

Jackson Care Connect (JCC) Primary Care Payment Model

2022 Program Description

Applications must be returned to Jackson Care Connect CCO via email to PaymentModel@careoregon.org by March 11, 2022.

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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

Jackson Care Connect CCO (JCC) 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 JCC 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.

Jackson Care Connect CCO PCPM At a Glance-Placeholder

The Jackson Care Connect (JCC) CCO 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 JCC 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 JCC PCPM application deadline.



- ✓ **500+ assigned JCC Members.**
A minimum of 500 JCC members must be assigned to provider organization, when combined across all contracted clinics.
- ✓ **Open assignment.**
Clinics must be open to assignment of new JCC 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.

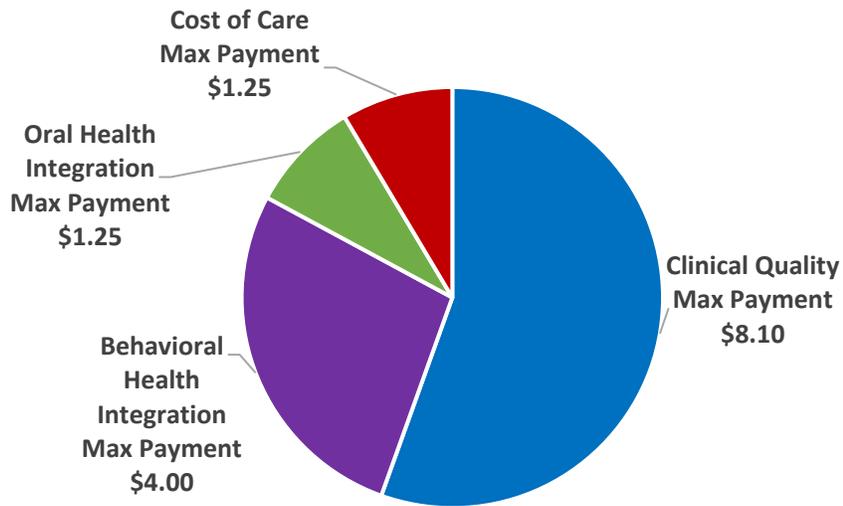
| Focus Area | Level 0 PMPM | Level 1 PMPM | Level 2 PMPM | Level 3 PMPM |
|-------------------------------|--------------|--------------|--------------|--------------|
| Clinical Quality | \$ 0.00 | \$ 3.40 | \$ 4.95 | \$ 8.10 |
| Behavioral Health Integration | \$ 0.00 | \$ 2.00 | \$ 4.00 | N/A |
| 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. Jackson Care Connect CCO 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 – JCC

One of two (2) clinical tracks must be selected for each participating clinic in the program application that best aligns with each clinic’s patient population: Family Practice/Internal Medicine or Pediatric. Each clinical track includes 11 total measures across all four focus areas.

| Focus Area | # | Family Practice/Internal Medicine Track | Pediatric Track |
|-------------------------|----|--|--|
| Clinical Quality | 1 | Kindergarten Readiness: Well-Child Visits 3-6-year-olds | Kindergarten Readiness: Well-Child Visits 3-6-year-olds |
| | 2 | Diabetes: HbA1c Poor Control | Childhood Immunization Status (Combo 3) |
| | 3 | Alcohol and Drug Misuse: SBIRT Rate 1&2 | Alcohol and Drug Misuse: SBIRT Rate 1&2 |
| | 4 | Screening for Depression and Follow-Up Plan | Screening for Depression and Follow-Up Plan |
| | 5 | Immunizations for Adolescents (MCV4, Tdap, HPV) | Immunization for Adolescents (MCV4, Tdap, HPV) |
| | 6 | JCC 12-Month Engagement Rate OR State APCM Care Steps Rate | JCC 12-Month Engagement Rate OR State APCM Care Steps Rate |
| | 7 | Equity Report: Improving Language Access | Equity Report: Improving Language Access |
| BHI* | 8 | JCC Population Reach | JCC Population Reach |
| | 9 | Choice of Sub-Population: - Patients with Positive SBIRT <i>or</i> - Patients with Diabetes: HbA1c > 9 | Choice of Sub-Population: - Patients with Positive SBIRT <i>or</i> - Patients with Positive Depression Screen |
| 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 |
| 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 |

*Only clinics that attest to delivering integrated behavioral health in alignment with JCC’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 <i>either</i> measure | \$ 2.00 ≥ 5.0 reach on <i>both</i> measures and < 12.0% on <i>either</i> measure. | \$ 4.00 ≥ 12.0% reach on <i>both</i> 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.

