



OHA VBP PCPCH Data and CDA VBP Data Template - General Instructions

1. 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"





"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 template is due to OHA by May 3, 2024, via the Contract Deliverables portal located at <https://oha-cco.powerappsportals.us/>. The submitter must have an OHA account to access the portal. 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).

			
<p>CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE</p>	<p>CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE</p>	<p>CATEGORY 3 APMS BUILT ON FEE -FOR-SERVICE ARCHITECTURE</p>	<p>CATEGORY 4 POPULATION – BASED PAYMENT</p>
	<p>A</p>	<p>A</p>	<p>A</p>
	<p>Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)</p>	<p>APMs with Shared Savings (e.g., shared savings with upside risk only)</p>	<p>Condition-Specific Population-Based Payment (e.g., per member per month payments payments for specialty services, such as oncology or mental health)</p>
	<p>B</p>	<p>B</p>	<p>B</p>
	<p>Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</p>	<p>APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</p>	<p>Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)</p>
	<p>C</p>		<p>C</p>
	<p>Pay-for-Performance (e.g., bonuses for quality performance)</p>		<p>Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)</p>
		<p>3N Risk Based Payments NOT Linked to Quality</p>	<p>4N Capitated Payments NOT Linked to Quality</p>

CCO NAME: Cascade Health Alliance LLC
 REPORTING PERIOD: 1/1/2023 - 12/31/2023

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 \times 0.75 + \$10.00 \times 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	-	\$	\$	NA	There are no Tier 1 clinics in our service area.
Tier 2 clinics	-	\$	\$	NA	There are no Tier 2 clinics in our service area.
Tier 3 clinics	1	\$	\$	NA	NA
Tier 4 clinics	2	\$	\$	NA	NA
Tier 5 clinics	2	\$	\$	NA	NA

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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
Capitation and risk sharing with local PCPCH offices including VBPs on percentage of panel seen, risk adjusting capitation payment based on acuity of the panel, and increasing panel size from prior year.	4A	14.97%	2C, 1A	\$18,702,293	Percentage of panel seen, risk adjusting capitation payment based on acuity of the panel, increasing the panel size from prior year, select OHA incentive metrics.	All services provided by the contracted PCPCH.	The capitation portion on the VBP is adjusted based on complexity.
Capitation and risk sharing with local dental offices including VBPs on percentage of panel seen.	4A	4.15%	2C, 1A	\$5,178,173	Percentage of panel seen, completion of OHA HIT survey.	All services provided by the contracted dental provider.	Does not take these factors into account.
Risk sharing with local hospital including VBPs on certain metrics.	3B	25.71%	2C, 1A	\$32,118,737	Early elective delivery rate, congestive heart failure all cause readmission rate, Engagement in Treatment quality metric.	All hospital services at local hospital.	Does not take these factors into account.
Risk sharing with local behavioral health facilities including VBPs on certain metrics.	3B	8.41%	2C, 1A	\$10,511,691	Percent of patients receiving qualifying billable services within 30 days of initial evaluation and improvement of documentation of severity of clinical conditions.	All services provided by the behavioral health provider.	Does not take these factors into account.
Risk sharing with local IPA of specialists including VBP attached to adjusting payment based on risk scores. (Multiple contracts with both individual practitioners and clinics.)	3B	6.85%	2C, 1A	\$8,562,963	Retrospective adjustment of payments made based on patient acuity using risk scores.	All services provided by the Klamath Falls IPA.	Medical complexity is taken into account when calculating retrospective risk based payments.

