



## **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).

version 02032024

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

CCO NAME: Columbia Pacific  
 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					No payments to tier 1 clinics because there none in CCO service area
Tier 2 clinics					No payments to tier 2 clinics because there none in CCO service area
Tier 3 clinics				N/A	
Tier 4 clinics				N/A	
Tier 5 clinics				N/A	

Please note, CPCCO has historically provided details on this tab specific to our Primary Care Payment Model Program. Our intention with this PCPM Program is to provide support to our PCPCH recognized clinics through a robust pay for performance PMPM model. We are still maintaining this PCPM Program and want to call out this continued support, but are providing feedback on this tab outside of the PCPM Program. Specifically, we have reported details on our infrastructure specific PMPM payments to PCPCH providers (LAN 2A payments).

CCO NAME:  
 REPORTING PERIOD:

Columbia Pacific  
 1/1/2023 - 12/31/2023

**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) <i>Note: For models listed at a LAN category 3B or higher, please list the risk sharing rate.</i>	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
Behavioral Health Capitation Subject to QIIP		100%	N/A		3-5		This model is meant to support members with complex behavioral health needs.
PCP Capitation		100%	N/A		7		Inadequate access to preventive services can contribute to persistent disparities in pediatric populations.
PCP Clinical Quality Improvement (PCPM QI)		100%	N/A		5		Inadequate access to preventive care can contribute to persistent health disparities in pediatric and adult populations.
Total Cost of Care Shared Savings Risk Agreement		100%	1A		7		N/A
PCP Behavioral Health Integration (PCPM BHI)		100%	N/A		2		This model is meant to improve access to behavioral health providers in primary care settings and meet the complex behavioral and physical health needs of members.

**Required implementation of care delivery areas by January 2024:** Refer to Value-based Payment Technical Guide for CCOs at <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf> for more information on requirements.

**Evaluation criteria for this worksheet:** Response required for each highlighted cell. If questions on rows 18 and 20 are not applicable, write N/A.

CCO NAME:	Columbia Pacific
Describe Care Delivery Area (CDA) <b>Note:</b> 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
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	This CDA ensures acute care access for members living in rural areas who may be at higher risk for persistent 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)
Severe sepsis and shock management bundle	CMS	Compare to provider's previous performance	
HCAHPS: Medication Explanation	CMS	Compare to provider's previous performance	
Transitions of Care - Medication Reconciliation	HEDIS	Compare to provider's previous performance	
Transitions of Care - Patient Engagement After Discharge	HEDIS	Compare to provider's previous performance	

**Required implementation of care delivery areas by January 2024:** Refer to Value-based Payment Technical Guide for CCOs at <https://www.oregon.gov/oha/HPA/ops-for/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.

CCO NAME:	Columbia Pacific
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)	
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	The agreement provides funding for necessary services for members with significant specialty behavioral health needs. The agreement also incentivizes providers to manage performance relative to related quality metrics specific for the type of service.
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. At 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)
Early Initiation and Engagement	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
Retention for Therapeutic Effect	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
Case Management for Clients with Schizophrenia	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
Withdrawal Management: SUD Follow-up Care	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
Withdrawal Management: MAT Follow-up Care	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
Residential: SUD Retention	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
Residential: SUD Follow-up Care	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
Residential: MAT Follow-up Care	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
SUD Outpatient: Engagement	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
SUD Outpatient: Retention	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	
SUD Outpatient: Primary Care Visit	Mutually agreed/created by plan and provider	Regional benchmarks were established based on network performance in CY2021 for each individual measure. Percentiles were calculated for each measure and performance distribution was analyzed in comparison to the percentiles. Benchmarks for each measure were selected based on this review.	







