2023 AMENDMENT
to the
PARTICIPATING PROVIDER AGREEMENT

Effective January 1, 2023 the Participating Provider Agreement (the "Agreement") between PacificSource Community Solutions ("Health Plan") and Central Oregon Community Mental Health Programs ("CMHPs") is amended to include the following:

1. New Attachments G and H.

Except for the changes described herein, the Participating Provider Agreement, and all other Exhibits, remain unchanged.

IN WITNESS WHEREOF, the Parties have entered into this Agreement as of the date first set forth above.

PACIFICSOURCE COMMUNITY SOLUTIONS		**DESCHUTES COUNTY HEALTH SERVICES**	
By:	_____ PETER MCGARRY	By:	_____ ANTHONY DEBONE, CHAIR
			_____ PATTI ADAIR, VICE CHAIR
			_____ PHIL CHANG, COMMISSIONER
Title:	VP PROVIDER NETWORK	Title:	BOARD OF DESCHUTES COUNTY COMMISSIONERS
Date:	_____	Date:	_____
Address:	PO Box 7469 Bend, OR 97701	Address:	2577 NE Courtney Drive Bend, OR 97701

JEFFERSON COUNTY HEALTH SERVICES
BOARD OF COUNTY COMMISIONERS

By:_____

Name: WAYNE FORDING

Title: COMMISSIONER

Date:_____

JEFFERSON COUNTY HEALTH SERVICES
BOARD OF COUNTY COMMISSIONERS

By:_____

Name: KELLY SIMMELINK

Title: COMMISSIONER

Date:_____

JEFFERSON COUNTY HEALTH SERVICES
BOARD OF COUNTY COMMISSIONERS

By:_____

Name: MARK WUNSCH

Title: COMMISSIONER

Date:_____

PACIFICSOURCE COMMUNITY SOLUTIONS

By:_____

Name: PETER MCGARRY

Title: VP PROVIDER NETWORK

Date:_____

CROOK COUNTY HEALTH SERVICES
BOARD OF COUNTY COMMISIONERS

By:_____

Name: SETH CRAWFORD

Title: COUNTY JUDGE

Date:_____

CROOK COUNTY HEALTH SERVICES
BOARD OF COUNTY COMMISIONERS

By:_____

Name:JERRY BRUMMER

Title: COUNTY COMMISSIONER

Date:_____

CROOK COUNTY HEALTH SERVICES
BOARD OF COUNTY COMMISIONERS

By:_____

Name: BRIAN BARNEY

Title: COUNTY COMMISSIONER

Date:_____

PACIFICSOURCE COMMUNITY SOLUTIONS

By:_____

Name: PETER MCGARRY

Title: VP PROVIDER NETWORK

Date:_____

ATTACHMENT G

RISK MODEL

1.0 RISK MODEL

The 2023 Risk model agreed upon by Health Plan, various primary care providers of St. Charles Medical Group, Mosaic Medical Group, and COIPA and also Central Oregon Community Mental Health Programs ("CMHP(s)") shall contain the following:

(A) A construct involving two (2) main Coordinated Care Organization (CCO) territories (Central Oregon CCO and Columbia Gorge CCO) and settlements within each CCO for OHP Members, as well as the potential for settlement impacts for CMHPs should CMHPs provide services to OHP Members from the Lane, Marion/Polk or Portland area CCOs. In the Central Oregon CCO, the separate Health Care Budget (HCB) settlements shall be for those OHP Members who are assigned to primary care providers of (i) St. Charles Medical Group (SCMG) combined with the primary care providers of Mosaic Medical Group, and (ii) COIPA. In the Central Oregon CCO, there are some OHP Members who are assigned to primary care providers other than SCMG, Mosaic Medical Group and COIPA, for whom there may be no HCB, and/or no settlement involving CMHPs.

(B) A Hospital Capitation Payment to St. Charles Health System (SCHS) for certain hospital services in the Central Oregon CCO as a component of the separate HCBs, and for which there is a Hospital Capitation Withhold (HCW) which shall be settled for SCMG/Mosaic Medical Group (Mosaic), COIPA, SCHS and the CMHPs in Central Oregon and distributed independently of any HCB settlement determining a surplus or deficit.

(C) Capitated payment for primary care providers of SCMG, Mosaic and COIPA for certain primary care services provided to any assigned OHP Members from any CCO, for which there will be no withhold and no independent settlement.

(D) Fee-for-service payment for all other professional services provided by SCMG, Mosaic and COIPA for any CCO members not designated as capitated primary care services per (C) above.

(E) Capitated and fee-for-service payment to the CMHPs for services provided as detailed in Attachment H. Fee-for-service payments shall have a Claims Risk Withhold.

(F) Patient-Centered Primary Care Home (PCPCH) and Behavioral Health Integration (BHI) per member per month payments for which primary care providers can qualify.

(G) Payment allocations for (B), (C), (D), (E), and (F) above, and separate HCB settlements for health care expenses to determine Claims Risk Withhold and Surplus returns for SCMG, Mosaic, COIPA, other providers, Community Mental Health Programs (CMHPs) and Health Plan.

(H) Separate risk models which features Revenue and Expenses for physical health, behavioral health/Chemical Dependency (CD), Alcohol/Drug – Residential, and Behavioral Health – Residential services under OHP, paid by the state of Oregon to Health Plan as a global capitation payment, and not otherwise designated as revenue contingent on innovation grants, and the exclusion of Revenue and Expenses in the following OHP categories:

--- "Dental Care" premium allocation and expenses.
--- "Non-Emergent Medical Transportation" premium allocation and expenses.
--- Payments to Central Oregon Health Council (COHC), taxes, adjustments and premium transfers.

