Conference Call Number: 1-888-808-6929
Public Participant Code: 915042#

Oregon Health Policy Board
AGENDA
June 7, 2016
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:30 p.m.

#	Time	Item	Presenter	Action Item
1	8:30	Welcome	Zeke Smith, Chair	X
2	8:45	Director's Report	Lynne Saxton, Director OHA	
3	9:15	Workforce Committee Update	Carla McKelvey, Vice-Chair	
4	9:30	Comprehensive Primary Care Plus (CPC+) update	Leslie Clement, OHA	
5	10:00	Value Based Payments discussion	Marge Houy, Bailit Health Purchasing	
6	10:45	Break		
7	11:00	Value Based Payments Panel & discussion	Bill Guest, CEO Willamette Valley Health Authority (WVHA) CCO & Dean Andretta, CFO WVHA CCO Will Brake, Director of Provider Network Transformation AllCare CCO Christi Siedlecki, CEO Grants Pass Clinic	
8	12:20	Public testimony	Chair	
9	12:30	Adjourn	Chair	

Next meeting:
July 15, 2016
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

Everyone is welcome to the Oregon Health Policy Board meetings. For questions about accessibility or to request an accommodation, please call 541-999-6983 or write HealthPolicyBoard.Info@dhsoha.state.or.us. Requests should be made at least 48 hours prior to the event. Documents can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request a document in another format or language please call 541-999-6983 or write to HealthPolicyBoard.Info@dhsoha.state.or.us

DRAFT

Oregon Health Policy Board
DRAFT May 3, 2016
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

Item
Welcome and Call To Order, Chair Zeke Smith **Present**: Chair Zeke Smith called the Oregon Health Policy Board (OHPB) meeting to order. Board members present: Zeke Smith, Carla McKelvey, Karen Joplin, Joe Robertson, Carlos Crespo and Felisa Hagins The Board approved the April '16 minutes unanimously.
Director's Report, Lynne Saxton, OHA Lynne Saxton briefed the Behavioral Health Town Hall process and report including community feedback regarding resources, services and priorities. She then briefed other related behavioral health initiatives and issues OHA is working on including the Behavioral Health statewide mapping tool, DOJ agreement status, collaboratives, various studies, Medicaid supported housing, certified behavioral health homes and other behavioral health related policy & program area updates. The Board discussed the report, the nature of the DOJ agreement and the timing of implementation. Director Saxton gave a brief tribal update, CCO report update, member services update, budget update, restructure update and Comprehensive Primary Care Plus initiative opportunity update; the Board discussed further details of the initiative including the timeline, needs and benefits. Lillian Shirley briefed the Cleaner Air Oregon initiative and gave an update regarding point source monitoring. The initiative is aimed at supporting enhanced coordination, finding gaps and ensuring safe and clean air starting with point source emissions. She briefed areas of collaboration between the Department of Environmental Quality (DEQ) and OHA and related processes and timelines. The Board discussed OHA & DEQ's roles and responsibilities, gaps, alignment with public health modernization, community feedback and enforcement regulation/regulatory authority. Lillian relayed that Oregon's emission levels are below criteria set by CDC. Lillian will provide materials for a future lead water update
Workforce Committee Update The Board approved Workforce Committee member Maria Lynne Kesler; Carlos asked that disabled membership be added to the perspective of the committee. Dr. McKelvey briefed initial survey results regarding integrated behavioral health care and demographics.

Oregon 1115 Waiver Briefing

Lori Coyner gave a presentation regarding Oregon's 1115 Waiver, see meeting materials for presentation. The Board discussed opportunities for housing supports, medical loss ratio & corridors, payment model bifurcations, dual coordination, public input opportunities and the current work of the Transformation Center. The waiver can be reviewed at https://www.oregon.gov/oha/healthplan/pages/waiver.aspx, comments should be emailed to Janna Star at Janna.STARR@dhsoha.state.or.us

Oregon 1115 Waiver Testimony

Vanessa Timmons testified on behalf of her domestic violence coalition and noted access, population health and social determinants of health needs related to domestic violence. She advocated for further coordination between CCOs, support services and victims of domestic violence.

Lorren Sandt testified on behalf of hepatitis C patients regarding CCO treatment.

John Mullin with the Oregon Law Center testified in support of some waiver elements like the transformation center and duals policy. He noted issues with the prioritized list and urged further coordination with Oregon Housing and Community Services, Department of Human Services and Department of Consumer Based Services.

