# Authorization Page

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## TEMPORARY ADMINISTRATIVE RULES

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|---|---|
| Oregon Health Authority, Health Systems Division: Medical Assistance Programs | 410 |
| Agency and Division | Administrative Rules Chapter Number |
| Sandy Cafourek | HSD.Rules@dhsoha.state.or.us |
| Rules Coordinator | Email Address |
| 500 Summer St. NE, 3rd Floor, Salem, OR 97301 | 503-945-6430 |
| Address | Telephone |
| Upon filing. | |
| Adopted on | |
| 08/01/2017 thru 01/27/2018 | |
| Effective dates | |

## RULE CAPTION

Creates Rules to Address Payments and Participation Requirements for Fee-For-Service Comprehensive Primary Care Plus Demonstration

Not more than 15 words

## RULEMAKING ACTION

**ADOPT:** 410-149-0100,410-149-0110,410-149-0120,410-149-0130,410-149-0140,410-149-0150

**AMEND:**

**SUSPEND:**

**Stat. Auth. :** ORS 413.042

**Other Auth.:**

**Stats. Implemented:** ORS 413.042, 413.259, and 414.065

## RULE SUMMARY

The Division needs to create these rules as part of its partnership with the Center for Medicare and Medicaid Services (CMS) in the administration of the Comprehensive Primary Care Plus Demonstration. Creation of these rules are necessary to ensure agency expectations of participating demonstration providers are met in order to receive special payments for their participation.

## STATEMENT OF NEED AND JUSTIFICATION

The adoption of OARs 410-149-0100, 410-149-0110, 410-149-0120, 410-149-0130, 410-149-0140, 410-149-0150

In the Matter of

CMS Comprehensive Primary Care Plus website viewable at https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus; The Oregon Health Authority Comprehensive Primary Care Plus website viewable at http://www.oregon.gov/oha/HPA/CSI-TC/Pages/Comprehensive-Primary-Care-Plus.aspx

Documents Relied Upon, and where they are available

The Division needs to create these rules as part of its partnership with the Center for Medicare and Medicaid Services (CMS) in the administration of the Authority's Comprehensive Primary Care Plus Demonstration for fee-for-service (open card) Oregon Health Plan clients. Creation of these rules are necessary to ensure agency expectations of participating demonstration providers are met in order to receive special payments for their participation.

Need for the Temporary Rule(s)

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and recipients of Medicaid benefits. These rules need to be adopted promptly so that the Authority may comply with state law and federal regulations.

Justification of Temporary Rules

| Authorized Signer | Printed Name | Date |
|---|---|---|
| Rhonda Busch | Rhonda Busch | 7/28/17 |

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Secretary of State

# STATEMENT OF NEED AND JUSTIFICATION

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Oregon Health Authority (Authority), Health Systems Division, (Division) 410

Agency and Division Administrative Rules Chapter Number

Creates Rules to Address Payments and Participation Requirements for Fee-For-Service Comprehensive Primary Care Plus Demonstration

Rule Caption: (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The adoption of OARs 410-149-0100, 410-149-0110, 410-149-0120, 410-149-0130, 410-149-0140, 410-149-0150

Statutory Authority: ORS 413.042

Other Authority:

Stats. Implemented: ORS 413.042, 413.259, and 414.065

Need for the Temporary Rule(s): The Division needs to create these rules as part of its partnership with the Center for Medicare and Medicaid Services (CMS) in the administration of the Authority's Comprehensive Primary Care Plus Demonstration for fee-for-service (open card) Oregon Health Plan clients. Creation of these rules are necessary to ensure agency expectations of participating demonstration providers are met in order to receive special payments for their participation.

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Justification of Temporary Rule(s): The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and recipients of Medicaid benefits. These rules need to be adopted promptly so that the Authority may comply with state law and federal regulations.