If there are significant fluctuations (+/-10%) in the revenue allocations/adjustments for Dental, NEMT, or taxes/adjustments/premium transfers, Health Plan will discuss such fluctuations with CMHPs as soon as possible to gain a mutual understanding of the fluctuation, and whether it was due to membership fluctuation by benefit category, or some other cause.

(I) Contract terms that are consistent with the Joint Management Agreement (JMA) and JMA budget signed between Health Plan and the COHC which specifies the rules, duties, obligation, limitations on Health Plan margin, "Health Services" allocations, and other obligations and expenses for Health Plan as a CCO for Central Oregon.

(J) Utilization and Process Metrics which specify the return of any HCW, and metrics which specify the return of part of the Surplus and Claims Risk Withhold which may result from health care costs measured against any HCB.

2.0 CAPITATION

2.1 Hospital Capitation Rate (HCR) paid to SCHS: The HCR shall be **$107.50** per member, per month (PMPM), which has been calculated for the membership in the month of November 2020, and will fluctuate with membership fluctuations in each Rate Category, consistent with the revenue components listed in Section 1,H above. The HCR and the resulting Hospital Capitation Payment to SCHS may vary as Estimated Earned Net Premium Revenue payments from the state of Oregon to Health Plan increase or decrease, and is a weighted average of the following Central Oregon CCO membership in various benefit categories (which will change each month with membership) and PMPM Capitation Rates specific to each Rate Category as indicated below:

Rate Category	PMPM Capitation Rate	Nov. 2020 Membership
Aid to Blind/Disabled & OAA with Medicare	$20.12	3,474
Aid to Blind/Disabled & OAA w/o Medicare	$389.97	2,132
CAF Children	$27.66	820
ACA Ages 19-44	$94.35	15,411
ACA Ages 45-54	$186.29	4,089
ACA Ages 55-64	$209.14	4,183
PLM, TANF and CHIP Children age < 1	$425.93	1,217
PLM, TANF and CHIP Children age 1-5	$26.36	6,333
PLM, TANF and CHIP Children age 6-18	$27.11	14,990
PLM Adults (includes pregnancy)	$654.94	420
TANF (Adults only)	$170.58	5,042
BCCP	$433.42	18

Weighted Average	**$107.50**
Total Average Membership, Central Oregon CCO	**58,128**

2.2 Hospital Capitation Withhold (HCW): The Hospital Capitation Payment will have an eight percent (8%) Hospital Capitation Withhold.

2.3 Hospital Capitation Services: The following hospital services provided to Central Oregon CCO OHP members will be reimbursed via the Hospital Capitation Payment paid to SCHS for services provided at St. Charles Medical Center – Bend, St. Charles Medical Center – Redmond, St. Charles Medical Center – Prineville, and St. Charles Medical Center – Madras:

- Hospital Inpatient Services, including swing beds and rehabilitation.
- Hospital Outpatient Services, including therapies.
- Home Health/Hospice Services billed by St. Charles Medical Center or its owned entities.

In the event of a significant shift in central Oregon community patterns-of-care that increase or decrease by more than five percent (5%) inpatient care, outpatient surgery, outpatient care, or the proportion of hospital care provided by out-of-area providers for any twelve-month period compared to a prior twelve-month period, the HCR may, upon mutual agreement by SCMG, Mosaic, SCHS, COIPA, CMHPs and Health Plan, be adjusted by Health Plan to account for such shifts in community patterns-of-care.

Both parties acknowledge the Hospital Capitation Payment is not intended to include reimbursement for behavioral health services funded via behavioral health/CD Residential or other OHP revenue. In the event of a duplicate payment to SCHS for such services paid under the Hospital Capitation Payment, Health Plan will present such information to all risk model entities adjust for such duplicate payment.

2.4 Other Hospital Services: The following hospital services provided to Central Oregon CCO OHP members will be reimbursed via methods other than the Hospital Capitation Payment:

- Professional Services billed by SCHS professional and hospital-based providers and billed on a CMS 1500 form or UB-04 or other form, which, unless covered under a separate agreement, will be reimbursed at one hundred percent (100%) of current OHP Allowable Amounts and eight percent (8%) claims risk withhold.

- Services provided by and billed under St. Charles Medical Group and St. Charles Family Care.

- Services provided by and billed under Sageview Behavioral Health.

- Inpatient and outpatient Behavioral Health/CD, Alcohol/Drug – Residential, or Behavioral Health – Residential services funded via OHP's Behavioral Health/CD, Alcohol/Drug - Residential or Behavioral Health – Residential revenue.

- Inpatient and outpatient Dental Services funded as the Oregon Health Plan and OHA's Dental revenue via dental care providers and Dental Care Organizations (DCOs).

2.5 Primary Care Capitation Rate. For services provided by SCMG, Mosaic Medical and COIPA who is providing certain primary care services for SCMG, Mosaic Medical and COIPA-assigned OHP Members, reimbursement will be made on or around the 15th of every month, and shall be:

Primary Care Capitation Rate negotiated as a variable per member per month

This Primary Care Capitation rate will be made as a per member per month amount for any Federally Qualified Health Centers or Rural Health Centers, upon identification as such by Health Plan.

This Primary Care Capitation Rate will be applied to the following PCP Adjustment Factors attributed to the individual rate categories, which are:

Rate Category	PCP Adjustment Factor
Aid to Blind/Disabled & OAA with Medicare	0.3475
Aid to Blind/Disabled & OAA without Medicare	2.2243
CAF Children	1.0280
ACA Ages 19-44	0.9551
ACA Ages 45-54	1.4266
ACA Ages 55-64	1.4900
PLM, TANF and CHIP Children age < 1	1.5641
PLM, TANF and CHIP Children age 1-5	0.9435
PLM, TANF and CHIP Children age 6-18	0.6882
Poverty Level Medical Adults (includes pregnancy)	0.9551
TANF (Adults only)	0.9551
BCCP	0.9551

Primary care providers shall submit a claim to Health Plan for every service provided, including capitated primary care services.

