CareOregon
Primary Care Payment Model

2022 Program Description

Applications must be returned to CareOregon via email to PaymentModel@careoregon.org by March 11, 2022.

CareOregon

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Overview

At the local, state, and national level, efforts are underway to encourage movement away from traditional volume-based or fee for service health care payments. In line with this goal, The Oregon Health Authority (OHA) has included annual value-based payment targets that Coordinated Care Organizations (CCOs) will be held accountable to over the 2020 through 2024-year period. The OHA has aligned implementation of this strategy with the Centers for Medicare and Medicaid Services (CMS) Health Care Payment Learning and Action Network (LAN) framework, a nationally accepted methodology. Additional information on this state and national work can be found on the OHA's value-based payment website. [1]

CareOregon has aligned with these strategies through the Primary Care Payment Model (PCPM) Program. The Program invests in critical services that are not adequately represented by fee for service (FFS) billable codes, and endeavors to shift the need for healthcare dollars from within the acute care service environments, to outpatient preventive services. Two program goals are to improve the health of our communities while also shifting reimbursement away from FFS models.

The aim of the Program is to support primary care transformation in the CareOregon network by facilitating:

1. Knowledge of and accountability for engaging assigned populations in a timely and clinically appropriate manner.
2. Reduction of health disparities through trauma-informed, culturally responsive, and inclusive care.
3. Integration of oral health and primary care.
4. Integration of behavioral health services into primary care.
5. Active contribution to reducing total cost of care.

CareOregon PCPM At a Glance-Placeholder

The CareOregon Primary Care Payment Model has four Focus Areas.

1. *Clinical Quality Focus Area*
   The Clinical Quality Focus Area drives outcomes and equity through seven quality measures which may include CCO focused measures, an access & engagement measure, and one equity report.

2. *Behavioral Health Integration Focus Area*
   The Behavioral Health Integration (BHI) Focus Area funds clinics that attest to following the CareOregon BHI Program Model.

3. *Oral Health Integration Focus Area*
   The Oral Health Integration Focus Area strives to promote collaboration and coordination by aligning priorities and incentives across both physical and oral health sectors.

4. *Cost of Care Focus Area*
   The Cost of Care Focus Area invests in clinics that are using the primary care medical home model—Primary Care Patient Centered Home (PCPCH)—to reduce unnecessary utilization and total cost of care of their patients.

[1] Value-based Payment. Oregon Health Authority. Retrieved from https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx.

Eligibility Requirements for Participation

Eligibility requirements must be met at the time of CareOregon Metro PCPM application deadline.

- ✓ **750+ assigned CareOregon Members.**
  A minimum of 750 CareOregon Metro members must be assigned to provider organization, when combined across all contracted clinics.
- ✓ **Open assignment.**
  Clinics must be open to assignment of new CareOregon Metro members for a minimum of nine (9) months of the year.

- ✓ **Tier 3+ Oregon PCPCH Recognition.**
  All participating clinics must hold Oregon PCPCH recognition of Tier Three (3) or above

Program Rates

Each focus area corresponds with a per member per month (PMPM) payment level, depending on performance. Each focus area is combined to make up a total PMPM payment.

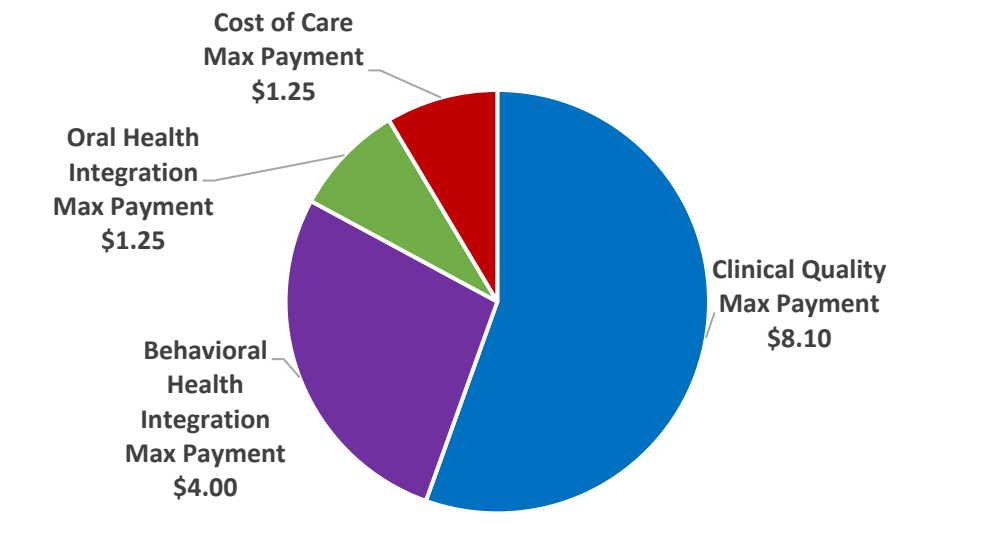
Focus Area	Level 0 PMPM	Level 1 PMPM	Level 2 PMPM	Level 3 PMPM
Clinical Quality	$ 0.00	$ 3.40	$ 4.95	$ 8.10
Behavioral Health Integration	$ 0.00	$ 2.00	$ 4.00	N/A
Oral Health Integration	$ 0.00	$ 1.25	N/A	N/A
Cost of Care	$ 0.00	$ 1.25	N/A	N/A

Example:

Clinic A achieved payment level 3 for Clinical Quality, level 1 for Behavioral Health Integration, level 1 for Oral Health Integration, and level 0 for Cost of Care. Based on their performance, Clinic A's total payment would be $11.35 PMPM.

Focus Area	Level 0 PMPM	Level 1 PMPM	Level 2 PMPM	Level 3 PMPM	Total PMPM
Clinical Quality	$0.00	$3.40	$4.95	$8.10	$ 11.35 PMPM
Behavioral Health Integration	$0.00	$2.00	$4.00	N/A	
Oral Health Integration	$0.00	$1.25	N/A	N/A	
Cost of Care	$0.00	$1.25	N/A	N/A	

Breakdown of Maximum Payments by Focus Area for the above clinic:



Risk Adjustment

Program rates displayed above reflect the minimum rates assigned to each payment level. Clinical Quality PMPM rates may be adjusted higher than the program rates displayed above depending on risk assignment. CareOregon reviews clinic risk assignment on an annual basis. Quality component PMPM rates range from $3.40 to $11.00 after risk adjustment is applied.

