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 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"

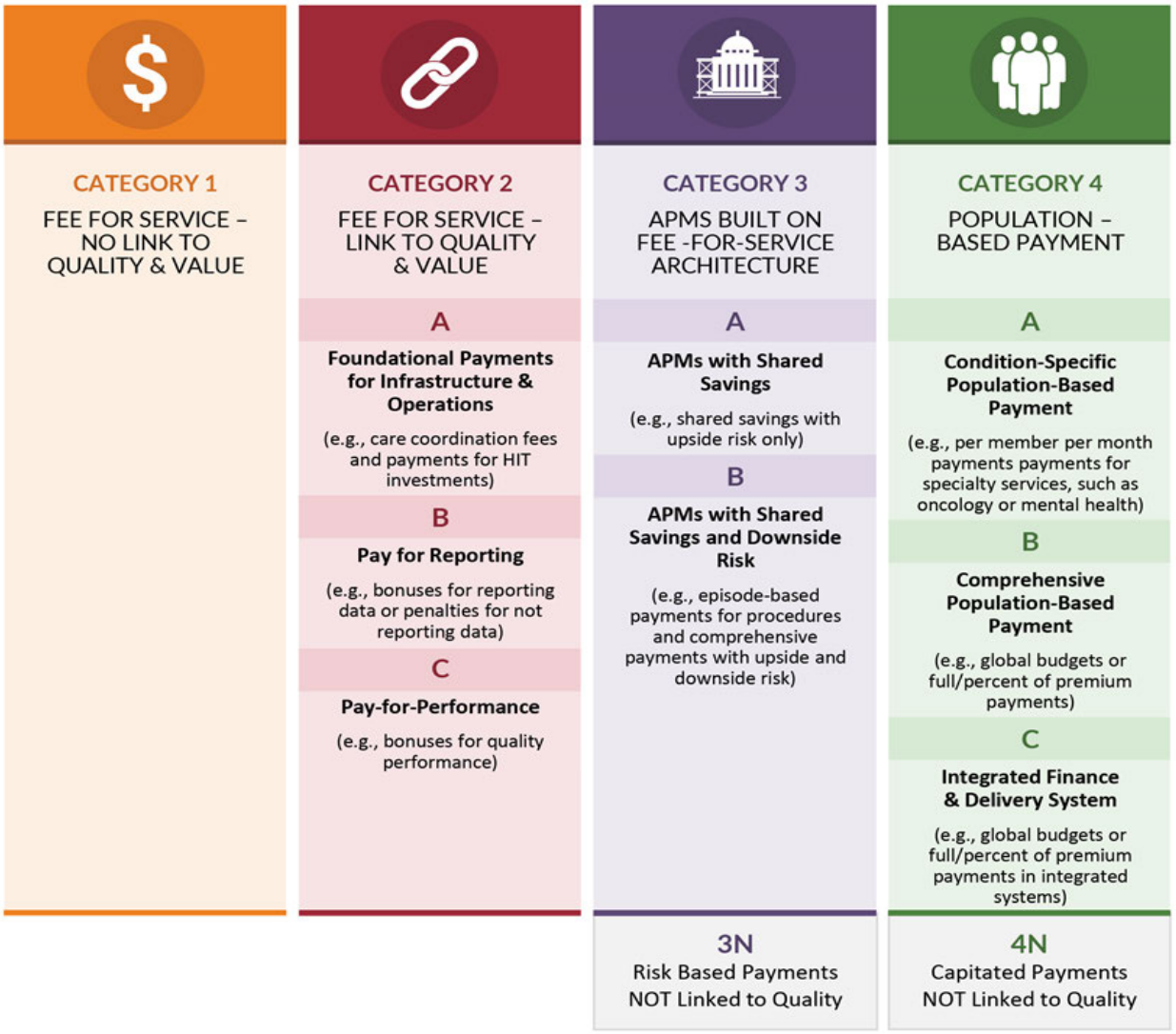
2. For payments that span multiple HCP-LAN categories, use the most advanced category. For example, if you have a contract that includes a shared savings arrangement with a pay-for-performance component – such as a quality incentive pool – then you should put the total value of the annual contract in 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).

version 02032023

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



CONTRACTO Umpqua Health Alliance
REPORTING F **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	[redacted]				
Tier 2 clinics					
Tier 3 clinics					
Tier 4 clinics					
Tier 5 clinics					