Mark Loveless testified as an infectious disease physician in regards to hepatitis C and urged further collaboration and continuum of care treatment given the opportunity.

Robert Shinney testified as a Hepatitis C patient and support group manager; he noted parallels between Hepatitis C and behavioral health challenges. He explained he is unable to receive treatment and experiences long wait times.

Steve Nemirow testified as a Hepatitis C patient and lawyer and spoke of human harm being done to Oregonians under a 2010 waiver because of the infection rate of Hepatitis C in Oregon.

BJ Cavanor testified as Exec. Director of One in Four Chronic Health regarding Hepatitis C. He reported estimates of 1900 people infected with both HIV and Hepatitis C and advocated for renewed support to treat patients with Hepatitis C.

OHPB Priorities Discussion

The Board discussed their priorities and the role they can play to engage and move those priorities forward. Felisa expressed a preference for a process that engages committees beforehand and Karen noted the coming priority briefings will inform the conversation. Dr. Robertson spoke about the coming legislative session and framing conversations and context for health policy issues likely to be legislated, like the future of CCOs. The Board's priorities are ongoing but the future of CCO conversation is timely. Zeke posited questions about what the Board can impact and influence in the next 6 months related to CCOs and the Board's priorities and noted the difference in roles developing policy between OHA and the OHPB. Felisa noted a role for the Board taking positions on coming legislation before September. Carlos spoke about SB 440 metrics which will inform gaps and priorities. Joe noted the Board could agree on principles and the "spirit" of transformation, e.g. common data set. The Board affirmed its role regarding defining what a CCO is as well as its legislative role. Zeke recalled the

Board's responsibility to represent and listen to consumers and solicited future feedback from Board members regarding input and engagement in the legislative process and long term priority planning.
Public Testimony Lorren Sandt testified regarding heating oil contamination and DEQ abatement in regards to DEQ regulatory authority and underground soil contamination. Tobi Rates testified as a mother of two autistic children and the Executive Director of the Autism Society of Oregon regarding Medicaid early and periodic screening, diagnostic and treatment for autism and waiver regulations regarding autism treatment.
OHPB video and audio recording To view the video, or listen to the audio link, of the OHPB meeting in its entirety click here.
Adjourn

Next meeting:
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OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:30 p.m.

OREGON STATE PUBLIC HEALTH DIVISION
Office of the State Public Health Director
Governor Kate Brown

800 NE Oregon Street, Suite 930
Portland, OR 97232
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Report to the Oregon Health Policy Board
Cleaner Air Oregon
Executive Summary

Air Toxics News since Last Meeting

- Ten day cease and desist order handed down by Governor Brown to Bullseye Glass
  - Based upon lead emission released May 9 and 10
  - Data recorded by air monitor located at nearby day care facility
  - Multnomah County offered free lead screening to day care attendees and employees
    - No increase in blood lead levels detected
- Second cease and desist order expected the week of May 30
- US Forestry Service plans to release additional moss metals data the week of May 30
  - Will include an additional 20 metals
- DEQ in the process of creating interactive tool that will allow for a visual of all metals facilities
  - Demonstration provided June 2 at DEQ NW Regional Office

Integrated Work Plan (OHA and DEQ)

- Permanent rulemaking for industrial toxic emissions using human health risk based information – co-agency team working now through December 2017
- Technical Work Group conducted June to July 2016
- Rules Advisory Committee (RAC) conducted November to December 2016
- Opportunities for public engagement throughout
  - Air toxics regulation webinars
  - Presentation on human health risk-based rules from Washington State and California
  - Public policy forums
- Fiscal Advisory Committee conducted February to April 2017
  - Will assess fiscal impacts of health risk-based rules
- Official public notice and comment period – May to July 2017

DEQ and OHA-hosted webinar – May 26

- Live-streamed on OHA's YouTube channel
- Presentations from DEQ, OHA, and EPA air emissions and toxicology experts
- Live Q & A
- Approx. 130 virtual attendees
- Second webinar scheduled for June 28 will feature speakers from Washington State and California. Speakers will be discussing their state's health risk-based standards
- Live Q & A will follow