Risk adjustment methodology is based on risk scores and rate codes used by OHA. This method uses the Chronic Illness & Disability Payment System (CDPS) risk model.

Clinical Tracks and Focus Area Measures-CareOregon

Clinical Tracks and Focus Area Measures

One of three (3) clinical tracks must be selected for each participating clinic in the program application that best aligns with each clinic's patient population: Family Practice, Pediatric, or Internal Medicine. Each clinical track includes 11 total measures across all four focus areas.

Focus Area	#	Family Practice Track	Pediatric Track	Internal Medicine Track
Clinical Quality	1	Kindergarten Readiness: Well-Child Visits 3-6 yo	Kindergarten Readiness: Well-Child Visits 3-6 yo	Colorectal Cancer Screening
	2	Immunizations for Adolescents (MCV4, Tdap, HPV)	Childhood Immunization Status (Combo 3)	Controlling High Blood Pressure
	3	Diabetes: HbA1c Poor Control	Immunizations for Adolescents (MCV4, Tdap, HPV)	Diabetes: HbA1c Poor Control
	4	Alcohol and Drug Misuse: SBIRT Rate 1&2	Alcohol and Drug Misuse: SBIRT Rate 1&2	Alcohol and Drug Misuse: SBIRT Rate 1&2
	5	Screening for Depression and Follow-Up Plan	Screening for Depression and Follow-Up Plan	Screening for Depression and Follow-Up Plan
	6	Clinic-Defined Measure: Access & Engagement	Clinic-Defined Measure: Access & Engagement	Clinic-Defined Measure: Access & Engagement
	7	Equity Report: Improving Language Access	Equity Report: Improving Language Access	Equity Report: Improving Language Access
BHI*	8	CareOregon Population Reach	CareOregon Population Reach	CareOregon Population Reach
	9	Choice of Sub-Population: - Patients with Positive SBIRT *or* - Patients with Diabetes: HbA1c > 9	Choice of Sub-Population: - Patients with Positive SBIRT *or* - Patients with Positive Depression Screen	Choice of Sub-Population: - Patients with Positive SBIRT *or* - Patients with Diabetes: HbA1c > 9
Oral Health Integration	10	Oral Health Assessment, Preventative Care, Referral, and Education - Pediatric Prevention and Diabetic Oral Health **	Oral Health Assessment, Preventative Care, Referral, and Education - Pediatric Prevention	Oral Health Assessment, Preventative Care, Referral, and Education - Diabetic Oral Health
Cost of Care	11	Inpatient and Emergency Department Utilization for Ambulatory Sensitive Conditions and Pediatric Cost of Care Narrative***	Pediatric Cost of Care Narrative Report	Inpatient and Emergency Department Utilization for Ambulatory Sensitive Conditions

*Only clinics that attest to delivering integrated behavioral health in alignment with CareOregon's BHI Model of Care are required to submit BHI Population Reach data.
** To meet the oral health integration metric, clinics choosing the Family Practice measure set must report on both the Pediatric Prevention and Diabetic Oral Health but need only meet one of the two requirements to pass the metric.
***To meet the Cost of Care metric, clinics choosing the Family Practice measure set must report on both the Inpatient and Emergency Department Utilization for Ambulatory Sensitive and submit a Pediatric Cost of Care Narrative but need only meet one of the two requirements to pass the metric.

Performance Evaluation

Performance is evaluated individually for each participating clinic. Clinics may achieve the PMPM amount that corresponds with the payment level based on performance in each focus area. Each focus area PMPM is combined to make up a total PMPM payment.

	Payment Level 0	Payment Level 1	Payment Level 2	Payment Level 3
Clinical Quality	$ 0.00 Improvement target or benchmark met on **< 50% measures**	(Unique to clinic) Range $3.40 to $8.10 Improvement target or benchmark met on **≥50% measures**	(Unique to clinic) Range $3.60 to $9.55 Improvement target or benchmark met on **≥60% measures**	(Unique to clinic) Range $4.60 to $11.00 Improvement target or benchmark met on **≥80% measures**
BHI	$ 0.00 < 5.0% reach on ***either*** measure	$ 2.00 ≥ 5.0 reach on ***both*** measures and < 12.0% on ***either*** measure.	$ 4.00 ≥ 12.0% reach on ***both*** measures.	
Oral Health Integration	$ 0.00 target **not met**	$ 1.25 target **met**		
Cost of Care	$ 0.00 target **not met**	$ 1.25 target **met**		

Improvement Targets

Several measures in the PCPM Program utilize improvement targets to determine performance. For these measures, participating clinics receive individualized improvement targets that are calculated using a baseline measurement of their performance during calendar year 2021. Measures using the Minnesota Method are denoted with "MM" in Appendix A.

Access & Engagement measures will be clinic specific and will have improvement over baseline targets ranging from 1 – 5%. This target will be set by CareOregon staff depending on the focus area of improvement and measure specifications.

Behavioral Health Integration reach measures have standard program benchmarks of 5% (Tier 1) and 12% (Tier 2) that all participating clinics must meet.

The Inpatient and Emergency Department Utilization for Ambulatory Sensitive Conditions Cost of Care measure has an improvement target of 1.5% and 3% over baseline for each reporting period, respectively. The Pediatric Cost of Care Narrative Report is required and must be submitted with completed answers to pass the measure.

Minnesota Method Improvement Target Calculation

To meet improvement targets, a minimum ten percent reduction in the gap between baseline and benchmark is required (*Figure 1: Improvement Target Methodology*) for all measures using this method except for the Oral Health Integration measures. Due to the current limitations on dental capacity, the Oral Health Integration measures need to be reported with the data submissions but will not have a PMPM impact during this program period.

Clinics that achieve or surpass the benchmark on any measure, are no longer required to meet an improvement target for that measure but must demonstrate maintenance of performance. In this case maintenance of performance will be defined as no less than a ten percent reduction between the benchmark and baseline (*Figure 2: Performance Maintenance Methodology*). If the reduction in performance is greater than ten percent, the measure will be deemed as not be met even if the benchmark is achieved.

Figure 1: Improvement Target Methodology

To meet improvement targets, a minimum ten percent reduction in the gap between baseline and the benchmark is required.