Both of the JCC Access and Engagement measures will have improvement targets of 1.5% and 3% over baseline for each reporting period, respectively.

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.

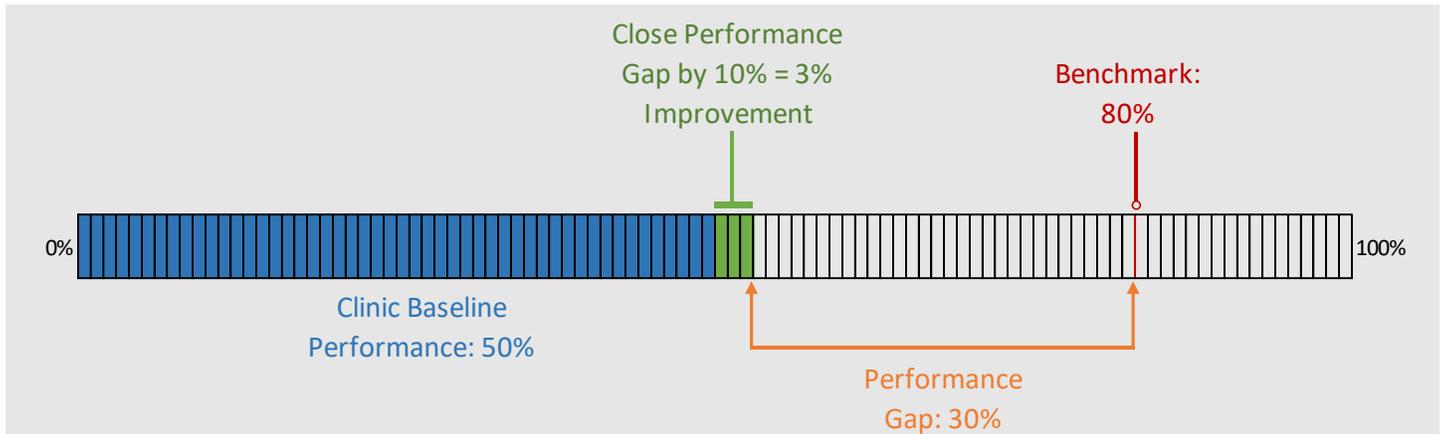
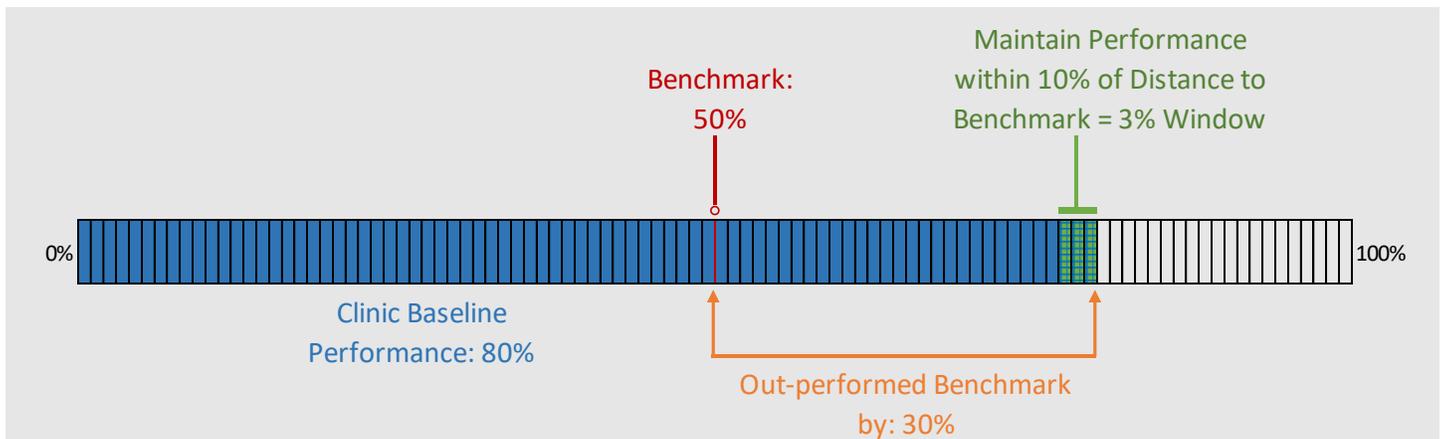


Figure 1 taken from Colorado Department of Health Care Policy & Financing

<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 JCC (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.