Environmental Health Risk Assessment and Community Engagement

- Community meetings and public health assessments conducted at Bullseye and Uroboros glass communities
- OHA and DEQ will continue to participate in face-to-face community meetings, as requested.
- September 1 – produce and release complete public comment version of Public Health Assessments for SE and North Portland
- March 2017 – produce and release complete Public Health Assessment report for each of the hotspots with public input

Interagency web site: http://cleanerair.oregon.gov/

Division of Health Policy and Analytics

Kate Brown, Governor

Oregon Health Authority

500 Summer Street
Salem, OR 97306

MEMO

To: Oregon Health Policy Board
From: Oregon Health Authority
Date: June 6th, 2016

Subject: Update and Next Steps on HB 3396

This memo is intended to provide stakeholders in Oregon's health care workforce provider incentive programs an initial, written update on Oregon's progress in addressing House Bill (HB) 3396 -- including ongoing stakeholder engagement activities and upcoming opportunities to provide input. These activities, in sum, are to address the legislature's charge to the Oregon Health Policy Board (OHPB) to provide recommendations on the future of health care provider incentives in Oregon by *September 1, 2016*.

Members of the 3396 Steering Group would like to share with interested parties key next steps as we understand them at this point, including where we hope to engage your thinking in a focused way around this work.

Background

HB 3396 articulates and responds to the Legislature's intention to "initiate a close look at how tax dollars are spent [on provider incentives] to ensure that taxpayers enjoy the best possible value…" The bill extends the sunset on the existing rural health care provider tax credits for two years and makes minor adjustments to the law concerning who may receive the credits. Additionally, the bill establishes the Health Care Provider Incentives Fund, to fund an OHA-directed health care provider incentives program.

The bill also directs the Health Policy Board to study and evaluate the effectiveness of the financial incentives offered by the state to recruit and retain providers in "rural and medically underserved areas" and make recommendations to the Legislature regarding:

- Continuation, restructuring, consolidation or repeal of existing incentives;
- Priority for directing the incentives offered by Health Care Provider Incentive Fund; and
- The establishment of new financial incentive programs.

In July 2015, the Oregon Health Policy Board adopted a charter directing the Health Care Workforce Committee (HCWF) to deliver to the Board a study and report on the efficacy of Oregon's provider incentives and recommendations on improvements to the current incentive, principally HB 3396. Oregon's Health Care Workforce Committee serves as the primary forum for stakeholder engagement for HB 3396. In relation to HB 3396, the committee's roles are to:

- Support selection of vendor
- Provide key input in determining criteria for evaluating the effectiveness of incentive programs
- Assist vendor with stakeholder engagement
- Review progress over time and provide direction to vendor and OHA staff
- Review incentive provider study from vendor and companion report to Health Policy Board

3396 Provider Incentive Study: Lewin, LLC

In January 2016, through a competitive procurement process OHA contracted with the Lewin Group, LLC to perform a series of tasks designed to ensure OHA and Health Policy Board are able to fulfill the requirements specified in HB 3396. Summarized below are the tasks OHA contracted Lewin to complete by *August 1st, 2016*.

- Task 1—analysis of Oregon health care market, provider data and Oregon's existing provider incentive programs; tentatively due, April 30th.
- Task 2— evaluation of program effectiveness and efficacy of Oregon's existing provider incentive programs; due, May 31st.
- Task 3— Development of policy and program recommendations; due, June 30th.
- Task 4— stakeholder engagement, February-July.
- Tasks — 5-6: development of reports and presentations to key stakeholders; due, July 31st.

Stakeholder Engagement

HB 3396 requires the Oregon Health Policy Board, in developing recommendations, to consult with a number of organizations including Graduate Medical Education Consortium, the Oregon Healthcare Workforce Institute, the Oregon Office of Rural Health, and the Oregon Center for Nursing among other appropriate entities. Summarized below is a comprehensive, multi-pronged strategy developed with input and guidance from the Health Care Workforce Committee (HCWF) and key stakeholders that serve on an external advisory group (i.e. 3396 Steering Group).

- 3396 Steering Group: meets monthly, Jan-July; intended to inform and guide the activity of Lewin in fulfillment of the RFP including providing feedback and responses to Lewin's analyses and deliverables; reports back to HCWF Committee bi-monthly.
- Health Care Workforce Committee: meets bi-monthly, provide oversight for the completion of the work required for the Health Policy Board to fulfill its legislative obligations under HB 3396.
- Oregon Health Policy Board: adopt and provide to the Oregon Legislature a set of recommendations with respect to health care workforce incentive programs.
- Regional Listening Sessions: members of the Steering Group, Health Care Workforce Committee and OHA staff will convene 4-5 regional meetings across Oregon to solicit feedback on the use of provider incentive programs; tentatively scheduled for June.

