on meeting a number of key quality metrics that are specific to the Mental Health and/or SUD services that they provide.	The goal of the BH Quality Improvement Incentive Program (QIIP) is to assess multiple indiactors of quality among netowrk providers and produce an overall provider performance report which can be used to drive imporvement in areas critical to serving all of our members	The payment program is based on the amount of services provided so providers that serve fewer but more complex patients would have their payment reflect the level of services that they are providing.
PCP Behavioral Health Integration	2C	100%	N/A	$5,902,104	Includes behavioral health services provided in primary care settings, focused on overall population reach and subpopulation reach	Primary Care providers receive PMPM payments for directly integrating behavioral health services. Not intended to provide specialty behavioral support, but same day access for immediate care needs.	This model is designed to specifically incentivize and reward clinics for providing on-site behavioral health staff to improve the integration of physical health and behavioral health services within the primary care medical home. The model directly benefits members with both physical and behavioral health needs.
MLR Risk Agreement	3B	100%	2C	$1,639,560	Includes immunization, SBIRT, well-child, pediatric dental, and language access metrics.	Yakima Valley Farm Workers is participating in a risk adjusted Medical Loss Ratio risk agreement. All physical health costs are included for assigned members, with limited exclusions (e.g., Hep C drugs) as negotiated with provider partners. Shared savings are gated by quality metric performance.	This model accounts for the risk of assigned members included in the risk share program. Members with higher risk and more complex conditions have a higher cost target and represent higher potential cost savings for the provider. The model takes into account the current year's risk adjustment to incentivize accurate coding and documentation of member conditions by the provider.

Required implementation of care delivery areas by January 2023: 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 questions on rows 18 and 20 are not applicable, write N/A.

CONTRACTOR/CCO NAME:	Health Share of Oregon (CareOregon ICN)
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	**Hospital Care**
LAN category (most advanced category)	**2C**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	**This payment arrangement incentivizes high quality care within Legacy Hospitals in the Metro Portland region. The program focuses on readmission rates, transition of care, and patient safety indicators. The payment arrangement is across all hospitalizations with the exception of a few types of hospitalizations such as transplant services.**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**This CDA program represents a percent of upside and downside-risk for each hospitalization, so it places greater weight on more complex hospitalizations.**
Total dollars paid	**115,841,549**
Total unduplicated members served by the providers	**10,582**
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	**4,459,725**
If applicable, maximum potential provider loss in dollars (e.g. maximum potential risk in a capitated payment)	**4,459,725**

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)
Plan All Cause Readmissions	NCQA	Compare to providers' previous year performance	performance improved, the O/E index target was ≤1.2422 and performance was 1.0276
Transitions of Care	HEDIS	this was a baseline year to assess against CMS benchmarks	reporting only
Severe Sepsis and Septic Shock: management bundle	NQF #0500	Compare to providers' previous year performance	performance improved across all facitlies (lower is better), average target was 46% and average performance was 37%
Cesarean Births		Compare to providers' previous year performance	reporting only
HCAHPS: Medication Explanation	CMS Care Compare	Compare to providers' previous year performance	performance was low across all facilities, average target was 67% and average performance was 63%
Reducing revisit for frequent ED users	OHA HTTP	this was a baseline year	reporting only

Required implementation of care delivery areas by January 2023: 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 questions on rows 18 and 20 are not applicable, write N/A.

CONTRACTOR/CCO NAME:	Health Share of Oregon (CareOregon ICN)
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	**Maternity Care**
LAN category (most advanced category)	**2B**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	**PMPM quarterly payments made to providers to support MAT/SUD services, and the necessary coordination and supports in a primary care setting. This program specifically focuses on pregnant people. WHA and Legacy midwifery**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**This program is specifically focused on the intersection of behavioral health and physical health needs. Members served represent the pregnant population that have been identified as benefitting from MAT/SUD services.**
Total dollars paid	**841,332**
Total unduplicated members served by the providers	**70**
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)
Timeliness of Postpartum Care	OHA	this was a baseline year	reporting only
Number of eligible members who received a service by the integrated perinatal/SUD care team	Nurture Oregon	this was a baseline year	reporting only

Required implementation of care delivery areas by January 2023: 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 questions on rows 18 and 20 are not applicable, write N/A.