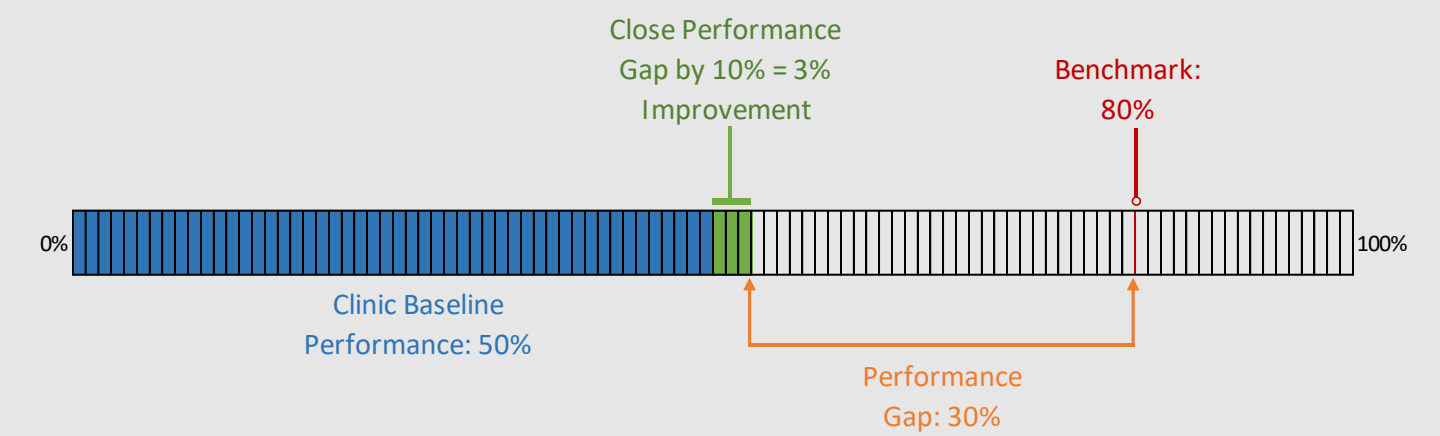
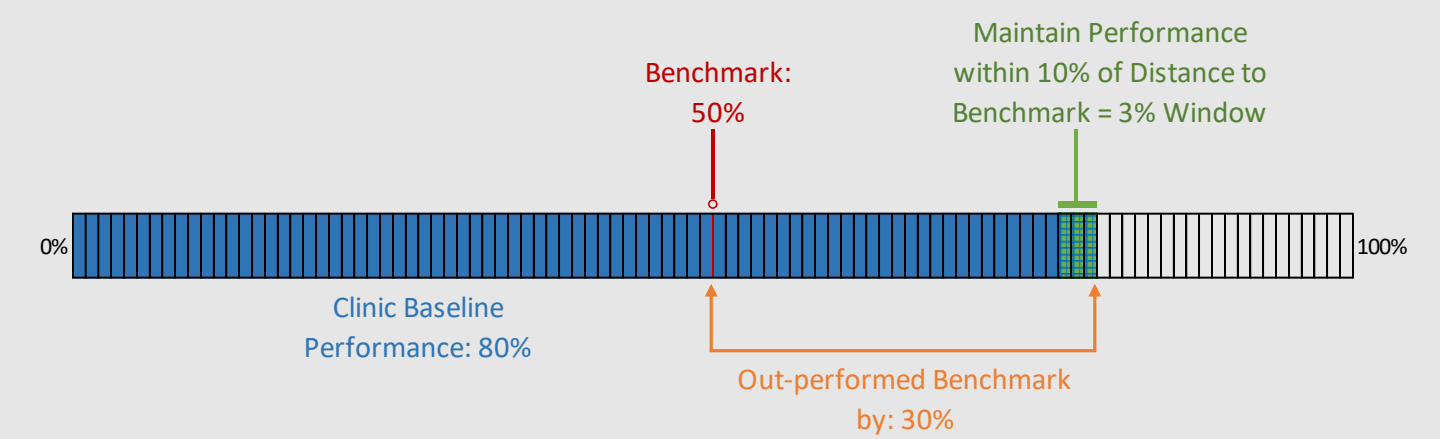


Figure 1 taken from Colorado Department of Health Care Policy & Financing
https://www.colorado.gov/pacific/sites/default/files/12.01.17%20Alternative%20Payment%20Model%20Survival%20Guide.pdf

Figure 2: Performance Maintenance Methodology

Clinics that achieve or surpass the benchmark on any measure, are no longer required to meet an improvement target for that measure but must demonstrate maintenance of performance with no more than a ten percent reduction between the benchmark and baseline.



Methodology Alignment

The methodology described above replicates that which is used by the OHA to administer the CCO quality pool program. This methodology is based on the Minnesota Department of Health's Quality Incentive Payment System, known as the "Minnesota Method" (MM) or "Basic Formula". All benchmarks and improvement floors mirror those chosen by the OHA for the CCO quality pool program.

More details on the methodology, including examples, can be found on the OHA website: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Improvement-Target-Methodology.pdf.

Data Submission Information

Performance evaluation occurs twice per year and determines payment level. The program includes various measure types in the performance evaluation. Detailed specifications for each measure can be found in Appendix B. The data submission process will occur through a secure, HIPAA compliant file sharing system called ShareFile. A data submission manual will be provided with usage instructions and additional details of this process.

Claims Measures

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

CareOregon will provide member-level and aggregate performance data to participating clinics quarterly. Performance data on most claims-based measures are available on the CareOregon Metrics Dashboard located on FIDO https://analytics.careoregon.org

EHR/eCQM Measures

For CCO EHR/eCQM measures, clinics that do not already provide CareOregon with data, or have data provided to CareOregon by another entity on the clinic's behalf, must submit member-level or aggregate performance data on all EHR/eCQM measures.

All data for EHR/eCQM measures must be submitted according to OHA specifications, which can be found on the OHA website: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/YearNine2021GuidanceDocumentation-final.pdf

Clinics for which this data is already provided to CareOregon are not required to submit member-level or aggregate performance data separately for PCPM. Please contact PaymentModel@careoregon.org with questions about whether CareOregon already receives this data for your clinic.

Roster Measures

The Family Practice and Pediatric clinical tracks each include one measure requiring member-level immunization status from EHR and/or Alert Immunization Information System (IIS). For these measures, CareOregon will provide clinics with a member roster twice annually at least 30 days prior to data submission deadline, of all assigned CareOregon members that meet inclusion criteria.

Equity Report

All participating clinics are required to submit an Equity report demonstrating their capacity to monitor and deliver language services. Equity Report specifications can be found in Appendix B.