Progress to Date: February thru May 2016

Lewin Deliverables

- February: Lewin submitted a comprehensive work plan and analytic plan.
- March-April: Lewin engaged the 3396 Steering Group and HCWF Committee; completed complete Task 1 as of May 15th.

Stakeholder Engagement

- 3396 Steering Group: OHA has convened an external group to help inform Lewin in its work. The committee meets monthly and includes members of the Health Care Workforce Committee, Oregon Health Workforce Institute, Oregon Center for Nursing, Oregon Office of Rural Health and Oregon Association of Hospitals and Health Systems.

Next Steps: June through September 2016

Lewin Deliverables

- Task 2 – Findings from Program Effectiveness and Efficiency: written report and supporting documentation on assessment of Oregon's provider incentive programs; due May 31st.
- Task 3 – Policy and Program Recommendations; due June 30th
- Task 4 – Stakeholder Engagement (see next section)
- Task 5 – Final report to Health Care Workforce Committee and Health Policy Board; July 31st.

Stakeholder Engagement

- Monthly meetings of the 3396 Steering Group (January through July)
- Report and discussion by the Health Care Workforce Committee on Lewin's data analysis, recommendations and final report (July 6th) in which public comment will be accepted.
- Formal stakeholder engagement by OHA and Health Care Workforce Committee through in-person meetings in multiple regions of the state, aided through technology around the evaluation of programs and the preliminary recommendations (March, May -- July).
- Oregon Health Policy Board—present Lewin's analysis and report along with recommendations from the Health Care Workforce Committee, July 15th and September 6th.

As noted above, the Health Care Workforce Committee will be conducting several in-person meetings in different parts of the state during the month of June (see next page for additional information). The goal of these meetings is to hear directly from health care clinicians, employers, local officials, and others impacted by the availability of health care provider, provide feedback on Lewin's recommendations, and hear from communities that have a stake in Oregon's provider incentive programs.

Feel free to contact us with your questions.

Marc Overbeck (Marc.Overbeck@state.or.us) and Oliver Droppers (Oliver.Droppers@state.or.us)

YOU ARE INVITED!

Listening Sessions on Health Care Workforce Provider Incentive Programs in Oregon

Oregon's Health Care Workforce Committee is discussing provider incentive programs in our state used to recruit and retain health care providers in areas that lack providers, and wants to hear from you.

In June, a series of meetings will be held around the state to hear directly from health care clinicians, employers, local officials, and others impacted by the availability of health care providers. Attendees will be invited to share their views and respond to key questions. The information shared by participants will be presented to the Health Care Workforce Committee and the Oregon Health Policy Board in July and August. The Health Policy Board will provide recommendations to the Oregon Legislature on the future of Oregon's incentive programs.

Below are the meeting locations for the listening sessions including locations, dates, and times. To reserve your space, please email pco.oregon@state.or.us and indicate the city you wish to attend.

If you cannot attend a meeting in person but would like to participate via webinar, you can do so by clicking on the links below.

- **St. Charles – Prineville** ***Monday June 20, 6-8pm***
  https://attendee.gotowebinar.com/register/107025737195714308
- **St. Anthony Hospital – Pendleton** ***Tuesday June 21, 6-8pm***
  https://attendee.gotowebinar.com/register/683992264848723971
- **Mercy Medical Center- Roseburg** ***Monday June 27, 6-8pm***
  https://attendee.gotowebinar.com/register/4919081257111744771
- **Good Samaritan Hospital – Lebanon** ***Tuesday June 28, 6-8pm***
  https://attendee.gotowebinar.com/register/5323322204621688323
- **Columbia Memorial Hospital – Astoria** ***Wednesday June 29, 6-8pm***
  https://attendee.gotowebinar.com/register/8335413418193208323

Topics that will be explored at each session include:

- *How do Oregon's current provider incentive programs impact your community with respect to recruiting health care professionals to your region?*
- *What types of provider incentive programs help address workforce shortages in your community?*
- *How is the ability to recruit and retain providers by specialty (primary care, behavioral, and oral health providers) affected by different incentive programs in your community?*
- *What types of other incentives could Oregon develop to recruit providers to your community or to retain providers who are already working your community?*