2.6 Covered Services Paid By Primary Care Capitation Rate

This Primary Care Capitation Rate, multiplied by the PCP Adjustment Factors, will be considered payment in full for the following CPT code services which are provided by primary care providers for their assigned OHP Members:

Services	CPT Codes
Office Visits	99201-99205, 99211-99215, 99241-99245
Home Services	99341-99345, 99347-99350
Other Office Services	92551, 92552, 93000, 93005, 93010, 93790, 95115-95134, 99000-99002, 99050, 99051, 99053, 99056, 99058, 99070, 99080, 99366-99368, 99429, 99441-99443
Minor Surgical Services	10060, 10061, 10080, 10120, 10140, 10160, 11720, 11721, 11740, 16000, 16020, 17110, 17111, 20550, 20600, 20605, 20610, 30300, 36415, 45300, 45303, 46600, 46604, 51701, 54050, 54055, 54056, 56501, 65205, 65220, 69200, 69210

3.0 COMPENSATION – ALL OTHER PROFESSIONAL SERVICES

For non-capitated primary care services and all specialty/ancillary services provided to OHP Members irrespective of primary care provider assignment, SCMG, Mosaic and COIPA shall be compensated based on Resource Based Relative Value Scale ("RBRVS") conversion factors or a percentage of the current OHP fee schedule. Payment will be less an established Claims Risk Withhold. On an annual basis, this Claims Risk Withhold will be returned in whole, in part, or not returned, based upon (a) the comparison of paid and incurred claims expenses and other costs, to separate HCBs in Sections 7 of this Exhibit B as well as the performance of quality metrics in Section 7.6, or (b) per the contract of the OHP Member's primary care provider, if other than SCMG, Mosaic or COIPA.

3.1 Medical Fee For Service

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE	CLAIMS RISK WITHHOLD
Services listed in the CMS Physicians Fee Schedule: OHA GPCI Adjusted RVUs for services listed in the July 2019 Medicare Physician Fee Schedule	conversion factor[1, 2, 3]	8%
Labor and Delivery: CPT Codes 59400-59622	conversion factor[1, 2, 3]	8%
Laboratory: Services classified by CMS using OHP Medical-Dental Fee Schedule	% of OHP Allowable[1, 3]	8%
Anesthesia: Services classified in the American Society of Anesthesiologists Relative Value Guide	per unit ASA Conversion Factor[4]	8%
Durable Medical Equipment, Prosthetics, Orthotics and Supplies: Services listed in the OHP Medical-Dental Fee Schedule	% of OHP Allowable[1, 3]	8%
Injectables, Vaccines, Immunizations: Services listed in the OHP Medical-Dental Fee Schedule	% of OHP Allowable[1, 3]	8%
Services and procedures without an OHP Allowable	% of Billed Charges	8%

Note: Payment will be based upon the lesser of the billed amount or Health Plan negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.

1. Updates to the schedules noted above shall be updated in accordance to OHP.
2. Facility and non-facility RVUs shall be used and determined by the setting in which the service occurs.
3. Health Plan will reimburse based on the rates published as of the date of adjudication
4. ASA Basic Unit Value and annual updates as defined by the American Society of Anesthesiologists Relative Value Guide. Time units shall be based on fifteen (15) minute increments.

3.2 Patient Centered Primary Care Home (PCPCH) Program and Behavioral Health Integration

Primary care providers shall be able to opt into Health Plan's Base or Program Participation PCPCH Program.

4.0 ALTERNATIVE PAYMENT MODELS

4.1 Pediatric Hospitalist Program.

SCHS shall be paid one dollar and twenty-five cents ($1.25) per OHP Member, per month, for OHP Members assigned to SCMG, Mosaic and COIPA's primary care providers in Central Oregon, to support a Pediatric Hospitalist Program (the "Program"). This amount will be an expense against separate HCBs to support the costs of the Program. Program revenue and costs, including FTE costs, will be reported showing any deficit/surplus. SCHS will provide, no less than quarterly, the accounting for the Program revenue and costs as described above to Health Plan.

4.2 Provider Incentives for Enhanced Access, Quality Improvement and PCPCH Certification

SCMG, Mosaic and COIPA shall be paid around three dollars and thirty cents ($3.30) per OHP Member, per month, for OHP Members assigned to SCMG, Mosaic Medical and COIPA. This amount will be an expense against their respective HCBs.

4.3 Deschutes Stabilization Center

Deschutes County shall be paid ninety-one cents ($0.91) per OHP Member, per month, for OHP Members assigned to SCMG, Mosaic, and COIPA primary care providers in Central Oregon, to support a Deschutes Stabilization Center. This amount will be an expense toward their respective HCBs.

5.0 PREMIUM ALLOCATION.

Health Plan and CMHPs have established the following allocation of premium in order to implement the compensation and risk incentive structure:

5.1 Definitions. Estimated Earned Net Premium Revenue. Estimated Earned Net Premium Revenue shall consist of those global capitation payments (including adjustments and reconciliations with the state of Oregon) received by Health Plan from the State of Oregon for OHP Members assigned to SCMG's/Mosaic's and COIPA's primary care providers in the Central Oregon CCO for health services under OHP, less premium allocations and/or payments for services in Section 1,H, which include: Dental Care premium allocation and claims paid to DCOs, Non-Emergent Medical Transportation premium allocation and claims paid to NEMT vendors, payments to COHC per the agreement with the COHC, taxes, adjustments, premium transfers, innovation grant revenue, OHA-required Hepatitis C reconciliations with OHA as necessary, and any portion of QIM bonus or QIM withhold retained per agreement with the COHC.