Behavioral Health Integration (BHI) Population Reach Measures

Clinics that attest to delivering integrated behavioral health in alignment with CareOregon's BHI Model of Care are required to submit aggregate data for unique CareOregon members that received a qualifying service from a behavioral health clinician (BHC). Although not a reporting requirement, these clinics will be asked during the data submission process to respond to a series of questions about their BHI model. Additional information about BHI measures can be found in Appendix B and C.

Qualitative or Narrative Submission Measures

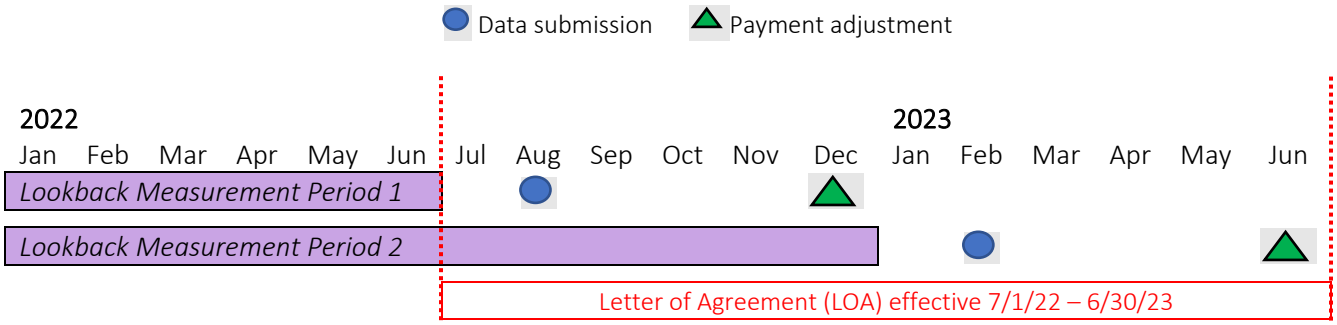
Measures that indicate a target as "Report Only", "Successful Qualitative or Narrative Submission" in Appendix A, require submission of all the specified data or information as described in Appendix B: Measure Specifications and Reporting Criteria for that measure to be considered as being passed during the specified data submission period.

Reporting Deliverable Timeline

January 1, 2022	Lookback measurement period begins.
August 31, 2022	Data submission 1 due to CareOregon for lookback measurement period 1.
December 1, 2022	Payment adjustment effective based on data submission 1.
February 28, 2023	Data submission 2 due to CareOregon for lookback measurement period 2.
June 1, 2023	Payment adjustment effective based on data submission 2.

Reporting and Payment Schedule

Clinics are evaluated for performance twice per year with data submissions due on the last day of August and the following February. Based on data submission performance payment will also be adjusted twice per year in December and June, respectively.



Application Process

Completed applications must be returned to CareOregon via email to PaymentModel@careoregon.org by March 11, 2022.

1. Attest to eligibility requirements.
2. Attest to BHI Model of Care requirements.
3. Select Clinical Track for each clinic.
4. Submit Oral Health Questionnaire Responses, and any baseline measurement data if needed*.

Step 1: Attest to Eligibility Requirements

All participating clinics must hold at minimum Oregon PCPCH recognition of Tier Three (3) or be in the review process with the OHA for PCPCH 5 Star recognition. Participating clinics must also belong to a system with at least 750 CareOregon members assigned and must also be open to assignment of new CareOregon members for a minimum of nine (9) months of the year.

Step 2: Attest to BHI Model of Care Requirements

To receive the BHI PMPM, clinics must attest to delivering integrated behavioral health services in alignment with CareOregon's BHI Model of Care. CareOregon BHI Model of Care requirement can be found in Appendix C.

Step 3: Select Clinical Track for Each Participating Clinic

A clinical track must be selected for each participating clinic, determining the measure set by which each clinic will be measured for performance: Family Practice/Internal Medicine or Pediatric.

Step 4: Complete Oral Health Incentive Participation Application questionnaire

In the submitted application, Clinics will be asked to provide information for participation in the Oral Health Integration Focus Area of the program. There will be 4 questions that require responses for clinic to be considered for receiving the $1.25 PMPM. Non completion of the questionnaire will result in the clinic being classified as not participating in the Oral Health Incentive.

***Note:** clinics new to participating in the PCPM program, clinics electing to change clinical tracks, or clinics that will be reporting on a different selected measure(s) than those included in the previous PCPM program, may need to submit historical measurement data at time of application. Prior year data is used to establish a baseline measure for determining measure performance and create program Letters of Agreements. The data should be obtained from activity occurring during the calendar year 2021. All data for EHR/eCQM measures must be timely submitted according to Agreement terms according to OHA specifications, which can be found on the OHA website: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/YearNine2021GuidanceDocumentation-final.pdf

Application Timeline

March 11, 2022	Application is due to CareOregon
May 13, 2022	Signed Letter of Agreement is due to CareOregon.
July 1, 2022	Letter of Agreement becomes effective.

Appendix A: Detailed Measure Sets for Clinical Tracks - Metro

1. Family Practice Clinical Track

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

Measure	Data Source	Lookback Measurement Period 1	Lookback Measurement Period 2	Baseline Measurement	Target 1 (Measurement Period 1) Due 8/31/2021	Target 2 (Measurement Period 2) Due 2/28/2022	Benchmark
Clinical Quality Focus Area							
Kindergarten Readiness: Well-Child Visits 3-6 yo (MM)	Claims	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	64.1%
Immunizations for Adolescents (MCV4, Tdap, HPV) (MM)	Roster	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	36.9%
Diabetes: HbA1c Poor Control (MM)	EHR/ eCQM	Jul 2021 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	27.5%
Alcohol and Drug Misuse: SBIRT Rate 1 and Rate 2 (MM)	EHR/ eCQM	Jul 2021 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	Rate 1: 68.2% Rate 2: 53.5%
Screening for Depression and Follow-Up Plan (MM)	EHR/ eCQM	Jul 2021 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	64.6%
Clinic-Defined Access & Engagement Measure	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	N/A
Equity Report: Improving Language Access	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	40 points	40 points	N/A
Behavioral Health integration Focus Area							
CareOregon Population Reach	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
CareOregon Sub-Population Reach: Patients with Positive SBIRT **or** Patients with Diabetes: HbA1c > 9	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
CareOregon Behavioral Integration Report	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Reporting Only	Reporting Only	N/A
Oral Health Integration Focus Area							
Oral Health Assessment, Preventative Care, Referral, and Education. - Pediatric Prevention **AND** Diabetic Oral Health **	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Successful Qualitative Submission	Successful Qualitative Submission	N/A

Cost of Care Focus Area							
Inpatient and Emergency Department Visits for ACSC* or Pediatric Cost of Care Narrative Report**	Claims/ Narrative Report	May 2021 – Apr 2022/Jan-June 2022	Nov 2021 – Oct 2022/Jan-Dec 2022	Organization - specific	1.5% reduction/ Narrative Submission	3% reduction / Narrative Submission	N/A

*Measure is aggregated to the system/organization-level instead of clinic-level. ** Family practice tracks will be required to provide both pediatric and adult measures for Oral and Cost of Care. Family Practice Track clinics must achieve one to receive credit in each focus area.