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REPORTING PERIOI **1/1/2022 - 12/31/2022**

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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**
[redacted]	4C	2%	*2B, 2C, 3B*	[redacted]	CCO Quality Metrics Performance (Plan); Readmission Rate; Follow Up Post Discharge from Hospital IP; Expected to Observed Mortality; High ED Utilization; MAT/Addiction Treatment in ED (SBIRT)	Recognizes that some quality metrics requires the full community of providers to achieve ER utilization, hospital readmission and 7-day follow-up after hospitalization are interconnected. Using the same metrics to incent improved processes within each accountable group ensures assumption of responsibility for action. Example: hospital discharge planning flows into 7-day follow-up by primary or specialist, and ER visits tie into hospitalizations. The metrics have allowed our community of providers to collaborate and support our community hospital in ensuring effective ER utilization, discharge planning, and effective follow up. UHA's VBP program uses a community based member attribution cost model, which includes community wide performance on CCO Metrics to determine risk sharing amounts to be held or paid to participating providers in the community.	Both of the groups mentioned above descr bed present greater challenges to ensure proper discharge planning, outpatient follow-up and ER management. If these are not addressed, then metrics will not be met.
[redacted]	4C	100%	*2C*	[redacted]	Readmission Rate; Follow Up Post Discharge from Hospital IP; Expected to Observed Mortality; High ED Utilization; MAT/Addiction Treatment in ED (SBIRT)	Recognizes that some quality metrics requires the full community of providers to achieve ER utilization, hospital readmission and 7-day follow-up after hospitalization are interconnected. Using the same metrics to incent improved processes within each accountable group ensures assumption of responsibility for action. Example: hospital discharge planning flows into 7-day follow-up by primary or specialist, and ER visits tie into hospitalizations. The metrics have allowed our community of providers to collaborate and support our community hospital in ensuring effective ER utilization, discharge planning, and effective follow up.	Both of the groups mentioned above descr bed present greater challenges to ensure proper discharge planning, outpatient follow-up and ER management. If these are not addressed, then metrics will not be met.

[redacted]	4A	8%	*2C, 4N*	[redacted]	Outpatient Access of Care; Initiation of Treatment Following Dx; Member Engagement; Member Retention; Residential Access of Care; Engagement of Members Admitted to Detox; Post-Detox Retention in Treatment; Residential Retention; Post-Residential Retention; Cigarette Smoking Prevalence; SUD Initiation/Engagement Metric	[redacted] provides the entire realm of substance use disorder services for UHA. This includes residential, detox, MAT services, and outpatient services. [redacted] is paid on a PMPM which has certain financial and quality target that it is at risk for.	Both populations noted above are more at risk for substance use disorder, in which [redacted] provides significant services to address those populations needs.
[redacted]	4A	3%	*2C, 4N*	[redacted]	ED Follow Up for dental related pain; Dental Utilization; Members Receiving Preventive Dental Services (aged 1-14); Oral Evaluation for Adults w/ Diabetes; Meaningful language access to culturally responsive health care	[redacted] provides global capitation services for UHA members seeking Dental Care. [redacted] provides the whole spectrum services to UHA members, and are awarded for achieving certain quality targets	One of the quality measures that [redacted] is incentivized on, is its ability to achieve certain penetration metrics. People with complex health needs, as well as individuals with racial and ethnic disparities, typically lag behind the rest of the population in obtaining health care services. The penetration metric incentivizes [redacted] by engaging these subpopulations in obtaining proper access and services.

[redacted]	4A	15%	*4N*	[redacted]	Days between crisis event and follow up - Emergent (1 day); Days between crisis event and follow up - Urgent (<2 days); % of people receiving crisis services that attend first follow up appt; Routine (non-crisis) requests for service offered a service within 14 days	[redacted] is Douglas County's Local Mental Health Authority, as well as the sole Community Mental Health Program (CMHP). Due to these designations, Compass provides the related fidelity programs, intensive behavorial health treatment, as well as traditional mental health services such as outpatient and intensive outpatient services.	Both populations noted above are more at risk for substance use disorder, in which Compass provides significant services to address those populations needs.