5.2 Allocation of Estimated Earned Net Premium Revenue.
After the application of any QDP/GME/MCO/Provider taxes, ACA taxes, OHA-required qualified directed pass-through payments, Health Plan Income Taxes for Medicaid, a payment to fund the COHC in the amount of one percent (1%) of gross premium (not counting pass-through funds), premium transfers for Dual Eligible Medicare premium and excluding: Dental Care premium allocation and claims paid to DCOs, Non-Emergent Medical Transportation premium allocation and claims paid to NEMT vendors, innovation grant revenue, OHA-required Hepatitis C reconciliation adjustments with the OHA/state of Oregon as necessary, and QIM withhold retained per agreement with the COHC, the remaining Estimated Earned Net Premium Revenue will be allocated as follows:

5.2.1 Administration. Eight and sixty hundredths percent (8.60%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to Health Plan for administration.

5.2.2 Amounts Allocated to the primary care provider HCB. Ninety-one and forty hundredths percent (91.40%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to the separate HCBs of SCMG/Mosaic, and COIPA.

6.0 ALLOCATIONS AND DISBURSEMENT

6.1 Computation of Budget Expenses.

For OHP Members assigned separately to primary care providers of SCMG/Mosaic and COIPA, all claims expenses (including Claims Risk Withhold), PMPM fees (including credentialing and any CPC+ expenses), reinsurance/stop loss premium expenses (less recoveries), Pharmacy Expenses (less rebates), Hospital Capitation Payments (including HCW), PCP Capitation Expense, subrogation adjustments, premium/MCO taxes, coinsurance expenses, out-of-area expenses, ancillary expenses, behavioral health/Chemical Dependency (CD) expenses paid to CMHPs, SCHS and other panel providers, Alcohol/Drug Residential expenses, Behavioral Health – Residential expenses, Health Services and other expenses iterated in the Joint Management Agreement (JMA) and JMA budget between Health Plan and the COHC shall be charged to the separate HCBs based on the day services were actually rendered with the exception of Late Claims, as defined in Section 6.2 below, which shall be charged to the next year's applicable budget.

6.2 Disposition of Late Claims.

Late Claims are those claims received, processed, and paid later than four months (120 days) after the close of the contract period. Late Claims will be attributed to the next year's applicable budget.

7.0 SETTLEMENT PARAMETERS.

7.1 Settlement Parameters for OHP Members

The following settlement parameters for this Section 7 are intended to approximate financial terms for OHP Members assigned to SCMG/Mosaic and COIPA's primary care providers. CMHP's role in settlements shall be consistent with the settlement terms of SCMG/Mosaic and COIPA, should such settlement terms differ from the terms and percentages otherwise indicated in this Section 7. CMHPs understand and agree to be subject to the settlement terms other primary care provider agreements when CMHPs provide services for OHP Members assigned to non-SCMG/Mosaic and non-COIPA entities.

7.2 Time Period.

Annual Claims Risk Withhold and HCW settlement reports will occur for the 2023 calendar year four months (120 days) after the close of the contract period ending December 31st. Any charges/credits to the applicable budgets that have occurred since the settlement of the previous contract period are accounted for in the settlement of the current period.

7.3 Claims Risk Withhold Settlement Summary.

Health Plan shall be responsible for computing, documenting, and reporting annual Claims Risk Withhold settlement summary. This report shall be submitted approximately five months (151 days) after year-end. In the event of a dispute regarding the accuracy and completeness of the data reported by Health Plan, Health Plan agrees to an audit of the data by an independent third party mutually agreed upon between Health Plan and providers, which shall be at the sole cost and expense of providers.

7.4 Settlement Sequence – First Settlement (HCW)

There will be two (2) independent settlements. The first settlement will be the settlement of the HCW for OHP Members assigned to primary care providers of SCMG/Mosaic and COIPA.

7.4.1 Allocation. Unless otherwise changed in the primary care provider agreements, the HCW of eight percent (8%) of the Hospital Capitation Payment as allocated for the OHP Members assigned to primary care providers of SCMG/Mosaic and COIPA will be held by Health Plan until the time of settlement of each entity's HCB.

- **SCMG/Mosaic or COIPA 49.00% of HCW**
- **SCHS 49.00% of HCW**
- **CMHPs 2.00% of HCW**

7.4.2 HCW settlement for CMHPs. HCW for OHP Members assigned to primary care providers of SCMG/Mosaic and COIPA will be awarded upon the meeting of performance goals in utilization and process areas as follows and as updated for automatic changes in calendar years or Oregon Health Authority benchmark changes, or as changed via amendment:

2023 CENTRAL OREGON CCO / SCHS PERFORMANCE MEASURES FOR HOSPITAL CAPITATION WITHHOLD RETURN

1. Follow-Up After Hospitalization for Mental Illness within 7 days	
Weighting	20%
Performance Monitoring	Health Plan reporting using Health Plan administrative claims data
Final Result[1]	Health Plan data, administrative claims only
Target	2022 CCO Final Rate plus one percentage point
Population	Central Oregon CCO Members
Measure Specification	OHA Current Specification: Follow-Up after Hospitalization for Mental Illness
Denominator	Per OHA Current Specification. Deviation from Specification: Discharges from Sage View only are included in the Denominator.
Numerator	Per OHA Current Specification
2. Prenatal & Postpartum Care - Postpartum Care	
Weighting	20%
Performance Monitoring	Health Plan reporting using Health Plan administrative claims data
Final Result[1]	OHA Central OR CCO 2023 Final Hybrid QIM Results
Target	OHA Central OR CCO 2023 QIM Measure Target
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: Prenatal and Postpartum Care
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification
3. Follow-up After ED Visit for Mental Illness within 7 days	
Weighting	20%
Performance Monitoring	Health Plan reporting using Health Plan administrative claims data
Final Result[1]	Health Plan data, administrative claims only
Target	2022 CCO Final Rate plus one percentage point
Population	Central Oregon CCO Members
Measure Specification	HEDIS Current Specification: Follow-Up After Emergency Department Visit for Mental Illness
Denominator	Per HEDIS Current Specification
Numerator	Per HEDIS Current Specification
4. Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence within 7 days	
Weighting	20%
Performance Monitoring	Health Plan reporting using Health Plan administrative claims data
Final Result[1]	Health Plan data, administrative claims only
Target	2022 CCO Final Rate plus one percentage point
Population	Central Oregon CCO Members
Measure Specification	HEDIS Current Specification: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
Denominator	Per HEDIS Current Specification
Numerator	Per HEDIS Current Specification

5. Standardized Healthcare-Associated Infection Ratio	
Weighting	*Clostridium difficile* (C. Diff) intestinal infections – 6% Central Line-Associated Bloodstream Infections (CLABSI) – 4% Catheter-associated Urinary Tract Infections (CAUTI) – 6% Methicillin-resistant *Staphylococcus Aureus* (MRSA) blood infections – 4%
Performance Monitoring	SCHS
Final Result[2]	SCHS[2] **Final result is subject to review and audit by Health Plan*
Target	Final rate is not statistically significantly worse than the expected rate. Each rate is measured and scored separately.
Population	All SCHS hospitalizations (entire SCHS population regardless of location)
Measure Specification	N/A – Measure Steward: NHSN, NCQA
Denominator	As per NHSN Specification for hospitals
Numerator	As per NHSN Specification for hospitals

[1]Final contract performance results will be available after final QIM results are delivered from OHA and will be included in the final reconciliation risk reports.

[2]SCHS must provide final results for all four (4) Standardized Healthcare-Associated Infection Ratio (SIR) measures by 11:59 PST on March 31, 2024 to be eligible for payout. Performance reporting for each of the four (4) SIR measures must include:

- Standardized Infection Ratio (SIR)
- Count of Observed Infections
- Expected (Predicted) Infections
- 95% Confidence Interval for SIR (low and high)

Final results must be sent via email to the following recipients:
RiskReportAnalytics@pacificsource.com
Beth.Quinlan@pacificsource.com
Peter.McGarry@pacificsource.com

7.4.5 Unearned HCW

Any HCW not paid shall be considered Unearned HCW. Unearned HCW shall be allocated in the following manner:

1st Used to offset any Deficits for the HCB settlement, after the application of Claims Risk Withhold for that settlement.

2nd Any remaining Unearned HCW will contribute to Health Plan margin, consistent with limitations in the Joint Management Agreement (JMA) between Health Plan and the COHC.

3rd Any remaining Unearned HCW will be treated as shared savings under the terms of the JMA.

7.5 Settlement Sequence – Second Settlement (HCB)

After completion of the HCW settlement, separate HCBs shall be settled.

7.5.1 The separate HCBs are established for the following health care expenses for those OHP Members assigned to primary care providers of SCMG/Mosaic and COIPA: Hospital Capitation Payments (including HCW) consistent with Section 2, PCP Capitation payments consistent with Section 2, claims expenses for professional services including those established by the reimbursement terms in Section 3 (including Claims Risk Withhold), Pharmacy expenses (less rebates), out-of-area expenses, and other provider PMPM fees per Sections 4, or other PMPM expenses, ancillary services, reinsurance premium (less recovery amounts), premium/MCO taxes, coinsurance expense, subrogation adjustments, behavioral health/Chemical Dependency (CD) expenses paid to CMHPs, SCHS and other panel providers, Alcohol/Drug – Residential expenses, Behavioral Health-residential expenses, and Health Services and other expenses iterated in the JMA and JMA budget between Health Plan and COHC.

7.6 Budget Surplus or Deficit.

For the contract period for the experience of OHP Members assigned to SCMG/Mosaic and COIPA, the separate HCBs will be compared to actual expenses incurred per Section 7.5 to determine whether a Surplus or Deficit exists.

7.6.1 Surplus. If the total value of total covered claims and expenses, including HCW and Claims Risk Withhold, is less than any HCB, a **Surplus** exists. Unless otherwise changed in the primary care provider agreements, Surplus will be limited to seventy percent (70%) of the Surplus amount, with any percentage increase beyond this amount contingent on a review of the one percent (1%) of gross premium allocated to COHC for community reinvestment. In the event of a Surplus, Claims Risk Withhold and Surplus share amounts will be returned/paid based on the below contingencies by approximately August 30 following the contract year. Any unknown final OHA determinations of QIM revenue or any OHA decisions on any revenue reductions will be applied and adjusted for the following contract year. Surplus amounts may be offset against amounts owed to Health Plan, if amounts owed are not otherwise paid to Health Plan. Surplus payment amounts are additionally determined according to the following:

Unless otherwise changed in the primary care provider agreements, Fifty-five percent (55%) of the Surplus will be earnable by the primary care entity (SCMG/Mosaic or COIPA), forty percent (40%) of the Surplus will be earnable by SCHS, and five percent (5%) of the Surplus will be earnable by the CMHPs and allocated proportionate to CMHP-represented county populations of OHP Members. Twenty-five percent (25%) of the Surplus and twenty-five percent (25%) of the Claims Risk Withhold are paid contingent on the performance of the below metrics, the majority of which are established and measured by the state of Oregon for the entire Central Oregon CCO, which are based on the final target setting for the Central Oregon CCO by OHA and will be awarded based on such state of Oregon measurement and state of Oregon final payment. Any other metric not established by the state of Oregon is an alternative metric and indicated with a (*) and is designed and measured by Health Plan. The following metrics will be used:

2023 CENTRAL OREGON CCO PROVIDER PERFORMANCE MEASURES FOR SURPLUS AND CLAIMS RISK WITHHOLD RETURN

1. Child Well-Care Visits (Age 3-6)	
Weighting	22.5%
Performance Monitoring	Health Plan reporting using Health Plan administrative claims data
Final Result	OHA Central OR CCO 2023 Final QIM Results
Target	OHA Central OR CCO 2023 QIM Measure Target
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: **Child and Adolescent Well-Care Visits**
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification
2. Members Receiving Preventive Dental or Oral Health Services	
Weighting	22.5%
Performance Monitoring	Health Plan reporting using Health Plan administrative claims data
Final Result	OHA Central OR CCO 2023 Final QIM Results
Target	OHA Central OR CCO 2023 QIM Measure Targets - This is a two-component measure with a target for Age 1-5 and a separate target for Age 6-14. Both targets need to be met to achieve measure.
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: **Members Receiving Preventive Dental or Oral Health Services**
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification
3. Diabetes: HbA1c Poor Control (>9.0%)	
Weighting	22.5%
Performance Monitoring	Health Plan reporting using Central Oregon CCO clinic submitted electronic health record data[1] excluding Weeks Family Medicine data
Final Result	OHA Central OR CCO 2023 Final QIM Results
Target	OHA Central OR CCO 2023 QIM Measure Target
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: **Diabetes: HbA1c Poor Control**
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification
4. Initiation and Engagement of Substance Use Disorder Treatment	
Weighting	22.5%
Performance Monitoring	Health Plan reporting using Health Plan administrative claims data
Final Result	OHA Central OR CCO 2023 Final QIM Results
Targets	OHA Central OR CCO 2023 QIM Measure Targets - This is a two-part measure with a target for Initiation and a separate target for Engagement. Both targets must be met to achieve measure.
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: **Initiation and Engagement of Substance Use Disorder Treatment**
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification

5. Immunizations for Adolescents (Combo 2)	
Weighting	10%
Performance Monitoring	Health Plan reporting using Health Plan administrative claims data
Final Result	OHA Central OR CCO 2023 Final QIM Results
Target	OHA Central OR CCO 2023 QIM Measure Target
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: **Immunizations for Adolescents (Combo 2)**
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification

1 Participating organizations must report monthly data to Health Plan by the 20th of each month. To be eligible for payout, final 2023 eCQM data submissions must be received by Health Plan from participating clinics no later than 11:59 PM PST on January 20, 2024. All submissions are subject to audit by Health Plan for accuracy.

All reporting data submissions must be sent via previously agreed upon SFTP or via email to the following recipient: ecqmreporting@pacificsource.com

7.6.2 Unearned Surplus and unearned Claims Risk Withhold Contingent On Quality

Any Unearned Quality Surplus and unearned Claims Risk Withhold shall be allocated in the following manner:

1st Used to offset any Deficits for any other Central Oregon OHP HCB settlements, after the application of Claims Risk Withhold associated with those other settlements.

2nd Used to contribute to Health Plan margin, consistent with the limitation in the Joint Management Agreement (JMA) between Health Plan and the COHC.

3rd Any remaining Unearned Surplus Contingent On Quality will be treated as shared savings under the terms of the JMA.

7.6.3 Deficit. If the value of total covered claims and expenses, including HCW and accumulated Claims Risk Withhold from all providers, is more than the single community HCB, a **Deficit** exists, and any and all Claims Risk Withhold will be used to satisfy the Deficit at an equal percentage for all providers. If any Claims Risk Withhold remains upon the Deficit being reduced to zero dollars ($0.00), it will be returned with twenty-five percent (25%) of any distributable Claim Risk Withhold return contingent on the performance of the quality metrics in Section 7.6.

7.6.4 Limited Liability. If the Deficit of the HCB exceeds the amount of total Claims Risk Withhold, no further amounts will be payable from CMHPs to reduce the Deficit beyond any unearned amounts.

8.0 GENERAL PROVISIONS.

8.1 Defined Terms.

Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

8.2 Precedence.

In the event of any conflict or inconsistency between this Exhibit and the Participating Provider Service Agreement, such conflict or inconsistency shall be resolved by giving precedence first to this Exhibit then the Participating Provider Agreement.

8.3 Health Plan Reporting

Health Plan shall provide accurate and timely reports to assist CMHPs in monitoring utilization, financial, and quality-related data. A schedule of reports and the frequency with which these reports are to be provided is listed below.

Existing Claims Risk Withhold Settlement Report, Central Oregon CCO	Monthly in 2023 and through March of 2024, by the end of the month, starting six (6) months after the beginning of the contract start date.