Questions? Contact Marc Overbeck at marc.overbeck@state.or.us

Oregon Healthcare Workforce Committee

Oregon Health Authority

Value Based Payments

Review and Possible Oregon Health Policy Board Next Steps

Marge Houy

June 7, 2016

bailit health

Presentation Agenda

1. Summary of Conversation Following VBP Webinar
2. Review of and Reflections on Current CCO VBP Activities
3. Options for OHPB to Support VBP Adoption
4. Discussion

Summary of Post-Webinar Discussion

- During the May 17th webinar introducing the concepts of value-based payment, we discussed:
  - Six different VBP models
  - How VBP models are impacting care delivery
  - What national and state VBP programs are underway
- Questions were raised about:
  - Whether there can be a one size fits all approach to VBP
  - Whether providers are ready for VBP
- Concerns led to wanting:
  - A better understanding of Oregon CCO VBP performance
  - How the Board can further facilitate the use of VBP

CCO's Current VBP Activities

- *All* CCOs are using performance incentives (e.g., "P4P")
  - Tied to meeting quality, utilization and/or access metrics
- 11 CCOs use partial capitation
  - 32% have PCP cap; 56% have dental care cap; 50% have BH cap; 50% have PT or transportation cap; 30% for medical specialty
- 3 CCOs use case rates (not always classified as an VBP)
  - Cover mental health and specialty services
- 2 CCOs make PMPM supplemental payments for non-visit functions
  - Usually care management services
  - Also for open access, embedded BH clinicians

CCO's Current VBP Activities (Cont'd)

- 2 CCOs have shared savings contracts
  - Most are with specific provider types, such as medical specialty care, behavioral health, dental care, acute hospital services, and not for total cost of care across most or all services
  - Only one focuses on a broader network of providers, including hospital, PCPs and behavioral health providers
- 2 CCOs have shared risk contracts
  - Shared risk phased in over time
- 1 CCO has a bundled payment for maternity care

Reflections on Current CCO Activity

- Extensive use of performance incentives, such as P4P, is consistent with moving from FFS to value-based payments
  - First step – incentives are generally small and no fear-of-loss motivator
  - Research suggests that level of payments must approach 10% of total revenue to be effective in driving behavior change
- 11 CCOs (73%) use partial capitation, which is higher than other states
  - Majority of arrangements (e.g., dental, BH, transportation) reflect legacy arrangements
  - Specialty partial capitation is unusual
  - PCP capitation is most effectively structured to provide PCPs with adequate funding to provide key services and flexibility not possible under fee-for-service payment (e.g., phone visit) - NOT to save money

Reflections on Current CCO Activity (Cont'd)

- Only 2 CCOs make supplemental payment for non-visit functions, which is lower that expected, unless PCP capitation includes this investment.
  - As CCOs move to Total Cost of Care arrangement, we would expect this percent to increase
- Only 2 CCOs have shared risk or shared savings contracts.
  - The percentage of shared shavings contracts, in particular, is lower than other states, which are promoting total cost of care contracting.
- Limited use of bundled payments is not unusual.

Options for OHPB to Support VBP Adoption

1. Set progressively higher annual targets for VBP adoption.
   - Include targets for “payment-under-the-payment.”
   - Require movement away from FFS, but only to the extent possible because of small numbers concerns.
2. Facilitate alignment with other payers (minimally PEBB and OEBB) regarding:
   - Payment model and target adoption rates
   - Payment methodology (e.g., attribution, risk-adjustment, treatment of outliers)
   - Measures

Options for OHPB to Support VBP Adoption (Cont'd)

3. Encourage VBPs for long-term services and supports.
4. Encourage true integration of physical health, behavioral health and dental services.
5. Provide policy direction to OHA regarding standards protecting against adoption of too much risk, and linking payment to financial performance associated with small population numbers.
6. Allow space for experimentation, especially for specialty services and high risk/high need populations.

Options for OHPB to Support VBP Adoption (Cont'd)

7. Encourage VBPs for "health-related services" and shared accountability with those providers
   - Use process similar to OHA's 2015 process to develop a Child & Family Well-being measure set to develop joint accountability measures for children and adults
   - Engage in discussion with sister state agencies about aligning payment models to encourage tighter coordination on addressing social determinants of health

Discussion

- Which of these strategies do you think would be most impactful to move VBP adoption forward in a responsible manner? Have you other ideas?
- What are some next steps the OHPB can consider regarding VBPs?

