Oregon Primary Care Association’s APCM
Introduction/Overview

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Oregon Primary Care Association

- State Primary Care Association
- 32 Community Health Centers (CHCs) Statewide
- Serve 1/10 Oregonians (over 420,000 individuals)
- Serve ¼ patients on the Oregon Health Plan
- 72% of patients are below the poverty line. 93% below 200% FPL.
OPCA North Star

Lead the transformation of primary care to achieve health equity for all
How we got here: APCM development
VISION OF A BETTER WAY

• Oregon FQHC leaders & stakeholders
• Pivotal site visit: 2006
• Model of excellence in medical home practice
  » Patient & population centered
  » Team-based
  » Data-driven
  » Integrated
EVOLUTION OF APPROACH

[2011] Isolated FFS Services
Medical care focus

[2011] Connection is key!

[2012] Robust PCMH Services
Patient-centered & team-based care

[2014] Emerging Model
Psychosocial and environmental factors as important as health care

Holistic customer orientation
PRESSURE ON THE SYSTEM

Cost increases

Budget deficit

System reform

Need to show value
OPCA’s GOAL
FOR ALTERNATIVE PAYMENT ADVANCED CARE MODEL (APCM)

Lead the development of and align payment with an efficient, effective, and emerging care model that achieves the Quadruple Aim in Oregon CHCs
APCM – What is IN and what is OUT of the payment model?
THE CALCULATION

**APM RATE =**

Applicable wraparound + Reconciliation revenue

Health center member months

- Applicable wrap and reconciliation revenue
  - (Total PPS payments – Managed Care payments) – PPS payments for OB, Dental, and MH
  - Carved out services defined by procedure or diagnosis codes
  - Member month calculation tracks active patients and their movement to other providers
TECHNICAL CONSIDERATIONS
LEGAL REQUIREMENTS OF AN ALTERNATIVE PAYMENT METHODOLOGY IN FEDERAL LAW

- Legal authority is Federal PPS law
- State Plan Amendment to CMS
- = or > PPS
- Reconcile to PPS
- Voluntary participation
TECHNICAL CONSIDERATIONS

BASIC FACTS ABOUT THE RATE

- Wrap payment converts to PMPM payment
- Ability to attribute based on primary care claim (active patients)
- MCO payment remains unchanged
- Wrap based on prior year payment
- Managed care bonus payments are outside of the model
- Budget-neutral design (state stipulation)

- Includes:
  - Physical health services for managed care, FFS, Medi-Medi, SBHC patients
- Currently carved out:
  - Mental health services
  - Dental services
  - Prenatal/deliveries
- Change-in-scope process
  - Conceptual agreement with State to align with PPS change in scope
Considerations for inclusions/exclusions

- Technical Issues and Definitions
- Attribution
- Scope and Scale

Included Services
Key Decision Points: **Inclusions and Exclusions**

- **Patients**
  - Dual Eligible
  - Open Card (FFS)
  - CAWEM Plus and CAWEM

- **Services/Scope**
  - Primary Care
  - OB
  - Mental Health
  - Oral Health

- **Sites**
  - Single site Organization
  - School Based Health Centers
  - Urgent Care
  - HIV Specialty Site
Carve Out Details: Mental Health
Similar process for Dental and OB/Prenatal

- Behavioral Health
  » Carved IN APCM
  » Behavioral health codes
  » Primary diagnosis is medical

- Specialty Mental Health
  » Carved OUT of APCM
  » Primary mental health diagnosis plus list of CPT/ICD 10 codes.
  » Paid outside of wrap cap through PPS reconciliation.
Modifications to rate process over time

- Carve outs more specific (codes, ICD 10)
- Clinic exceptions (HIV clinic; urgent care)
- Open card (FFS) transition
- ACA expansion potentially
- Align with changes to attribution policy, patient engagement, carve outs.
Revisit the Calculation – take out exclusions!

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