

January 28, 2016

Board of County Commissioner
Clackamas County

Members of the Board:

Approval for a Revenue Agreement with CareOregon for the
Primary Care Incentive Payment Model (PCPM) Incentive Program

Purpose/Outcomes	Provides Clackamas County Health Centers Division (CCHCD) an incentive bonus for reporting on select Coordinated Care Organization (CCO) measures and Medicare metrics.
Dollar Amount and Fiscal Impact	Based on number of clients reported and by what percentage the measure was increased during reporting period. This is a no maximum agreement. No County General Funds are involved. No matching funds required.
Funding Source	CareOregon
Duration	Effective October 1, 2015 and terminates on September 30, 2016
Previous Board Action	The Board previously approved agreements on January 23, 2014 – Agenda item 012314-A3 and November 26, 2014 Agenda item 112614-A1
Strategic Plan Alignment	1. Individuals and families in need are healthy and safe 2. Ensure Safe, healthy and secure communities
Contact Person	Deborah Cockrell 503-742-5495
Contract No.	7474

BACKGROUND:

The Clackamas County Health Centers Division (CCHCD) of the Health, Housing and Human Services Department requests the approval of a Revenue agreement with CareOregon for the Primary Care Incentive Payment Model (PCPM) Incentive Program.

CareOregon offers an incentive bonus to organizations that have been qualified as a Patient Centered Primary Care Home and who have a Primary Care Services Agreement with CareOregon. This contract has been reviewed by County Counsel on December 16, 2015.

This contract is effective October 1, 2015 and continues through September 30, 2016. The agreement is retro-active due to late receipt of funding approval by the State.

RECOMMENDATION:

Staff recommends the Board approval of this contract and authorizes Richard Swift, H3S Director to sign on behalf of Clackamas County.

Respectfully submitted,

Richard Swift, Director
Health, Housing & Human Services

CareOregon, Inc.

Letter of Agreement

Primary Care Payment Model

CareOregon, Inc (CareOregon) and Clackamas County acting by and through its Health, Housing, and Human Services Department, Health Center Division (Provider) hereby agree to the following terms and conditions:

Recitals:

- A. CareOregon and Provider are independent companies.
- B. This Letter of Agreement is distinct and separate from the Primary Care Services Agreement in place between CareOregon and Provider, and shall be applicable only so long as the Primary Care Services Agreement remains in place and is effective between CareOregon and Provider.
- C. This Letter of Agreement shall be applicable only so long as Provider is recognized by the state of Oregon as a Patient Centered Primary Care Home (PCPCH).
- D. Both entities acknowledge that this is a pilot program that will be reviewed periodically.
- E. If the State of Oregon or the contracted Coordinated Care Organization changes the requirements for PCPCH Supplemental Payment, this Letter of Agreement will be re-evaluated.
- F. This Letter of Agreement shall be applicable for the time period between October 1, 2015 and September 30, 2016.
- F.G. [The terms of this agreement shall not be waived, altered, modified, supplemented, or amended, in any manner whatsoever, except by written instrument signed by both parties.](#)

Patient and Population Centered Primary Care Clinic Quality Incentive Payments:

For the time period between October 1, 2015 and September 30, 2016, Provider shall be eligible for a quality bonus based on the quality outcomes measures described in the CareOregon Patient and Population Centered Primary Care Payment Model (described in Attachment A).

Under this payment model, Provider is eligible for a risk adjusted PMPM depending on Level of achievement in the payment model of:

Payment Model Level	Risk Adjusted PMPM	Risk Adjusted PMPM
	Gladstone	Beavercreek, Sandy, Sunnyside
Level 1	\$4.00	\$4.54
Level 2	\$7.32	\$9.08
Level 3	\$11.00	\$13.62

Participating Clinics:

Beavercreek Clinic
Gladstone Clinic

Sandy Health & Wellness
Sunnyside Health & Wellness

Terms:

- Payment will be made monthly based on the members assigned to the Provider as of the fifth (5th) of the month.
- Payment level is based on prior 6 months performance and will be increased or decreased based on level of achievement in the payment model. Level placement will be re-evaluated every 6 months.
- All new participating providers will begin the first six months at Level 1.
- Measurement data is due April 30th for October – March and October 31st for April to September.
- Payment is determined by CareOregon’s Patient and Population Centered Primary Care Home Payment Model.
- Risk Adjustments are based on September 2015 calculation by CareOregon.
- This agreement is renewable on an annual basis at the discretion of CareOregon.
- Quality data reports are required to be submitted at agreed upon deadlines. Increased quality payment is contingent on quality data being submitted by deadline.

Confidentiality:

This Letter of Agreement contains confidential and proprietary information and is considered a trade secret of CareOregon. To the extent authorized by Oregon law, neither party will disclose this or any other proprietary information or trade secret without the express written approval of the other party.

Agreed to on behalf of Clackamas County:

Agreed to on behalf of CareOregon, Inc.:

By: _____

By: _____

Name: Richard Swift

Name: Scott Clement

Title: Director, Health Housing and Human Services

Title: Chief Network Officer

Date: _____

Date: _____

Attachment A

CareOregon 2015 – 2016 Primary Care Incentive Payment Model

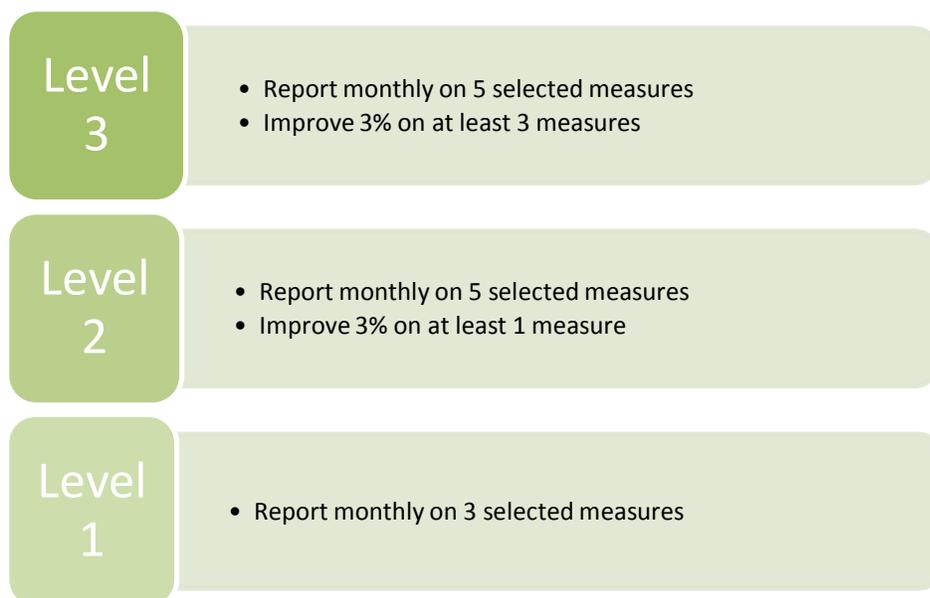


General Information

Eligibility

All clinics that are assigned CareOregon members and are certified at any Tier in Oregon PCPCH Program.

Model



In general, the Levels will be paid at the following levels (**these will be risk-adjusted by clinic**):

- Level 1: \$4 pmpm
- Level 2: \$8 pmpm
- Level 3: \$12 pmpm

There are three components to the model:

Report and Improve Clinical and Operational Performance. Clinics will select 5 measures from the menu to report on **every month from their data, for their entire population**, for the year. **At least three measures must be CCO incentive metrics.** Measures should be chosen to reflect the needs of the population served and current organizational priorities. Clinics who improve 3 percentage points within 6 months on at least 1 measure will be moved up to Level 2 and clinics who improve on at least 3 measures will be moved up to Level 3. *Note: At launch, all clinics will be Level 1 and will have the opportunity to qualify for a higher level at the second data submission. Metrics will be re-evaluated every 6 months and clinics will go up or down levels based on current performance.*

Participate in Patient Attribution Improvement Project. Clinics will also receive reports on the % of their assigned membership that have had contact with the clinic along with rosters of assigned members.

Simple Budget Reporting. Report on allocation of pmpm dollars to support improvement work at practice site.

Measure Menu

In order to support the ongoing work of the CCO and Medicare, at least 3 measures chosen must be one of the preferential measures (listed in orange) that applies to the clinics patient population.

There is an opportunity to select one of the 5 measures that is outside the list of measures below for practices that have a compelling reason to include them based on patient population and clinic priorities. Practices will be asked to submit documentation on the requested measure, evidence for selected the measure, and specifications that will be used.

Stretch targets apply to clinics working on the preferential metrics. If clinics meet or exceed the stretch target percentage at the end of a six month reporting period, clinics will receive one credit towards the next period's payment level increase. Clinics baseline (1st month of reporting in a period) must start below the stretch target to be eligible to receive credit towards next period's level increase.

Monthly reporting period on selected measures will start October 2015.

	Measure Description	Stretch Target	Measure Choice
Choose at least 3	Adolescent Well Care Visits	60%	X
	Adult BMI assessment	91%	
	Blood pressure control, HTN pts	70%	
	Breast Cancer screening	81%	
	Colorectal Cancer Screening	55%	X
	Developmental screening	55%	X
	Diabetes: Blood Pressure Management (% BP < 140/90)	75%	
	Diabetes: Eye Exam	77%	
	Diabetes: Hemoglobin A1c Poor Control (% A1c > 9.0%)	14%	
	Diabetes: LDL Management and Control (% LDL < 100)	62%	
	Diabetes: Nephropathy Testing	94%	
	Effective use of contraception	37%	
	Eligible population with a flu shot	81%	
	SBIRT screening and intervention/treatment (can be 18+ or 12+)	15%	
	Medication Review among patients 66+	87%	
	% patients with ED visits receiving a follow up call	90%	
	Prenatal care in first trimester	90%	
	Screening for Depression and Follow up Plan	50%	
Menu	Advanced care planning among patients 65+		
	Alcohol and Other Drug Dependence Treatment (initiation)		
	Cervical cancer screening		
	Childhood BMI assessment & nutrition/exercise counseling		

Measure Description	Stretch Target	Measure Choice
Childhood immunization rate		
Well-Child visits in the First 15 months of life (5+)		
Follow up Care for Children prescribed ADHD medication		
Immunization for Adolescents		
Patients assigned vs. Seen (CareOregon Members assigned vs those that have been seen in clinic)		X
Use of appropriate asthma meds		
Telephone call abandonment rate		X
Tobacco use & cessation intervention		
Other: please describe		

Specification Links for use if needed. Clinics can adapt specifications to meet their specific clinical population and to align with other like-metrics:

CCO Incentive Metrics: <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>

NQF: <http://www.qualityforum.org/QPS/QPSTool.aspx>

HEDIS: <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx>

Bonus Metrics:

Bonus Metrics are measured throughout the year from July 2015 – December 2015 and January 2016 – June 2016. Improvement is calculated as an average between these two reporting periods. The average of the two values will be evaluated at the end of the reporting year. Any clinic that improves these metrics 3% over the year will increase 1 (one) Level for the subsequent reporting period. There is no risk of decreasing payment levels for this metric.

Please select one Bonus Metric:

Metric #	Bonus Metric Description
1	Total Per Member Per Month Cost
2	ED Visits for Any Cause/1000 members X
3	Any Cause Hospital Admissions/1000 members