An illustrated guide to (some) current Oregon APMs

OREGON HEALTH & SCIENCE UNIVERSITY

Oregon health care organizations are actively exploring alternative payment arrangements – many (though not all) as part of coordinated-care organization innovation. The diagram at the right shows where some of these current experiments fit within the traditional network of fee-for-service contracting.

Predominantly FFS payment

Current APM example

A SAMPLER OF PAYMENT INNOVATIONS IN OREGON

A **Oregon CCO Transformation** State (Oregon Health Authority) uses global budget with set annual growth rate to purchase medical, dental, and behavioral health services from coordinated care organizations.

B **Fixed-rate Medicaid hospital contracts** St. Charles Health System and PacificSource Community Solutions CCO have negotiated fixed-rate payments for hospital services provided to the CCO's Medicaid patients.

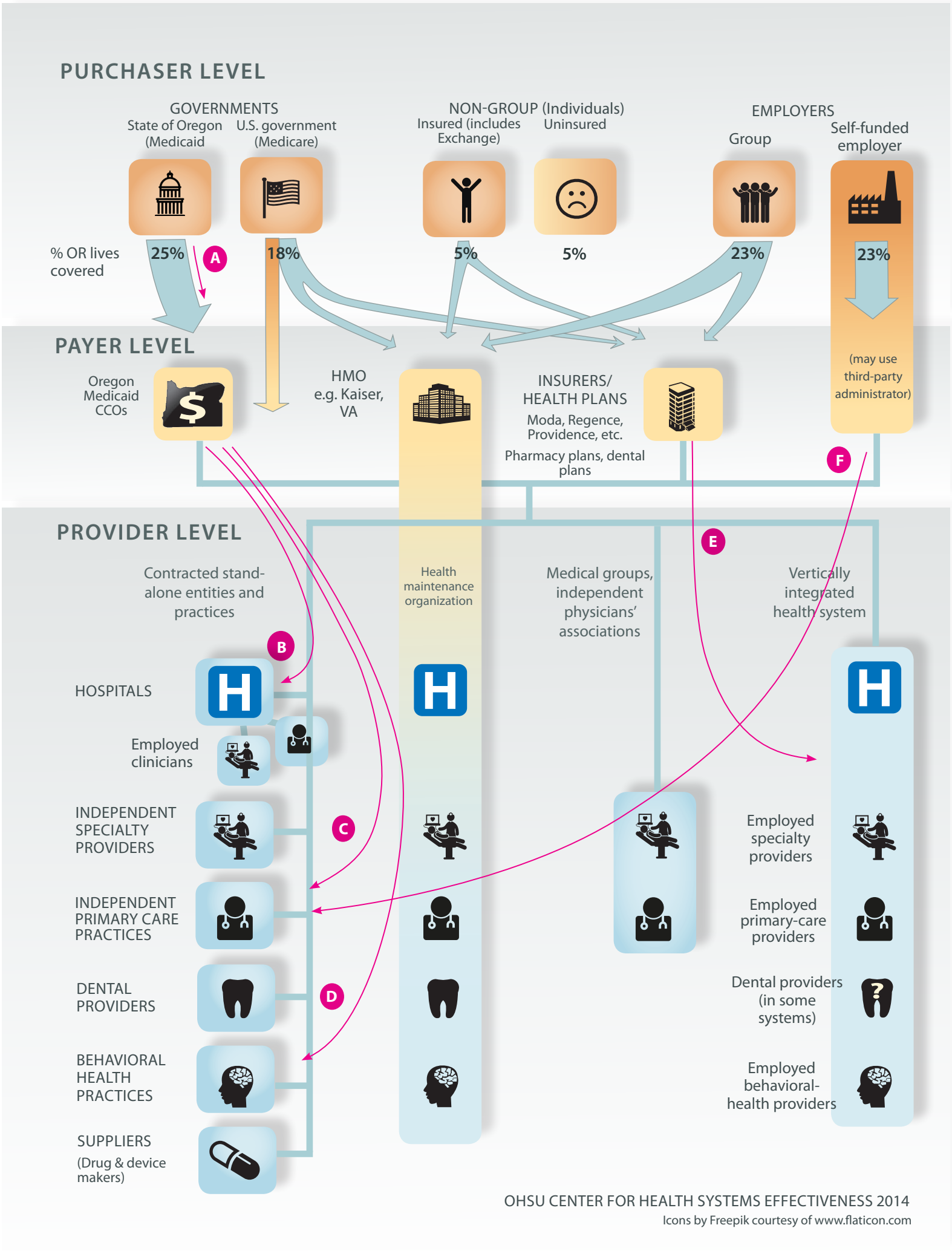
C **Oregon Primary Care Association demonstration pilot** Eight Federally Qualified Health Clinics are paid on a capitated basis for medical-home oriented primary care services as part of a pilot approved by the U.S. Center for Medicare and Medicaid Services. Per-member per-month payments are negotiated with each clinic based on previous claims experience and features of the populations served.