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:	Umpqua Health Alliance
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken his approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	**Hospital Care and Maternity Care**
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)	**A combined hospital/maternity case rate with the sole community hospital**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**UHA is dedicated to improving health equity. According to the CDC, black women are significantly more likely to experience conditions such as a weakened heart muscle, thrombotic pulmonary embolism, and high blood pressure, which can contribute to a significantly higher proportion of pregnancy-related deaths in comparison to white women. Addressing these issues with the mother during prenatal care could potentially improve the mother's safety and well-being, but also help eliminate unnecessary costs. In addition, preterm birth rates for minorities are disproportional against their white counterparts. According to the March of Dimes, in 2015, the overall preterm rate was 9.6%, but 13.4% of black infants were preterm, as compared to the 8.9% rate for white infants. Furthermore, non-white infant mortality caused by preterm birth and related complications was significantly higher (44.2% for black infants compared to 31.5%).**
Total dollars paid	[redacted] Net
Total unduplicated members served by he providers	**390**
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)	**-**

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)
C-Section Delivery Rate at Contracted Hospital; <=22%		**Based on provider historical rate and negotiated improvement target; nationwide average was 32.1% in 2021 (March of Dimes)**	**Provider performance is trending positively**

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.

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Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken his approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	**Maternity Case Rate w/ WH**
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)	**A combined hospital/maternity case rate with the sole community hospital**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**UHA is dedicated to improving health equity. According to the CDC, black women are significantly more likely to experience conditions such as a weakened heart muscle, thrombotic pulmonary embolism, and high blood pressure, which can contribute to a significantly higher proportion of pregnancy-related deaths in comparison to white women. Addressing these issues with the mother during prenatal care could potentially improve the mother's safety and well-being, but also help eliminate unnecessary costs. In addition, preterm birth rates for minorities are disproportional against their white counterparts. According to the March of Dimes, in 2015, the overall preterm rate was 9.6%, but 13.4% of black infants were preterm, as compared to the 8.9% rate for white infants. Furthermore, non-white infant mortality caused by preterm birth and related complications was significantly higher (44.2% for black infants compared to 31.5%).**
Total dollars paid	[redacted] Net
Total unduplicated members served by he providers	**390**
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)	-

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)
C-Section Delivery Rate at Contracted Hospital; <=22%		**Based on provider historical rate and negotiated improvement target; nationwide average was 32.1% in 2021 (March of Dimes)**	**Provider performance is trending positively**

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:	Umpqua Health Alliance
Describe Care Delivery Area (CDA) ***Note:*** a VBP may encompass two CDAs concurrently. If your CCO has taken his approach, list both CDAs; no more than two CDAs can be combined to meet the CDA requirement.	**Behavioral Health Access Program**
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)	**PCPCH Tier 3 or higher clinics. Members with MMMI/SUD diagnosis in the past 12 months**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	
Total dollars paid	[redacted]
Total unduplicated members served by he providers	**8,983**
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)	

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)
Behavorial Health Services provided to assigned members of PCPCH Tier 3 or higher participa ing clinics wi h a MMMI/SUD diagnosis.			
Behavioral Health Integration Checklist; Percentage of members served by assigned PCPCH Clinic	**IBHC Atlas**	**UHA is using integrated care as a model to improve access to specialty behavioral health. By encouraging clinics that invest in integrated care models, it allows for whole person care in their PCPCH. UHA uses claims data to review previous provider claims for PCP and BH. The goal is to treat mild to moderate behavioral health in the PCP office when appropriate. Freeing up access to specialty Behavioral Health. Historically what you see is when a person is referred to behavioral health, they tend to stay in the specialty services and not be referred back to the PCP for continued treatment. UHA uses DX codes from the PCP claims to reward them for treatment of mild to moderate mental illness (MMMI) or substance use disorders (SUD). PCPs treating MMMI and/or SUD frees up access to specialty behavioral health for more severe needs.**	**Year one was opt-in to the metric and year two added more providers increasing access to specialty care. Over 90% of UHA membership is assigned to PCPCHs participating in the VBP.**

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:	Umpqua Health Alliance
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.	**Focus on increasing services rendered to children in DHS Custody**
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)	**Additional payment made to the first physician group who renders a relevant service that meets numerator criteria for children in DHS Custody**
If applicable, describe how this CDA serves populations with complex care needs or those who are at risk for health disparities	**The CDA focuses on expediency of services for children entering DHS care**
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)
Children in DHS Custody CCO Metric	**OHA**	**Measure against CCO Performance Contract settlement begins July 1, 2024**	**UHA rate increased from 77% to 89% ('20 to '21) first year utilizing VBP is 2023**

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:	Umpqua Health Alliance
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:

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