Summary Table of Alternative Payment Models Used by Oregon CCOs as of March 2015

	PMPM for non-visit functions	Performance Incentives	Shared Savings	Shared Risk	Case Rates	Bundled Payments	Capitation		Total	% of APMs
							Full	Partial		
% of CCOs using APM	2 (13%)	15 (100%)	2 (13%)	2 (13%)	3 (20%)	1 (7%)		11 (73%)	36	**100%**
% of APMs focused on Primary Care	3 (14%)	11 (50%)				1 (5%)		7 (32%)	22	**30%**
% of APMs focused on medical specialty care		5 (50%)	1 (10%)		1 (10%)			3 (30%)	10	**14%**
% of APMs focused on dental care		3 (33%)	1 (11%)					5 (56%)	9	**12%**
% of APMs focused on BH services	1 (7%)	5 (36%)			1 (7%)			7 (50%)	14	**19%**
% of APMs focused on acute hospital services		4 (66%)	1 (17%)					1 (17%)	6	**8%**
% of APMs focused on network of providers		2 (40%)	1 (20%)	2 (40%)					5	**7%**
% of APMs focused on other services (e.g., transportation, PT)		2 (33%)			1 (17%)			3 (50%)	6	**8%**
% of APMs focused on Rx			1 (100)						1	**2%**
TOTAL	4	32	5	2	3	1	0	26	73	
% of APMs	**5%**	**44%**	**7%**	**3%**	**4%**	**2%**	**0%**	**35%**		**100%**

Oregon Coordinated Care Organization (CCO) APM Activities
Updated: 5/10/16

Payment Models:

1) PMPM payments for non-visit functions (e.g., care coordination fees)

   The provider receives additional payment (often PMPM payments) for providing services that are not traditionally reimbursed under the fee-for-service payment model.

2) Performance incentive payments (e.g., pay-for-performance)

   The provider may earn additional payments if the practice meets specified quality or financial performance targets. Payments are paid retrospectively after the CCO has been able to assess the practice's performance level. Pay-for-performance payments may be funded by dollars withheld from CCO payment or from supplemental dollars from the CCO.

3) Shared savings

   Services are paid on a fee-for-service basis. At the end of the year, the cost of services is compared against a pre-determined annual budget. If the cost of services is below the budget amount, the provider will share savings with the CCO. Shared savings arrangements may have an integrated quality component, such that the level of shared savings distributed to the provider is tied to the provider's performance on quality measures.

4) Shared risk

   Services are paid on a fee-for-service basis. At the end of the year, the cost of services is compared against a pre-determined annual budget. If the cost of services is below the budget amount, the provider will share savings with the CCO. If the cost of services is above the budget amount, the provider will share losses with the CCO.

5) Case rates

   A case rate is a flat amount, such as a per diem rate, that covers a defined group of procedures and services, usually provided by a single provider at one point in time, such as a case rate for colonoscopy.

6) Prospective and retrospective bundled payments for defined set of services or for specific conditions

   A bundled payment is a flat amount paid for an individual patient receiving a defined set of services (e.g., joint replacement; maternity care) or for a specific condition (e.g., adult asthma) that often covers services provided across the continuum of care by multiple providers for a specified period of time.

7) Capitation: full (i.e., global payments) or partial (e.g., primary care capitation)

Fixed dollar payments for a defined set of services are paid to a provider for each person cared for by the capitated provider. Payments are based on estimated costs of most or nearly most services that the person may need (full capitation) or for a smaller set of services such as some or all behavioral health or primary care services (partial capitation). Payments are prospectively paid, usually via a PMPM payment, and usually involve the provider accepting full risk for the capitated services.