8.4 Health Services Understanding

Health Plan and SCMG and COIPA signed a separate Letter of Understanding in July of 2015 which detailed the appropriate allocation of certain health care expenses as being part of any HCB. Consistent with that understanding Health Plan (a) has entered into a contract with OHA whereby Health Plan has agreed to manage programs to optimize cost, quality and experience of care for OHP Members, (b) is mandated to operate such programs with auditable reporting requirements, (c) has signed an agreement with OHA (consistent with OHA rules and regulations) which stipulates such program expenses are accounted for outside Health Plan administrative/general expenses and are part of health care expenses which are part of any HCB in this Agreement, and (d) calculates a PMPM expense as a percentage of the CCO global budget, to pay for such Health Services programs.

8.5 Requirements

CMHPs will participate in and attest to performing (a) data submission activities pertinent to CCO eCQMs EHR-based incentive metrics, (b) data submission requirements including sending accurate data in time and formats determined by CCO to comply with OHA measure specifications, (c) submitting eCQM data to Health Plan on a monthly basis by the 20th of the month and acknowledging reports for the first four months of the calendar year will be provided as early as possible based on the delivery from CMHPs' software vendor, (d) requests for surveys or other information, (e) requests to complete successful CCO data collection/submission activities, and (f) reporting expectations for eCQMs for diabetes, hypertension, depression, tobacco prevalence and BMI. CMHPs acknowledge that submission of these requirements is essential as failure to do so for each EHR-based incentive will lead to failure for each eCQM measure, failure to meet the population threshold required and will cause the entire Central Oregon CCO to fail the measure.

CMHPs will perform patient satisfaction surveys in alignment with PCPCH standard requirements and will share such survey results with Health Plan upon reasonable request.

CMHPs will cooperate with Health Plan on Health Plan's CAHPS Improvement Plans.

CMHPs allows Health Plan to share individual provider performance information such as quality performance metrics with CCO-contracted providers and Health Councils.

8.6 Oregon Health Plan/OHA Capitation Administration Regulations

In the event of (a) requirements rules, regulations or guidance related to applicable provider capitation payments made by Health Plan to CMHPs, and per Health Plan Exhibit L filing and Medical Loss Ratio filings submitted to OHA, and/or (b) Health Plan's and/or OHA's interpretation of applicability of such requirements, rules, regulations, or guidance and applicability of Health Plan's capitation payment methodology with CMHPs, Health Plan may enact the following:

- A charge commensurate with any OHA recoupment, demand for repayment, charge, tax or fee, to be charged against any HCB, and/or

- A renegotiation with CMHPs to revert all payment methodologies entailing CMHP's capitation, to a fee-for-service payment methodology.

CMHPs shall cooperate with Health Plan to produce reports for Health Plan and/or OHA that satisfy to Health Plan and OHA discretion, the requirements, rules, regulations or guidance from OHA related to capitation payments.

8.7 Oregon Health Plan/OHA Possible Premium Revision / MLR-based repayment to OHA

In the event of a revision of premium levels for OHP Members by the state of Oregon/OHA by a net amount deemed by Health Plan to be inconsistent with the 2023 (a) CMHP capitation rate, (b) conversion factors, or (c) hospital capitation rates agreed to in this 2023 amendment to the Agreement, Health Plan will notify CMHPs of such inconsistency in writing, and both parties will enter into a renegotiation of 2023 reimbursement rates in order to achieve consistency with any new Oregon Health Plan/OHA premium levels.

In the event OHA determines Health Plan must pay OHA any sum because the Central Oregon CCO Medical Loss Ratio (MLR), as determined by OHA, does not meet a minimum threshold for the entire population or any benefit-category specific sub populations, Health Plan reserves the right to (a) deduct a pro-rata portion of such repayment from any HCB in Section 7, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with CMHPs and the COHC.

8.8 MLR Reporting for 2022.

CMHPs shall submit to Health Plan a report for the cost year January 1, 2022 – December 31, 2022 no later than March 30, 2023 using a format accepted by OHA. CMHPs shall refer to "2022 Medical Loss Ratio Rebate Instructions" (as published on the OHA CCO Contract Forms website at http://www.oregon.gov/oha/healthplan/Pages/cco-contract-forms.aspx) for support.

8.9 MLR Reporting for 2023.

CMHPs shall submit to Health Plan reports for the cost year January 1, 2023 – December 31, 2023 no later than March 30, 2024 using a format accepted by OHA. CMHPs shall refer to "2024 Medical Loss Ratio Rebate Instructions" (as published on the OHA CCO Contract Forms website at http://www.oregon.gov/oha/healthplan/Pages/cco-contract-forms.aspx) for support.

8.10 Health Related Services (Flexible Services and Community Based Health-Related Services.

Consistent with the Health-Related Services Rule adopted by the OHA (which includes member-level disbursements often called "flexible services", and community-based Health-Related Services, often called "Community Benefit Initiatives") and the Health-Related Services Brief released by the OHA, along with Health Plan policies approved by OHA, Health Plan will make certain disbursements from any HCB from time to time and at Health Plan's discretion. These disbursements are distinct from Health Plan-provided Health Services.

8.11 Community Health Improvement Plan, Transformation Plan and Health Council Activities.

CMHPs will collaborate with Health Plan, the COHC, and other stakeholders in completing a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP), and in carrying out activities to implement the CHIP including any recommendation tied to community access studies. CMHPs will collaborate with Health Plan, the COHC, and other stakeholders to carry out the Transformation And Quality Strategies. For purposes of the CHA, CHIP, or Transformation And Quality Strategies, for reporting to the COHC or any of its subcommittees, or for reporting to OHA, Health Plan may share CMHP's utilization, membership numbers, and additional performance data. CMHPs will collaborate with Health Plan and the COHC to meet Transformation And Quality Strategies requirements and participate in Transformation And Quality Strategy projects.