2. Pediatric Clinical Track

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

Measure	Data Source	Lookback Measurement Period 1	Lookback Measurement Period 2	Baseline Measurement	Target 1 (Measurement Period 1) Due 8/31/2021	Target 2 (Measurement Period 2) Due 2/28/2022	Benchmark
Clinical Quality Focus Area							
Kindergarten Readiness: Well-Child Visits 3-6 yo (MM)	Claims	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	64.1%
Childhood Immunization Status (Combo 3) (MM)	Roster	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	71.1%
Immunizations for Adolescents (MCV4, Tdap, HPV) (MM)	Roster	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	36.9%
Alcohol and Drug Misuse: SBIRT Rate 1 and Rate 2 (MM)	EHR/ eCQM	Jul 2021 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	Rate 1: 68.2% Rate 2: 53.5%
Screening for Depression and Follow-Up Plan (MM)	EHR/ eCQM	Jul 2021 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	64.6%
Clinic-Defined Access & Engagement Measure	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	N/A
Equity Report: Improving Language Access	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	40 points	40 points	N/A
Behavioral Health integration Focus Area							
CareOregon Population Reach	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
CareOregon Sub-Population Reach: patients with Positive SBIRT **or**	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A

Patients with Positive Depression Screen							
CareOregon Behavioral Integration Report	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Reporting Only	Reporting Only	N/A
Oral Health Integration Focus Area							
Oral Health Assessment, Preventative Care, Referral, and Education - Pediatric Prevention	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Successful Qualitative Submission	Successful Qualitative Submission	N/A
Cost of Care Focus Area							
Pediatric Cost of Care Narrative Report	Narrative Report	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Narrative Submission	Narrative Submission	N/A

3. Internal Medicine Clinical Track

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

Measure	Data Source	Lookback Measurement Period 1	Lookback Measurement Period 2	Baseline Measurement	Target 1 (Measurement Period 1) Due 8/31/2021	Target 2 (Measurement Period 2) Due 2/28/202	Benchmark
Clinical Quality Focus Area							
Colorectal Cancer Screening (MM)	Claims	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	61.1%
Controlling High Blood Pressure (MM)	EHR/ eCQM	Jul 2021 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	71.0%
Diabetes: HbA1c Poor Control (MM)	EHR/ eCQM	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	27.5%
Alcohol and Drug Misuse: SBIRT Rate 1 and Rate 2 (MM)	EHR/ eCQM	Jul 2021 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	Rate 1: 68.2% Rate 2: 53.5%
Screening for Depression and Follow-Up Plan (MM)	EHR/ eCQM	Jul 2021 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	64.6%
Clinic-Defined Access & Engagement Measure	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	Jan – Dec 2021 Clinic Specific	TBD Clinic-specific	TBD Clinic-specific	N/A

Equity Report – Improving Language Access	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	40 points	40 points	N/A
Behavioral Health integration Focus Area							
CareOregon Population Reach	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
CareOregon Sub-Population Reach: Patients with Positive SBIRT **or** Patients with Diabetes: HbA1c > 9	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Tier 1: 5.0% Tier 2: 12.0%	Tier 1: 5.0% Tier 2: 12.0%	N/A
CareOregon Behavioral Integration Report	Clinic Reported	Jan 2022 – Jun 2022	Jan 2022 – Dec 2022	N/A	Reporting Only	Reporting Only	N/A
Oral Health Integration Focus Area							
Oral Health Assessment, Preventative Care, Referral, and Education - Diabetic Oral Health	Clinic Reported	N/A	Jan 2022 – Dec 2022	N/A	Successful Qualitative Submission	Successful Qualitative Submission	N/A
Cost of Care Focus Area							
Inpatient and Emergency Department Visits for ACSC*	Claims	May 2021 – Apr 2022	Nov 2021 – Oct 2022	Organization-specific	1.5% reduction	3% reduction	N/A

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

Appendix B: Measure Specifications and Reporting Criteria

1. Clinical Quality Measure Specifications

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

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

Measure specifications can be found at the Oregon Health Authority's website:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

The most current specifications provided by the OHA will be used at the time of the performance evaluation. Participants shall be responsible for monitoring specification updates.

2. Clinic-Defined Access & Engagement Measure Requirements

CareOregon recognizes that primary care medical home models look different in every organization. The aim of the clinic-defined Access & Engagement measure is to support the work clinics are already engaged in to improve access to services and member engagement.

Thus, participating clinics may select a measure of access or engagement that they already track and monitor as part of their ongoing continuous quality improvement work.

Access Measure Definition: A measure of the potential or capacity for patients to access primary care services (e.g. third next available appointment).

Engagement Measure Definition: A measure of actual use of primary care services by members (e.g. % of assignment members who had at least 1 visit or care touch with the primary care team during the previous 12 months).

As part of the application process, clinics must provide the following information to define their selected Access & Engagement measure:

Standard or Custom Measure
Name of Measure
Measure Description
CareOregon Members Only or Total Patient Population?
Baseline Period
Measurement Period

If standard measure:

Link to Measure Specifications

If custom measure:

Numerator Inclusion Criteria
Denominator inclusion Criteria
Exclusion Criteria

For this measure, baseline data must also be submitted for each participating clinic site.

CareOregon will review the selected measure for suitability and will contact clinic for follow-up as needed.

Equity Report: Improving Language Access

The Equity Report will be scored by the total number of points earned from clinics providing affirmative responses to the questions listed below. The Equity Report score has a total of 50 possible points. Part 1 has 12 points; Part 2 has 20 points and Part 3 has 18 points. To pass the measure, the clinic must receive the minimum number of points listed in the detailed measure set table.