Rhonda Busch Rhonda Busch 7/28/17

Authorized Signer Printed name Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

## NEW RULES

## Comprehensive Primary Care Plus Demonstration for FFS OHP Clients

**410-149-0100**

**Definitions**

(1) "Alternative Payment Methodology (APM)" means a payment mechanism that is at least a partial alternative to fee-for-service (FFS) payments for Track 2 practice sites. APMs shall allow Track 2 practice sites the flexibility to provide comprehensive care outside of the constraints of a billable office visit.

(2) "Attributed Members" means those Oregon Health Plan (OHP) clients assigned to the CPC+ practice under the Comprehensive Primary Care Plus (CPC+)demonstration who are not enrolled with a managed care plan or CCO for physical health services.

(3) "Care Management Fees" means per-member per-month (PMPM) incentive payments issued by the Oregon Health Authority (Authority) to CPC+ practice sites for attributed members.

(4) "Participating Providers" means the health care providers practicing within the practice site approved by CMS to participate in CPC+.

(5) "Patient-Centered Primary Care Home" means a primary care practice site that has applied and achieved recognition as a PCPCH at a particular tier level by the Authority.

(6) "Performance Based Incentive Payment (PBIP)" means a PMPM payment made to the CPC+ practices, based on annual performance on quality measures, patient experience of care, and utilization measures.

(7) "Practice" means the practice site that has been selected by CMS to participate in the CPC+ demonstration.

(8) "Track 1 Practice" means a CPC+ practice designation issued by CMS as one of two possible designations that stipulate the advanced care requirements and payment options available to the practice.

(9) "Track 2 Practice" means a CPC+ practice designation issued by CMS as one of two possible designations that stipulate the advanced care requirements and payment options available to the practice.

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 413.042, 413.259, and 414.065

**410-149-0110**

**Technical Requirements for Participation in the Authority CPC+ Demonstration**

(1) The Authority shall recognize CPC+ practice sites as a Patient-Centered Primary Care Home (PCPCH) under the 2017 PCPCH recognition standards.

(2) Individual CPC+ practice sites shall be enrolled with Oregon Medicaid with a site specific Oregon Medicaid ID number.

(3) The CPC+ practice site shall execute the Comprehensive Primary Care Plus Agreement with the Authority.

(4) The practice must have access to the Oregon Medicaid Management Information System (MMIS) Provider Web Portal to attribute members for care management and PBIPs.

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 413.042, 413.259, and 414.065

**410-149-0120**

**CPC+ Practice Reimbursement and Program Integrity**

(1) All funds received through the CPC+ demonstration shall be used to support the participating practice site.

(2) As a condition of payment, a participating CPC+ practice shall require and ensure that its participating providers and staff implement the care delivery requirements set forth in their Comprehensive Primary Care Agreement.

(3) Practices shall be entitled to care management fees for all attributed members that had a primary care visit in the prior 18 months from January 1, 2017, and any new attributed members with a primary care visit after January 1, 2017. Under the care management fees, no changes to FFS rates shall be made as additional compensation for services provided.

(4) No part of the care management fee, APM, or PBIPs may be used as an inducement for practices to promote or otherwise affect the provision of any health care item or service owned or distributed by the Authority.

(5) PBIP may be issued prospectively and reconciled to the practice's actual performance score once quality and utilization measurement data becomes available.

(6) Care management fees are provided for care management services and not healthcare service delivery and not subject to Oregon insurance laws and regulations on provider contracting and payment. Any healthcare services rendered by the provider shall be governed by the participating provider agreement between the provider and the Authority.

(7) The enrolled CPC+ practice must use aggregate payments received solely to support infrastructure and provide salary support in meeting the terms, conditions, and milestones of CPC+ as directed by CMS.

(8) If the practice fails to comply with the terms and conditions of the CPC+ demonstration, the Authority may seek reimbursement for any fees paid to the practice.

(9) The Authority shall give the practice prior notice that it has determined the practice was not making a good faith effort to comply with the terms and conditions of the CPC+ demonstration and allow the practice an opportunity to take corrective action, within 90 days of the notice send date, to avoid having to reimburse fees to the Authority.