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
AllCare Health Plan	PCPs located in Josephine County and 1 clinic in Jackson County	Partial capitation	Prospective; paid as tiered PMPM based on patient acuity	All attributed members	Upside and downside for providers receiving capitation as base payment	Financial and quality	No	Operational
AllCare Health Plan	PCP's in all network service areas	Mix of partial capitation and FFS both with a shared savings incentive program	Retrospective	All attributed members	Incentive program is upside only	Providers can qualify separately for a portion of shared savings based on their performance on a set of quality metrics (utilization and access) and ability to meet a set of benchmarks.	Yes	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
AllCare Health Plan	Targeted Medical and Surgical Specialists	FFS with shared savings	Retrospective	All attributed members	Upside only	Providers can qualify separately for a portion of shared savings based on their performance on a set of quality metrics (utilization and access) and ability to meet a set of benchmarks.	Yes for some of the specialists, but not for all	Operational
AllCare Health Plan	Oral Health	Payment to DCO's is full capitation with provider level payment based on a mix of capitation or FFS with shared savings	Prospective for capitation and Retrospective for incentive program	All attributed members	Upside and downside for capitation. Upside only for incentive program	Providers can qualify separately for a portion of shared savings based on their performance on a set of 7 quality metrics (utilization and access) and ability to meet a set of benchmarks.	Yes	Operational
AllCare Health Plan	Behavioral Health (separately mental health and alcohol and mental health)	Partial capitation	Prospective for capitation and retrospective for incentive program	All attributed members	Upside and downside for capitation. Upside only for incentive program	Providers can qualify separately for a portion of shared savings based on their performance on a set of 7 quality metrics (utilization and access) and ability to meet a set of benchmarks.	Yes	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
AllCare Health Plan	Hospitals, Nursing Homes and Surgery Centers	FFS with shared savings	Retrospective	TBD	Upside only	1. Reduced ED Visits within 7 Days of Discharge 2. Reduced Readmissions within 7 Days of Discharge 3. Patients receiving follow-up care with PCP within 14 days of discharge from a hospital or SNF 4. Patient Satisfaction results 5. Facility-specific measures	TBD	Operational
Columbia Pacific CCO	Network Partners (hospitals, PCPs, behavioral health)	FFS with shared savings and risk	Retrospective	All attributed members	Yr 1 and Yr2: upside only Y3: upside and downside	Financial	None specified (under consideratio n)	Under development
Columbia Pacific CCO	MH	Case Rate	Prospective	Service Received		Quality	Yes	Operational
Columbia Pacific CCO	Specialty	Case Rate	Prospective	Service Received (member enrolled)		Quality	No	Operational
Columbia Pacific CCO	PCPs Hospitals	Shared Risk	Retrospective	All attributed members	Upside and downside	Quality and financial	Yes	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Columbia Pacific CCO	PCPs	FFS with quality incentive (P4P paid as PMPM)	Retrospective	All attributed members	N/A	Financial and quality, when utilization bonus is included in calculation 1. Level 1: $x PMPM (Report monthly on three measures) 2. Level 2: $y PMPM (Report monthly on five metrics, improve 3% on at least one metric.) 3. Level 3: $z PMPM (Report monthly on five metrics, improve 3% on at least three metrics.) Utilization bonus metrics 1. Total PMPM cost, 2. Emergency Department visits of any cause per 1000 members, and 3. Hospital admission for any cause per 1000 members.	Yes	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Columbia Pacific CCO	PCPs	FFS with P4P (pay for implementing adult access & engagement initiatives)	Retrospective	All attributed members	N/A	Quality	Not specified	Operational
Columbia Pacific CCO	PCPs	FFS: Enhanced Fee Schedule (additional reimbursement for medical home svcs)	Retrospective	Only if service rendered	N/A	Payment for non-traditional services provided by medical home	No	Operational
Columbia Pacific CCO	PCPs	PMPM: BH Integration	Prospective	All attributed members	N/A	Quality	Yes	Under development (launch in June 2016)
Eastern Oregon CCO	Behavioral Health and NEMT	Full Capitation	Prospective	All attributed members	Upside and downside	**Financial**	No	Operational
Eastern Oregon CCO	Primary Care	Partial capitation	Prospective	All attributed members	Upside and downside risk	**Financial**	No	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Eastern Oregon CCO	Hospitals, PCPCHs, PCPs, Specialists and IPAs	FFS with risk sharing (Pool created with withhold on hospital, Rx, transportation and DME claims)	Retrospective	All attributed members	PCP Fund:	Financial and quality - Portion of any surplus distributed based on quality measure performance	Not specified	Operational