CONTRACTOR/CCO NAME:	Health Share of Oregon (CareOregon ICN)
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	**Behavioral Health**
LAN category (most advanced category)	**2C**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	**Performance incentive payments driven by quality metric performance related to mental health and substance use disorder services. Providers are evaluated on a range of metrics specific to either mental health or SUD services and calibrated to the services they provide.**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**This program specifically focuses on members that receive mental health or SUD services. The payments to providers are based on the level of services they provide so the size of the payments would be higher for providers that serve more complex patient populations or offer more complex treatment modalities.**
Total dollars paid	**888,674,379**
Total unduplicated members served by the providers	**477**
If applicable, maximum potential provider gain in dollars (i.e., maximum potential quality incentive payment)	**5,834,436**
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)
Access to Care - third next available non-urgent OP MH assessment appt	Mutually agreed/created by plan and provider	internally agreed upon benchmark based on regional benchmarks	performance is based on days out for third next available thresholds
Case Management for Clients with Schizophrenia - % of clients with schizophrenia diagnosis who received at least one case management service for every 90 days in service	Mutually agreed/created by plan and provider	internally agreed upon benchmark based on regional benchmarks	Improvement targets were set using the minnestoa method with no floor or gap, using estalished benchmarks based on baseline year performance. Final performance is TBD.
SUD follow-up care after withdrawal managmement - % of withdrawal management episodes where clients receive or more SUD treatment services during the episode or within 14 days after episode ends	Mutually agreed/created by plan and provider	compare to provider's previous performance	Improvement targets were set using the minnestoa method with no floor or gap, using estalished benchmarks based on baseline year performance. Final performance is TBD.
Primary Care Visit - for clients without prior primary care, the % of all outpatient SUD treatment episodes with one or more primary care encounters during the episode or within 30 days after episode ends	Mutually agreed/created by plan and provider	compare to provider's previous performance	Improvement targets were set using the minnestoa method with no floor or gap, using estalished benchmarks based on baseline year performance. Final performance is TBD.

Required implementation of care delivery areas by January 2023: In 2022, CCOs were required to implement three new or expanded CDA VBP arrangements from an existing contract (in hospital care, maternity care, and behavioral health care). In 2023 and 2024, CCOs are required to implement a new or expanded VBP at the beginning of each year in each of the remaining CDAs (children's health care and oral health care). VBP contracts in all five CDAs must be in place by the beginning of 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: CCO must fill out a worksheet for either oral health or children's health. The remaining worksheet (for the remaining CDA) is optional.

CONTRACTOR/CCO NAME:	Health Share of Oregon (CareOregon ICN)
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the 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)
Oral Health assessment, preventive care, referral, and patient education - pediatric population (narrative process measure)	developed by dental team, aligned with existing OHA measures	narrative reporting	this measure was focused on processes and workflows and was scored as Pass/No Pass based on standardized scoring rubric
Oral Health assessment, preventive care, referral, and patient education - adults with diabetes population (narrative process measure)	developed by dental team, aligned with existing OHA measures	narrative reporting	this measure was focused on processes and workflows and was scored as Pass/No Pass based on standardized scoring rubric

Required implementation of care delivery areas by January 2023: In 2022, CCOs were required to implement three new or expanded CDA VBP arrangements from an existing contract (in hospital care, maternity care, and behavioral health care). In 2023 and 2024, CCOs are required to implement a new or expanded VBP at the beginning of each year in each of the remaining CDAs (children's health care and oral health care). VBP contracts in all five CDAs must be in place by the beginning of 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: CCO must fill out a worksheet for either oral health or children's health. The remaining worksheet (for the remaining CDA) is optional.

CONTRACTOR/CCO NAME:	Health Share of Oregon (CareOregon IDN)
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken this approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	**Children's Health**
LAN category (most advanced category)	**2C**
Briefly describe the payment arrangement and the types of providers and members in the arrangement (e.g. pediatricians and asthmatic children)	Incorporates providers that achieve PCPCH tier recognition, and provides payments based on quality, behavioral health and oral health integration, and cost of care performance, with a track and measures focused on pediatrics
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	
Total dollars paid	$ 25,717,199.75
Total unduplicated members served by the providers	163,375
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)
Well Child Visits 3-6 yo	NCQA	compare to providers' previous performance and set improvement targets against benchmarks	Improvement targets were set using the minnestoa method based on prior year performance. We are in the process of finalizing performance.
Immunizations for Adolescents	NCQA	compare to providers' previous performance and set improvement targets against benchmarks	Improvement targets were set using the minnestoa method based on prior year performance. We are in the process of finalizing performance.