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 413.042, 413.259, and 414.065

**410-149-0130**

**Care Management Fees**

(1) The Authority shall provide care management fees as a PMPM payment to practice sites for FFS OHP attributed members. These payments shall be used to:

(a) Provide up-front investment in participating practices; and

(b) Assist practices to continue practice transformation efforts and offer comprehensive integrated services for patients.

(2) Care management fees vary by practice track and PCPCH tier and are issued in the following amounts:

(a) Track 1:

(A) Tier 1 PCPCH qualifies for $2 PMPM;

(B) Tier 2 PCPCH qualifies for $4 PMPM;

(C) Tier 3 PCPCH qualifies for $6 PMPM;

(D) Tier 4 PCPCH qualifies for $8 PMPM;

(E) Tier 5-STAR PCPCH qualifies for $10 PMPM.

(b) Track 2:

(A) Tier 3 PCPCH qualifies for $9 PMPM;

(B) Tier 4 PCPCH qualifies for $12 PMPM;

(C) Tier 5-STAR PCPCH qualifies for $18 PMPM.

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 413.042, 413.259, and 414.065

**410-149-0140**

**Performance Based Incentive Payments (PBIP)**

(1) To assess quality performance and eligibility for the CPC+ PBIP, both Track 1 and Track 2 practices shall be required to report electronic clinical quality measures (eCQM) to CMS annually at the practice site level.

(2) Additional PMPM payments shall be available based on performance measures included in eCQM from CMS and utilization measures calculated by the Authority:

(a) Practices must report to CMS on nine of the 14 eCQMs for the measurement period in order to receive PBIP payments;

(b) PBIP payments may be issued prospectively prior to eCQM performance results and reconciled at a later date when eCQM performance is available.

(3) PBIP vary by practice track and are issued in the following amounts:

(a) Track 1:

(A) PMPM amount for achieving maximum eCQM targets is $1;

(B) PMPM amount for achieving maximum utilization targets is $1.

(b) Track 2:

(A) PMPM amount for achieving maximum eCQM targets is $2;

(B) PMPM amount for achieving maximum utilization targets is $2.

(4) Practices shall be eligible to achieve the maximum eCQM and utilization incentive amounts or partial amounts. Incentive percentage available shall be calculated by CMS based on each individual eCQM measure and by the Authority for two utilization measures.

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 413.042, 413.259, and 414.065

**410-149-0150**

**CPC+ Alternative Payment Methodology**

(1) The APM for Track 2 practices is a lump sum payment based on the percentage of FFS payments issued by the Authority to the practice in the prior calendar year. FFS payments shall be reconciled or adjusted down by the same percentage of the APM payment (e.g., 20 percent lump sum payment in January 2018 causes FFS payments issued throughout 2018 to be reduced by 20 percent):

(a) This structure is intended to allow Track 2 practices flexibility to deliver comprehensive care outside of the constraints of billable office visits;

(b) Track 1 practices are not eligible for the APM;

(c) Track 2 practices shall receive lump sum APM payments based on expected revenue for FFS Medicaid beneficiaries beginning in 2018, after Track 2 practice confirms FFS claims from prior year.

(2) Track 2 practices shall receive an additional 1 percent investment payment for each 10 percent payment the practice receives up front with up to 5 percent overall increased investment for practices receiving 50 percent of FFS Medicaid payments as a lump sum.

(3) Track 2 lump sum APM payments shall increase by 10 percentage points per year over the five years of the demonstration to a maximum of 50 percent up front.

(4) Beginning in Year 2, CY2018, eligible practices shall receive 20 percent of expected FFS payments from the Authority for FFS Medicaid beneficiaries, based on claims paid in CY2017.

(5) Practices participating in Track 2 shall continue to bill Oregon Medicaid FFS or CCOs through existing Authority protocols.

(6) The Authority may reconcile Medicaid APM dollars if quality and utilization performance targets are not met in the fourth and fifth years of the CPC+ demonstration.

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 413.042, 413.259, and 414.065