

Fee-for-Service Provider Webinar

Frequently Asked Questions

As the Oregon Health Plan moves away from a fee-for-service model of care towards coordinated care, we want to make sure providers around the state are up-to-date and know what to expect as this transition occurs.

Below are some of the frequently asked questions from the October 2012 [Fee-for-Service \(FFS\) Provider Webinar](#).

Please visit www.health.oregon.gov for additional basic information about the transition to Coordinated Care Organizations (CCOs) and the health transformation effort.

Transitioning to coordinated care

Q: I see Oregon Health Plan clients who have fee-for-service, or open card, coverage. Can I continue seeing my patients?

A: By November 1, 2012, most OHP clients will move to a Coordinated Care Organization (CCO) for physical, chemical dependency and mental health care services. FFS providers who wish to continue seeing their patients should contact the CCO in their area and inquire about contracting with them. FFS providers can also help coordinate a transfer of care to another qualified provider in the CCO's network.

To find contact information for the CCO in your area, visit www.health.oregon.gov and click on "Info for providers."

Q: Once a FFS client moves into a CCO, are they assigned a new provider?

A: When a client enrolls in a CCO, the CCO will help them find a provider(s) to meet their needs.

Q: How is a CCO held accountable for improving care and lowering the cost of care?

A: Metrics and quality measures are used by the Oregon Health Authority to determine whether CCOs are effectively and adequately improving care, making quality care accessible, eliminating health disparities and controlling costs for the population they serve.

The [Metrics and Scoring Committee](#) is responsible for identifying outcome and quality measures, including measures of outcome and quality for ambulatory care, chemical dependency and mental health treatment, oral health care and all other health services provided by CCOs.

Triple Aim objectives of Health System Transformation (Better Health, Better Care, and Lower Costs) are the objectives we will measure success by and the various metrics being developed are designed to accomplish those objectives.

Q: How is coordinated care different from managed care? What services do CCOs provide?

A: A member's OHP benefit level will not change. However, CCOs have the flexibility within their budget to provide services alongside today's OHP benefits to support new models of care that are patient-centered, team-focused, reduce health disparities and focus on prevention.

Before CCOs, the health care system separated physical, behavioral and other types of care – that made things more difficult for patients and more expensive for the state. Under CCOs, providers will be better able to work together communicating and coordinating a member's care, working to improve the quality and effectiveness of overall care and lower costs.

Please [contact your local CCO](#) for more information about their efforts to achieve the Triple Aim of better health and better care at lower costs.

General billing and out-of-area services

Q: How will the payment structure change with the transition to CCOs? Is the FFS payment going away completely?

A: The payment structure will remain the same. If an OHP member is enrolled in a CCO, and the service provided is within the scope of the CCO, the CCO is responsible for delivery and payment. If a member is not enrolled in a CCO, or the service is not within the scope, OHA is responsible. Under both options, requirements outlined in rule must be met for the reimbursement to be appropriate.

Fee-for-service payments will not be going away completely. OHA expects a small subgroup of individuals to remain FFS. That number will be much smaller than exists today. In addition, some services are being transitioned to CCOs over time. Services that remain outside the scope of a CCO will be paid directly by OHA.

Q: Will providers be paid at different rates?

A: Providers will be reimbursed based on their agreements with the entity responsible for payment. They may need agreements with more than one entity to provide services to all whom they currently provide services.

Q: Can OHP clients see providers in other areas than their CCO, i.e. for specialty care?

A: The individual should contact their CCO to arrange for care. There may be individual cases where the CCO will arrange for, and authorize payment for, care from providers who are outside the CCO's service area. For example, if the service that is clinically appropriate for the member is not available within the service area.

Q: As a provider, how are we paid for the services we provide to a client that comes to us from an out-of-area CCO?

A: Providers should [contact the responsible CCO](#) to arrange payment terms.

Q: Will providers in bordering states or contiguous counties still be able to see FFS patients?

A: Yes, although as described above the number of FFS individuals is expected to decrease.

Prior Authorizations

Q: How will the prior authorization (PA) process change under CCOs?

A: Providers should contact the CCO to learn about their PA process.

Q: Will existing PAs be valid when OHP clients transition to a CCO? Will the CCO be provided the authorization from DMAP?

A: A letter was sent to CCOs outlining [expectations regarding continuity of care](#). Providers should contact the CCO to learn about their process and to ensure expectations are being met.

Other questions

Q: Will Tribal Clinics be able to contract with CCOs?

A: Some tribal clinics are contracted with the CCO in their service area. Others have arranged to include tribal clinics as primary care homes for tribal members enrolled in the CCO and to accept their referrals to specialty care. Other tribal clinics are, or will be, in discussions with local CCOs about participation in their networks. OHA is helping to facilitate these discussions. Regardless of contract status, tribal members may access care at tribal and IHS clinics and are reimbursed for those services.

Q: I am a naturopathic provider serving FFS clients. How will continuity of care issues be addressed during the transition to CCOs?

A: OHA will be looking at individual cases of clients who have seen a naturopathic provider to determine when and how to transition those clients into a CCO.

Q: Is a CCO required to contract with providers who have seen open-card clients?

A: It is up to each CCO to have an adequate network of providers, but CCOs are not required to contract with any particular provider, even if it is the preferred provider of the CCO member. Providers who want more information on a CCO's network should contact the CCO directly.

Provider contact information for each CCO is available by visiting www.health.oregon.gov and clicking on "Info for providers."