Jackson Care Connect CCO 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 JCC with data, or have data provided to JCC 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 JCC are not required to submit member-level or aggregate performance data separately for PCPM. Please contact PaymentModel@careoregon.org with questions about whether JCC 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, JCC will provide clinics with a member roster twice annually at least 30 days prior to data submission deadline, of all assigned JCC 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 JCC’s BHI Model of Care are required to submit aggregate data for unique JCC 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.

Annual Quality Pool Report

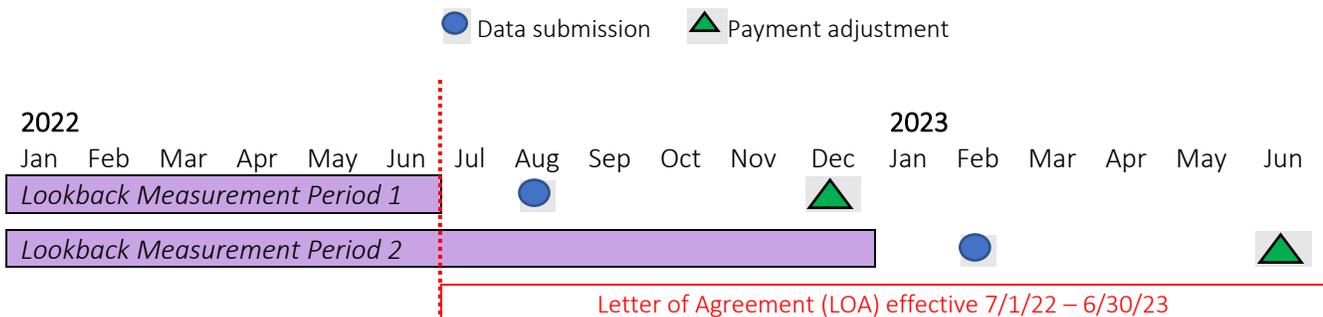
Each year JCC makes a one-time pay-for-performance payment to eligible clinics to recognize their contributions to the CCO incentive measure program. A portion of the money that JCC earns in the state CCO Quality Pool Program are passed directly to PCP clinics through this one-time payment. **Note: eligibility for PCPM program does not guarantee eligibility for the annual quality pool payment.**

Reporting Deliverable Timeline

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

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 500 Jackson Care Connect members assigned and must also be open to assignment of new JCC 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 JCC's BHI Model of Care. Jackson Care Connect CCO 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.

Step 5: Provide Baseline data for the Screening for Depression Measure in the Program Application.

***Note:** All clinics participating in the Family Practice/Internal Medicine Track will need to provide JCC with baseline data for the Screening for Depression Measure on the program 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. Additionally, 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 additional historical measurement data at time of application. All data for EHR/eCQM measures must be 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

May 13, 2022

July 1, 2022

Application is due to Jackson Care Connect CCO.

Signed Letter of Agreement is due to Jackson Care Connect CCO.

Letter of Agreement becomes effective.

Appendix A: Detailed Measure Sets for Clinical Tracks - JCC

1. Family Practice/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 8/21/21 | Target 2 (Measurement Period 2) Due 2/28/22 | Benchmark |
|---|---------------------------------|--|-------------------------------|-----------------------------------|---|---|--------------------------------------|
| Clinical Quality Focus Area | | | | | | | |
| Kindergarten Readiness: Well-Child Visits 3-6 (MM) | Claims | Jan 2022 – Jun 2022 | Jan 2022 – Dec 2022 | Jan – Dec 2021 Clinic Specific | TBD Clinic-specific | TBD Clinic-specific | 64.1 |
| 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% |
| 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% |
| 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% |
| JCC 12-month Engagement Rate or State APCM Care Steps Rate | Claims or Clinic Reported | Jul 2021 – Jun 2022 or 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 | | | | | | | |
| JCC 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 |
| JCC 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 |
| JCC 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 Quantitative Submission | N/A |
| | | | | | | | |
| 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 | Target 2 | Benchmark |
|---|----------------------------------|--|-------------------------------|--------------------------------|------------------------------------|------------------------------------|--------------------------------|
| | | | | | (Measurement Period 1) Due 8/21/21 | (Measurement Period 2) Due 2/28/22 | |
| Clinical Quality Focus Area | | | | | | | |
| Kindergarten Readiness: Well-Child Visits 3-6 (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% |
| Immunization 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% |
| JCC 12-month Engagement Rate or State APCM Care Steps Rate | Claims or Clinic Reported | Jul 2021 – Jun 2022 or Jan 2021 – | Jan 2022 – Dec 2022 | Jan – Dec 2021 Clinic Specific | TBD Clinic-specific | TBD Clinic-specific | N/A |