Part 1: Identification and assessment of communication needs

Question 1: Maximum 6 points

Please answer yes or no for each of the following statements on how your clinic identifies patients needing communication access (e.g. LEP, sign language users)

	Yes or No
The clinic has a **process to respond to individual requests** for language assistance services (including sign language)	
The clinic has a **process for self-identification** by the Deaf or hard of hearing person, non-English speaker or LEP individual.	
The clinic has a **process for using open-ended questions** to determine language proficiency on the telephone or in person	
The clinic's front desk and scheduling staff are **trained to use video relay or** TTY for patient services	
The clinic uses **"I Speak" language identification cards or posters**	
The clinic has a **process for responding to patients' complaints about** language access and clearly communicates this process to all patients.	

Question 2: 3 Maximum points

Please answer yes or no for each of the following statements about collecting data.

	Yes or No
The clinic collects data on the **number of patients served who are Limited English Proficient (LEP)**	
The clinic collects data on the **number of patients served who are Deaf and hard of hearing**	
The clinic collects data on the **number of and prevalence of languages spoken by their patients**	

Question 3: Maximum 3 points

Please answer yes or no for each of the following statements about members that refused, did not need, or needed interpretation services but were not identified as such.

	Yes or No
The clinic collects data on the number of patients served **who self-identified as LEP but refused interpretation services**	
The clinic collects data on the number of patients served **who are Deaf and hard of hearing but refused interpretation services.**	
The clinic collects data on the number of **patients served who were not identified in the chart as LEP or Deaf and hard of hearing, but who requested interpretation services**	

Part 2: Provision of Language Assistance Services

Question 4: Maximum 4 points

Please answer yes or no to each of the following statements about tracking language access services at your clinic.

	Yes or No
The clinic tracks **the primary language** of person encountered or served.	
The clinic tracks **the use of language assistance services such as interpreters and translators**	
The clinic tracks **bilingual and sign language staff time spent** on language assistance services	
The clinic tracks **the use of spoken and sign language assistance services by modality** (e.g. in person; telephonic, video, other)	

Question 5: Maximum 7 points

Which types of language assistance services are used by your clinic in providing care to CareOregon members?

-Select Yes – CO vendor only, if your only source of contracted interpretation services is one of the CO provided vendors.

-Select Yes if you have other interpretation contracts outside of CO.

Both responses will count as "yes" in the evaluation scoring.

	Yes, Yes – CCO vendor only, or No
Bilingual staff and providers	
In-house interpreters (spoken and sign)	
In-house translators (for documents)	
Contracted in-person interpreters	

Contracted translators (for documents)	
Contracted telephonic interpretation services	
Contracted video interpretation services	

Question 6: Maximum 7 points

Please select yes or no to the language assistance services that your clinic can provide detailed member level information on, such as member ID, date of service and interpreters' credential.

	Yes or No
Bilingual staff and providers	
In-house interpreters (spoken and sign)	
In-house translators (for documents)	
Contracted in-person interpreters	
Contracted translators (for documents)	
Contracted telephonic interpretation services	
Contracted video interpretation services	

Question 7: Maximum 1 point

	Yes or No
Does your clinic have policies on the use of family members or friends to provide interpretation services?	

Question 8: Maximum 1 point

If yes to the previous question, please briefly describe or attach your policies on when or how family members can provide interpretation services.

Part 3: Data Reporting

Percent of member visits with interpreter need in which interpreter services were provided: 18 points possible

Numerator: Denominator visits that were provided with interpreter services

Denominator: Visits at the practice site during the measurement period with a CareOregon member who self-identified to the OHA as having interpreter needs

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

Measuring Performance: To achieve points, the clinic is required to report the data provided from the CCO on the population identifying as needing an interpreter. Member level data by visit will be used for 2022. The required data to be reported for each member visits to be counted towards the point total are:

1. The Interpreter Type, Certification status, and OHA Registry Number is complete.

   Or

2. Interpreter was a Bilingual Staff is complete

   Or

3. Member refused interpreter service and the service refusal reason is complete

The point scoring assignment structure will be based on percent of the member list that has the required data completed. 100% complete = 18 points. 78% complete = 14 points. 50% complete = 9 points. 28% complete = 5 points.

Reporting Format:

The CCO will provide visit data for those members assigned to clinic and self-identified as needing an interpreter to the OHA. Please fill out the fields using the drop downs in the data set. Follow the data dictionary below for allowed answers.

Column Name	*Valid Input Value*	*Additional Instructions for Completing the Reporting Template*
Member ID	Member's Medicaid ID	
Visit Type/Care Setting	Office Outpatient Telehealth Other	Please report only one visit per member per day. If multiple types of visits occurred on the same day, then please select one type of visit using the order of selections as a hierarchy. If an office outpatient visit and telehealth occurred on the same day, report the office outpatient visit, etc.
Visit Date	Visit Date YYYY/MM/DD	Please report only one visit per member per day.
In-person Interpreter Service	Yes No	Report all that apply during the visit date
Telephonic Interpreter Service	Yes No	
Video Remote Interpreter Service	Yes No	
Was the Interpreter OHA Certified or Qualified	OHA Certified OHA Qualified Not Certified or Qualified by OHA	

Interpreter's OHA Registry Number	OHA Registry number	
Was the Interpreter a Bilingual Staff	Yes No	
Did the member refuse Interpreter Service	Yes No	
Reason for member refusal	Enter reason code 1-4: 1. Member refusal because in-language visit is provided, 2. Member confirms interpreter needs flag in MMIS is inaccurate, 3. Member unsatisfied with the interpreter services available, 4. Other reasons for patient refusal	Scenario 1: The member confirms the provider for the visit can perform in-language service and therefore no interpreter service is needed. To note, if the in-language service provider is OHA certified or qualified, it could be a numerator hit for the metric. Scenario 2: OHA recommends initiating correction of the interpreter flag in MMIS. Visits with refusal reasons 1 or 2 can be excluded IF the CCO attests collecting corresponding information in the CCO self-assessment survey question #11. Scenarios 3 and 4 do not qualify for denominator exclusion.

2. BHI Population Reach Measure Specifications

Measure	Numerator (n) and Denominator (d) Descriptions	
CareOregon Member Population Reach	n	Members in denominator with a service by BHC during measurement period.
	d	Unique CareOregon members seen by clinic during measurement period.

3. BHI Sub-Population Measure Specifications

Measure	Numerator (n) and Denominator (d) Descriptions	
Depression (Pediatric only)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique CareOregon members with a positive depression screen as indicated by the measurement tool during measurement period.
Diabetes: HbA1c > 9 (Family Practice only)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique CareOregon members with a Diabetes: HbA1c > 9 during measurement period.
Alcohol & Drug Screening (Any clinical track)	n	Members in denominator with a service by BHC during measurement period.
	d	Unique CareOregon members with a positive SBIRT screen during measurement period.