8.12 Corrective Action Plans

Health Plan, at its sole discretion and consistent with the expectations of Health Plan by OHA, may determine that CMHP's performance of obligations, duties and responsibilities under the terms of this Agreement is deficient. In reaching that conclusion, Health Plan may, but is not required to consider third-party audit or other formal review results, peer review results, quality measures, written or oral feedback from members or patients, and any other issues which may be identified by Health Plan. If Health Plan determines CMHP's performance is deficient for any reason, but that such deficiency does not constitute a Material Breach of the terms of this Agreement, Health Plan may institute a corrective action plan ("CAP") subject to internal review. Health Plan will notify CMHPs of the terms of the CAP and will provide a CAP reporting template. Health Plan will supply supporting information/data to CMHPs at that time. CMHPs shall have thirty (30) days to resolve the CAP to Health Plan's satisfaction. Failure to resolve the CAP shall constitute a Material Breach by CMHPs, and Health Plan may terminate this Agreement immediately.

8.13 Cooperation and Engagement in Quality Improvement Process.

The COHC voted to support QIM-related positions within Health Plan and area providers. CMHPs agrees to cooperate with the QIM Practice Facilitator, QIM Improvement Coordinator, QIM Program Manager, and the ED Improvement Coordinator to support success on regional quality measures including the QIMS, as well as to engage and cooperate with the Provider Engagement Panel to support quality improvement in the region.

8.14 Member Assignment

Health Plan may, at its discretion, assign OHP Members to primary care providers. Revisions to assignment procedures may be made in response to objective data related to quality performance, patient access, patient experience, or in response to other information available to Health Plan.

Attachment H

CCO Fee-for-service and Capitation for Behavioral Health Services
Community Mental Health Program for Central Oregon CCO

Effective 01/01/2023

1. CMHP Fee-for service and Monthly Capitation Payment

For services provided to OHP Members in the counties where the CMHPs are the designated Community Mental Health Program, Health Plan will reimburse CMHPs for Therapy Services and Assessment Services on a fee-for-service basis and on a capitation PMPM basis for Non-Encounterable Health Care Costs and Program Allocation costs according to the below rate schedule. These expenses will be charged and allocated to the separate Health Care Budgets (HCBs) in Attachment G.

Services provided to OHP Members from other CCOs and other counties for which the CMHP is not the designated Community Mental Health Program, CMHPs shall be reimbursed per a separate agreement for such services.

Intensive In-Home Behavioral Health Treatment (IIBHT) Deschutes County Health Services:

CMHP shall provide access to Intensive In-Home Behavioral Health Treatment (IIBHT) services for all eligible OHP Members aged twenty (20) and younger in accordance with OARs 309-019- 0167, 410-172-0650, and 410-172-0695. For Deschutes County, IIBHT services shall be submitted using HCPCS code of H0023 and shall be reimbursed through the below capitation table. The services under H0023 are separate from services billed for Behavioral Health outreach and engagement, for which a CPT code will be designated by Health Plan. Until such a time as an alternative code is identified, CMHP will submit non-billable Behavioral Health Outreach and Engagement (H0023) claims valued at the agreed rate of $169.90 and attributed to Non-Encounterable Healthcare Services Costs in the capitation portion of this contract.

Intensive In-Home Behavioral Health Treatment (IIBHT) Jefferson County Health Services and Crook County Health Services:

CMHP shall provide access to Intensive In-Home Behavioral Health Treatment (IIBHT) services for all eligible OHP Members aged twenty (20) and younger in accordance with OARs 309-019- 0167, 410-172-0650, and 410-172-0695. For Jefferson County and Crook County CMHPS, IIBHT services shall be submitted using HPCPS code H0023 and shall be reimbursed at one hundred percent (100%) of the current OHA allowable, with an eight percent (8%) Claims Risk Withhold to be settled per Attachment G.

Deschutes Stabilization Center
Deschutes County's CMHP shall be paid ninety-one cents ($0.91) per OHP Member, per month, for OHP Members assigned to SCMG, Mosaic, COIPA, and other primary care providers in Central Oregon, to support a Deschutes Stabilization Center. This amount will be an expense allocated to the separate HCBs.

Therapy Services for all CMHPs: Therapy Services FFS CPT Codes: 90832, 90834, 90837, 90846, 90847, H0004, H0005, H0016, H0038 shall be reimbursed at one hundred and thirty-two percent (132%) of the current OHP fee schedule, for services provided to OHP Members domiciled in the county for which Provider is the designated Community Mental Health Program. Allowable amounts will have an eight percent (8%) Claims Risk Withhold to be settled per Attachment G.

Assessment Services for all CMHPs: Assessment Services FFS CPT Codes: 90791, 90792, H0001, H0031, H2000 shall be reimbursed at one hundred seventy percent (170%) percentage of the current OHP fee schedule for services provided to OHP Members domiciled in the county for which Provider is the designated Community Mental Health Program. Allowable amounts will have an eight percent (8%) Claims Risk Withhold to be settled per Attachment G.

Non-Encounterable services/other billed services and Program Allocation Definition:
CMHPs shall provide and report non-encounterable services and system supports. Non-encounterable services and system supports include, but are not limited to: travel, prevention, education and outreach, internal case consultation, co-provided services, outreach and engagement, socialization, and psycho-educational services that are not otherwise encounterable. Payments shall be an expense against the HCBs detailed in Attachment G. Payments for such services and programs shall be as follows:

	Non-Encounterable services and all other CMHP-billed services PMPM	**Program Allocation PMPM**
Deschutes County Health Services, Public Health Division members domiciled in Deschutes/Klamath County	$18.67	$6.63
BestCare members domiciled in Jefferson County	$16.09	$10.39
BestCare domiciled in Crook County	$16.09	$10.39