| | | | | | | | |
|---|------------------|---------------------|---------------------|-----|-----------------------------------|------------------------------------|-----|
| | | Jun 2021 | | | | | |
| 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 | | | | | | | |
| JCC 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 |
| JCC Sub-Population Reach: Patients with Positive SBIRT or Patients with Positive Depression Screen | 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 |
| JCC 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 Quantitative Submission | N/A |
| Cost of Care Focus Area | | | | | | | |
| Pediatric Cost of Care Narrative Report | Narrative Report | Jan-June 2022 | Jan-Dec 2022 | N/A | Narrative Submission | Narrative Submission | N/A |

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. Access and Engagement Measure Specifications for JCC

State APCM Care Steps

A Care STEP is a specific direct interaction between the Health Center staff and the patient, the patient's family or authorized representative(s) through in person, digital, group visits, or telephonic means. It was developed by the Oregon Health Authority and Oregon Primary Care Association for the state FQHC Advanced Payment and Care Model. There are currently 18 Care STEPs, grouped into four categories:

- 1) New Visit Types,
- 2) Education, Wellness and Health Promotion,
- 3) Coordination and Integration, and
- 4) Reducing Barriers to Health

Care STEPs documentation can demonstrate the range of ways in which Health Center teams are providing access to services and value to patients. Care STEPs data are collected and submitted quarterly to OHA, in order to better understand the non-billable and non-visit-based care and services that are being delivered, as the Patient-Centered Primary Care Home model advances under APCM.²

APCM Care STEPs Numerator

Members with at least one Care STEP during the measurement period with *any* primary care clinic or primary care provider within their assigned clinic's organization

² <https://www.oregon.gov/oha/HSD/OHP/Tools/APM%20FAQs.pdf>

APCM Care STEPs Denominator

Active members with primary physical health coverage through JCC assigned to clinic

Jackson Care Connect 12 Month Engagement Measure

Description

JCC’s 12 month engagement rates measures the percent of assigned members who were in engaged in primary care services with their assigned provider within the previous 12 months

Numerator

Members with at least one primary care service in previous 12 months with *any* primary care clinic or primary care provider within their assigned clinic’s organization

Denominator

Active members with primary physical health coverage through JCC assigned to clinic

Technical Notes

1. Primary care visits are identified by claim form type (1500) and provider specialty
2. Specialty types designated as “primary care” are: family practice, adolescent medicine, general practice, geriatrics, internal medicine, naturopathic medicine, pediatrics, preventive medicine, physician assistant.

3. 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 JCC 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 JCC 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.

| <i>Column Name</i> | <i>Valid Input Value</i> | <i>Additional Instructions for Completing the Reporting Template</i> |
|-------------------------------|--|---|
| Member ID | Member's Medicaid ID | |
| Visit Type/Care Setting | Office Outpatient Telehealth Other | <u>Please report only one visit per member per day.</u> If multiple types of visits occurred on the same day, then please select one type of visit <u>using the order of selections as a hierarchy.</u> 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 | <u>Please report only one visit per member per day.</u> |
| In-person Interpreter Service | Yes No | |



| | | |
|--|---|---|
| Telephonic Interpreter Service | Yes No | Report all that apply during the visit date |
| 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 Reason for member refusal | Yes No 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. |

4. BHI Population Reach Measure Specifications

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

5. 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 JCC 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 JCC 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 JCC 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:
 - 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.
 - Documented consultations and shared care planning with internal primary care team members.
 - Documented consultations, care coordination and case management with external partners such as specialty behavioral health, hospitals, schools, families, etc.
 - Care management activities that include outreach and engagement services.
 - 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.

6. 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?

7. 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/Internal Medicine 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

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.

8. 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 JCC 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

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

9. 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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ✓ 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)*: <ul style="list-style-type: none"> ✓ 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 JCC’s BHI Program.



Appendix D: What Payment Level Will I Start At?

Prior participation and performance in JCC 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. ✓ <u>All clinics new to participation</u> 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 JCC BHI with payment level 0 at time of LOA effective date. ✓ Clinics that do not attest to JCC BHI Model of Care. | \$ 2.00 ✓ Clinics currently participating in JCC 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 JCC 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 ✓ <u>All</u> 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. ✓ <u>All</u> clinics <u>new to</u> participating in PCPM | | |