Oregon's CCOs also experiment with primary-care capitation within the CCO contract network.

D **Capitated contracts for behavioral-health care** Numerous CCOs hold capitation-based contracts with behavioral-health providers covering Medicaid patients.

E **Providence payment bundles** Providence Health & Services offers bundled-payment options to insurers for orthopedic surgeries, cardiac artery bypass grafts, and maternity care.

F **Intel on-site primary care clinics** In Hillsboro, Intel contracts directly for primary care with Take Care Health Systems, part of Walgreens Health and Wellness Division, which provides on-site clinics for employees and their dependents. Previously, Intel sidestepped traditional insurer-based contracting for employees at its Rio Rancho, New Mexico facility to purchase integrated care directly from Presbyterian Healthcare Services through a shared-risk agreement.


PURCHASER LEVEL
GOVERNMENTS
State of Oregon (Medicaid
U.S. government (Medicare)
NON-GROUP (Individuals)
Insured (includes Exchange)
Uninsured
EMPLOYERS
Group
Self-funded employer
% OR lives covered
25%
A
18%
5%
5%
23%
23%
(may use third-party administrator)
PAYER LEVEL
Oregon Medicaid CCOs
HMO e.g. Kaiser, VA
INSURERS/ HEALTH PLANS
Moda, Regence, Providence, etc.
Pharmacy plans, dental plans
F
PROVIDER LEVEL
E
Contracted stand-alone entities and practices
Health maintenance organization
Medical groups, independent physicians' associations
Vertically integrated health system
B
HOSPITALS
Employed clinicians
INDEPENDENT SPECIALTY PROVIDERS
C
INDEPENDENT PRIMARY CARE PRACTICES
DENTAL PROVIDERS
D
BEHAVIORAL HEALTH PRACTICES
SUPPLIERS
(Drug & device makers)
Employed specialty providers
Employed primary-care providers
Dental providers (in some systems)
Employed behavioral-health providers
OHSU CENTER FOR HEALTH SYSTEMS EFFECTIVENESS 2014
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Alternative payment models, in brief

Fee for Service (FFS)	**How it works** Providers bill payers for services performed based on procedure or diagnoses codes **Used for:** Everything **Who's at risk?** Payers (who pass rates on to purchasers)
Global budget	**How it works** Purchasers contract with payers or providers for care of a given patient population over a given period of time. Quality targets may be included. Rates are usually negotiated based on the population's historical utilization of services and an analysis of risk factors. Since "global budget" usually refers to the high-level contract between purchasers and payers (such as the Oregon Health Authority's contracts with the 16 Medicaid CCOs), other payment forms can exist between payers and providers underneath the global-budget umbrella. For example, many providers within CCOs are still paid on a fee-for-service or shared-savings basis. **Used for:** Usually, comprehensive care of a population **Who's at risk?** Payers, contracted providers
Capitation, sub-capitation	**How it works** Payers contract with providers for care of a given patient group for a category of services over a given time period. Payment is negotiated at a "per-member per-month" rate. Quality targets may be included. **Used for:** Comprehensive care, primary care, traditionally carved-out care such as mental health or substance-abuse treatment **Who's at risk?** Providers
Shared Savings	**How it works** Overlays fee-for-service billing. If providers meet a contracted spending target for caring for a group of patients, they get a portion of the savings. Quality metrics are usually included. **Used for:** Comprehensive care, primary care, various combinations of integrated services **Who's at risk?** Payers retain FFS-based risk, with limited risk for providers
Pay-for-Performance	**How it works** Overlays fee-for-service billing. Providers who achieve contracted quality targets receive incentive payments based on underlying FFS claims paid **Used for:** Comprehensive care, primary care, various combinations of integrated services **Who's at risk?** Payers retain FFS-based risk, with limited risk for providers
Bundled or Episodic Payment	**How it works** Providers receive a set payment for performing all care surrounding a particular procedure (e.g. knee replacement) or for treating a patient with a particular diagnosis or condition (e.g. normal maternity care) **Used for:** Generally, specialty services, services with well-defined procedures, and services with definable beginning- and end-points. **Who's at risk?** Providers