Numerator and Denominator Specification Notes
Inclusion criteria for patients seen by BHC (numerator): ✓ All billable services, paid and unpaid, including face-to-face and telehealth interventions both scheduled and same-day appointments. ✓ Visits where the BHC assists in service delivery along with the medical provider resulting in increased medical complexity that is billed under the medical provider. ✓ Non-billable services including, but not limited to: o Documented introductions of the patient and/or patient support system to the BHC. These BHC introductions are sometimes referred to as a warm hand-off. o Documented consultations and shared care planning with internal primary care team members. o Documented consultations, care coordination and case management with external partners such as specialty behavioral health, hospitals, schools, families, etc. o Care management activities that include outreach and engagement services. o Non-billable services can be documented via EHR portal messages, phone encounters, letters documented in the patient record, interim notes, etc. **Exclusion criteria for patients seen by BHC (numerator):** ✓ Mass email/EHR messages to patients ✓ Telephone encounters where you are leaving a message ✓ Reminder messages (phone/EHR/text) ✓ Text messaging **Inclusion criteria for patients seen in Primary Care (denominator):** ✓ Any PCP or BHC appointment (e.g. 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99401, 99402, 99403, 99404, 99411, 99412, G0507, G0505, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 99408, G0396, 99409 G0397, 99406, G0436, 99407, G0437, 96110, 96127, 90791, 90832, 90834, 90837, 98966, 98967, 98968). Lists are not all inclusive, the intent is that services provide some sort of clinical intervention or insight to the patient or on the patient's behalf.

4. BHI Report Specifications

The following questions will be included in the BHI report.

a. What types of services did you include when calculating reach? (e.g., CPT codes, warm hand offs, telephone encounters, etc.)

b. Please help us understand the trends in your data (such as: challenges or successes, difficulties in capturing or reporting data, staffing changes, new approaches to care, PDSAs, etc.)

c. Tell us how you're using telehealth in the delivery of your integrated behavioral health program (example: providing telehealth to patients with BHCs in the clinic, providing telehealth to patients with BHCs off site, etc.)

d. Share 1-2 key wins/learnings. Is there a specific patient and/or provider story that demonstrates how integration has advanced your practice?

e. Is there anything else you would like us to know, or do you have any requests from us that would help with your integration efforts?

5. Oral Health Integration Measure Specifications

The reporting for the oral health integration focus area will be different for each reporting event.

Reporting period 1: Qualitative Submission - Implement clinic workflows and strategies

A narrative report is to be submitted describing workflows and confirmation of clinic's capability to submit claims (if applicable). Please see the list of topics below for clinic's selected measure track.

Pediatric Clinical Quality Tracks

- Design and document referral pathway(s) to dental services for all Medicaid members in target groups (kids ages 1-14)
- Design and document pediatric screening or assessment and patient education workflow
- Design and document fluoride varnish application workflow for Medicaid members in age group – Ages 1 to 14.

Family Practice Clinical Quality Tracks

- Design and document referral pathway(s) to dental services for all Medicaid members in target groups (kids ages 1-14 and diabetic patients)
- Design and document pediatric screening or assessment, referral, and patient education workflow
- Design and document fluoride varnish application workflow for Medicaid members in target group – Ages 1 to 14.
- Design and document brief oral health screening, referral, and patient education process for patients diagnosed with Diabetes

Internal Medicine Clinical Quality Track

- Design and document brief oral health screening and patient education process for patients diagnosed with Diabetes.

Scoring of the narrative will be documented on an evaluation form and shared with the clinics as part of the initial performance results communication phase of each data submission.

Reporting period 2: Design and implement clinic workflows and strategies – Narrative Form (Narrative submission with scoring system that includes required workflows and confirmation of ability to submit claim (if applicable))

Pediatric Clinical Quality Tracks

- Fluoride Varnish Application
    a. Provider/Staff/Clinic have the workflows and clinical skills to place fluoride varnish; clinical orders, chart documentation and billing mechanisms are/will be implemented
- Oral Health Assessment of children aged 1 to 14
    a. Provider (MD, NP, DO, PA, ND) can conduct an oral health assessment using an approved risk assessment tool; required provider training has been completed.
- Oral Health Screening of patients diagnosed with diabetes
    a. Provider/Staff/Clinic provide a brief oral health screening to patients
- Patient Education
    a. Provider/Staff/Clinic have the basic skills to discuss the importance of oral health with their patient and provide guidance as needed

- Oral Health Referral
    a. Option 1: Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care using the Referral Portal
    b. Option 2: Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care using the Referral Portal and other pathways; a workflow submission for each workflow is required
    c. Option 3: Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care.

Family Practice Clinical Quality Tracks

- Fluoride Varnish Application
    a. Provider/Staff/Clinic have the workflows and clinical skills to place fluoride varnish; clinical orders, chart documentation and billing mechanisms are/will be implemented
- Oral Health Assessment of children aged 1 to 14
    a. Provider (MD, NP, DO, PA, ND) can conduct an oral health assessment using an approved risk assessment tool; required provider training has been completed.
- Oral Health Screening of patients diagnosed with diabetes
    a. Provider/Staff/Clinic provide a brief oral health screening to patients
- Patient Education
    a. Provider/Staff/Clinic have the basic skills to discuss the importance of oral health with their patient and provide guidance as needed
- Oral Health Referral
    a. Option 1: Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care using the Referral Portal
    b. Option 2: Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care using the Referral Portal and other pathways; a workflow submission for each workflow is required
    c. Option 3: Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care.

Internal Medicine Clinical Quality Track

- Oral Health Screening of patients diagnosed with diabetes
    a. Provider/Staff/Clinic provide a brief oral health screening to patients
- Patient Education
    a. Provider/Staff/Clinic have the basic skills to discuss the importance of oral health with their patient and provide guidance as needed
- Oral Health Referral
    a. Option 1: Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care using the Referral Portal
    b. Option 2: Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for dental care using the Referral Portal and other pathways; a workflow submission for each workflow is required
    c. Option 3: Provider/Staff/Clinic have referral processes in place to refer all CO Medicaid members for

6. Family Practice Cost of Care Measure Specifications

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

Numerator

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

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

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

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Each visit to an ED for one of the above PQIs is included in the numerator. Multiple ED visits on the same date of service are counted as one visit.

