Oregon Primary Care Association's APCM Introduction/Overview

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Oregon Primary Care Association

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

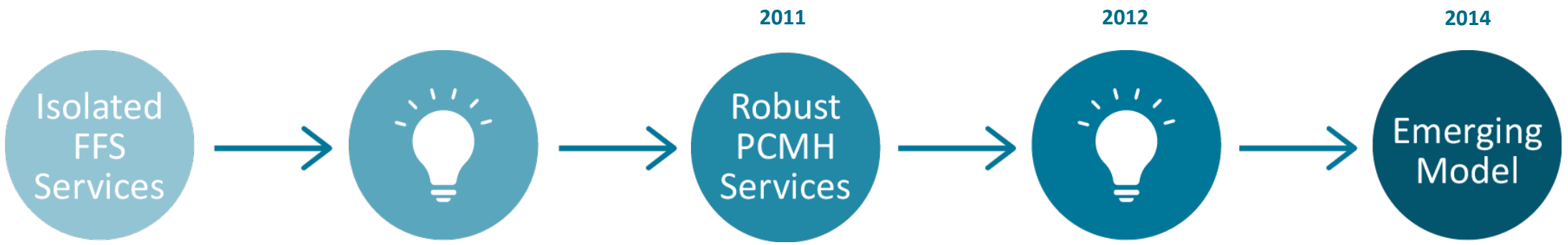
How we got here: APCM development

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

Southcentral Foundation

EVOLUTION OF APPROACH



Medical care focus

Connection is key!

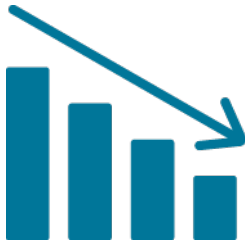
Patient-centered & team-based care

Psychosocial and environmental factors as important as health care

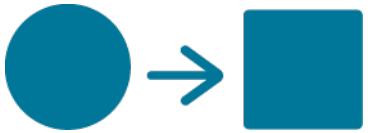
Holistic customer orientation

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 =

$$\frac{\text{Applicable wraparound} + \text{Reconciliation revenue}}{\text{Health center member months}}$$

- 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

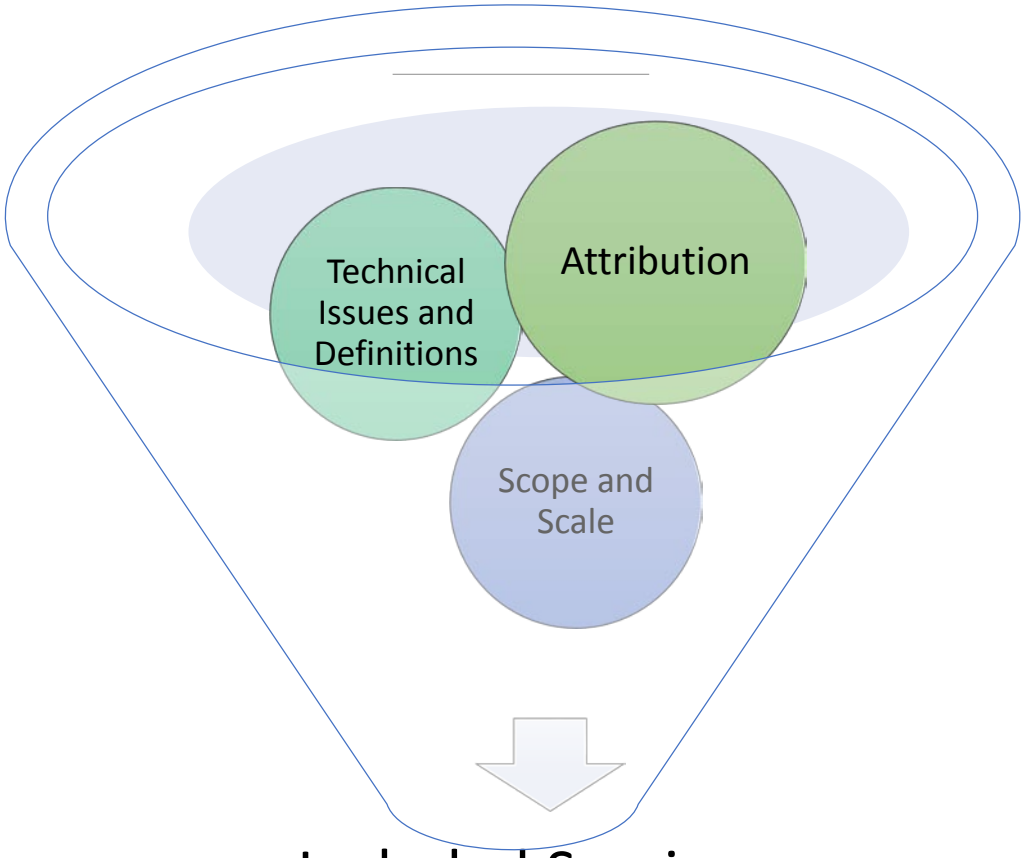
TECHNICAL CONSIDERATIONS

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



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 v **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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