Emergency Department visits are specified by the codes identified in the OHA ED Utilization:
https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Ambulatory-Care-Avoidable-ED-visits-2018.pdf

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

Denominator

Member months for all CareOregon assigned population aged 19 and older.

Data elements required denominator: 1,000 Member Months.

Technical Notes:

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

CareOregon may update and re-release Cost of Care Measure Specifications if there are significant updates made to the PQIs by AHRQ.

7. Pediatric Cost of Care Narrative Report Specifications

This PCPM program contains a new CCO Quality Metric, "System-Level Social Emotional Health". This metric aims to address complex system-level factors that impact services kids and families receive that support social-emotional health. To address these gaps and, in preparation for upcoming OHP requirements, we are incorporating aspects of the quality metric into our PCPM, Pediatric Cost of Care Measure

Narrative reports are evaluated based on completeness of the submission. A template will be provided for providers to fill out during data submission events. **Payment will be awarded provided that the clinic submits the cost of care report and responds fully to each section.**

Each section must address the following three reporting components.

1. Behavioral Health/Integrated Behavioral Health Staffing (BH/IBH)
2. Social Emotional Health Assessments and Services Process
3. Community partnerships and educational opportunities

Reporting Component 1: Behavioral Health/Integrated Behavioral Health Staffing

Submit a roster of Behavioral Health providers with the following:

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

If your staffing model excludes behavioral health staff, you will be asked to provide a narrative addressing:

- How social emotional assessments are incorporated within your practice
- Provide a response advising if your practice is expecting to hire new BH/IBH staff or implement new BH/IBH programs, accompanied by an estimated timeline
- Program description.

Reporting Component 2: Social Emotional Health Assessments and Services Process

Provide descriptions of how the clinic assesses social emotional health that may include

- Emotional assessments
- Neurobehavioral statutes exams
- Health & Behavior assessments

Reporting Component 3: Community partnerships and educational opportunities

Consider community-based organizations, advocacy groups, and early learning providers that represent children and families in your community on the components listed below:

- List name of organization and primary contact (Excel format will be accepted)
- What social-emotional services are provided by the organization?
- What gaps does the organization address?
- For clinics not having a social worker(s), track current barriers & opportunities for improvement to access services

Appendix C: Behavioral Health Integration Model of Care

1. Structural Behavioral Health Integration Criteria (BHI)

Behavioral Health Integration Criteria	Tier 1	Tier 2
Staffing: ✓ At least 0.5 FTE licensed behavioral health clinician (BHC) as defined by subset of ORS 414.025 (Table 4) is on-site, located in the same shared physical space as medical providers. ✓ Mental Health, Substance Use Disorder, and Developmental Screening strategy is established with documentation for on-site local referral resources and processes. ✓ BHC(s) provide care at a ratio of 1 FTE BHC for every 6 FTE Primary Care Clinicians.	✓ ✓ ✓	✓ ✓ ✓
Communication around Shared Patients: ✓ Primary care clinicians, staff, and BHCs document clinically relevant patient information in the same medical record at the point of care. ✓ Care team and BHC routinely engage in face-to-face collaborative treatment planning and co-management of shared patients.	✓ ✓	✓ ✓
BHC as an Integrated Part of the Primary Care Team: ✓ Warm hand-offs/introductions between care team members and BHC. ✓ BHC is a regular part of practice activities (i.e., team meetings, provider meetings, quality improvement projects, case conferences). ✓ Pre-visit planning activities (i.e., scrubbing and/or huddling for behavioral health intervention opportunities).	✓ ✓ ✓	✓ ✓ ✓
Same-Day Access: ✓ On average, ***≥ 25%* of BHC hours** at the practice each week are available for same-day services (may include average weekly late-cancelation/no-shows converted to same-day services).	✓	
Same-Day Access: ✓ On average, ***≥ 50%* of BHC hours** at the practice each week are available for same-day services (may include average weekly late-cancelation/no-shows converted to same-day services).		✓

2. Qualifying Behavioral Health Clinicians

Qualifying Behavioral Health Clinicians (BHC)*:
- ✓ Licensed psychologist
- ✓ Licensed clinical social worker
- ✓ Licensed professional counselor or licensed marriage and family therapist
- ✓ Certified clinical social work associates, professional counselor associates, or marriage and family therapist associates
- ✓ Intern or resident who is working under a board-approved supervisory contract in a clinical mental health field

*This list is a subset of ORS 414.025 and indicates the exhaustive list of BHCs that qualify as part of CareOregon's BHI Program.

Appendix D: What Payment Level Will I Start At?

Prior participation and performance in CareOregon alternative payment models determines which payment level and corresponding payment rate each participating clinic site will receive when the Letter of Agreement becomes effective, July 1, 2022. The information below indicates the criteria for determining the particular payment levels and rates for each focus area.

	Payment Level 0	Payment Level 1	Payment Level 2	Payment Level 3
Clinical Quality	$ 0.00 ✓ Clinics currently participating in PCPM with Quality payment level 0 at time of LOA effective date.	$3.40 to $4.60 (Unique to Each Clinic) ✓ Clinics currently participating in PCPM with Quality payment level 1 at time of LOA effective date. ✓ All clinics new to participation in a PCPM Quality Component.	$4.95 to $6.75 (Unique to Each Clinic) ✓ Clinics currently participating in PCPM with Quality payment level 2 at time of LOA effective date.	$8.10 to $11.00 (Unique to Each Clinic) ✓ Clinics currently participating in PCPM Track 2 with Quality payment level 3 at time of LOA effective date.
BHI	$ 0.00 ✓ Clinics currently participating in CareOregon BHI with payment level 0 at time of LOA effective date. ✓ Clinics that do not attest to CareOregon BHI Model of Care.	$ 2.00 ✓ Clinics currently participating in CareOregon BHI with payment level 1 at time of LOA effective date. ✓ Clinics new to BHI will start at payment level 1.	$ 4.00 ✓ Clinics currently participating in CareOregon BHI with payment level 2 at time of LOA effective date.	
Oral Health Integration	$ 0.00 ✓ Clinics not participating in this program component. ✓ Clinics that do not provide application questionnaire responses.	$ 1.25 ✓ All clinics approved to participate in the Oral Health Component of Program. ✓ All clinics meeting data submission criteria to maintain PMPM		
Cost of Care	$ 0.00 ✓ Clinics currently participating in PCPM with Cost of Care payment level 0 at time of LOA effective date.	$ 1.25 ✓ Clinics currently participating in PCPM with Cost of Care payment level 0 at time of LOA effective date. ✓ All clinics new to participating in PCPM		