Eastern Oregon CCO	PCP clinics certified as a PCPCH	PMPM	Prospective	All attributed members	N/A	Financial	Not specified but implied	Operational
Eastern Oregon CCO	DCO's	PMPM	Prospective	All attributed members	Upside and downside risk	Financial	No	Operational
FamilyCare	15% of primary care contracts	PMPM payment for non-billable services, including open access, embedded behaviorists, PCPCH status, case/care management, and behavioral health case management	Retrospective	All attributed members		No	No	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
FamilyCare	Approx. 40% of our primary care contracts, expanding to include maternity and dental	Performance incentive payments	Retrospective	All attributed members		Quality	Yes	Operational
FamilyCare	Approx. 9% of our behavioral health contracts	Case Rate to cover the following billable and non-billable type services	Prospective	Service received				Operational
FamilyCare	Maternity care	Bundled payment	Retrospective					Operational
FamilyCare	Approx. 19% of our primary care contracts	Capitated	Prospective		Upside	Quality		Operational
FamilyCare	Approx. 1% of our primary care contracts	Shared savings			Upside			Operational
Health Share of Oregon	NEMT	Partial Capitation / Shared Savings	Prospective	All attributed members	Upside and downside	Financial and quality	No	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Health Share of Oregon	Behavioral Health	Case rates for most outpatient services	Prospective	Only if services are received	Upside and downside	Financial only	No	Operational
Health Share of Oregon	Primary Care	Partial Capitation (PMPM payments; two levels based on level of behaviorist integration)	Prospective	All attributed members		Financial only		Operational
Health Share of Oregon	PCPs and other unspecified providers (multiple subcapita-ted plan programs)	FFS plus P4P	Retrospective		Upside only	Quality only: prevention, screenings and chronic disease management	Yes	Operational
Health Share of Oregon	Pediatric High Risk Care Coordina-tion	Payment for non-visit function	Not specified	Only if services is received	N/A	Financial only	No	Operational
Health Share of Oregon	PCPs	Bundled payments						Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Health Share of Oregon	Dental	Partial Capitation	Prospective	For all attributed members	Upside and downside			Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Intercommunity Health Network	PCPs	Partial capitation paid as tiered PMPM based on patient risk	Prospective	For all attributed members	Upside risk only	Financial only	Yes	Operational
Intercommunity Health Network	PCPs	P4P	Retrospective (FFS)	If service received	Upside only	Quality only	Yes	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Jackson Care Connect	PCPs	FFS with P4P (paid PMPM)	Retrospective	All attributed members	N/A	Financial and quality, when utilization bonus is included in calculation 6. Level 1: $x PMPM (Report monthly on three measures) 1. Level 2: $y PMPM (Report monthly on five metrics, improve 3% on at least one metric.) 3) Level 3: $z PMPM (Report monthly on five metrics, improve 3% on at least three metrics.) Utilization bonus ($40 PM) metrics 7. Total PMPM cost, 2. Emergency Department visits of any cause per 1000 members, and 3) Hospital admission for any cause per 1000 members	Yes	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Jackson Care Connect	PCPs	FFS with P4P (pay-for-reporting - paid one time focused on BH integration)	Retrospective	All attributed members	N/A	Quality (met reporting requirements)	No	Operational
Jackson Care Connect	PCPs and MH and CD providers	FFS with P4P (pay for implementing adult access & engagement initiatives)	Retrospective	All attributed members	N/A	Quality	Not specified	Operational
Jackson Care Connect	PCPs	FFS: Enhanced Fee Schedule (additional reimbursement for medical home svcs)	Retrospective	Only if service rendered	N/A	Payment for non-traditional services provided by medical home	No	Operational
Jackson Care Connect	PCPs	PMPM: BH Integration	Prospective	All attributed members	N/A	Quality	Yes	Under development (launch in June 2016)
Jackson Care Connect	PCPs, Hospital, MH, and CD providers	FFS with P4P (pay for implementing care coordination initatives)	Prospective	All attributed members	N/A	Quality	Yes	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Primary Health of Josephine County	OB/GYN clinic	Partial capitation (risk-stratified PMPM) with P4P bonus	Prospective	All attributed pregnant members through 60 days postpartum	Upside and downside	Financial and quality Quality targets *not* tied to payment: 1. 100% of all patients (not just PHJC mbrs) receive 5Ps (SBIRT) prenatal screening 2. 100% of pregnancies screened for prenatal depression	Yes	Operational
Primary Health of Josephine County	PCPs	Partial capitation	Prospective	All attributed members	Upside and downside	Financial and quality	Yes	Operational
Primary Health of Josephine County	PCPs	P4P Bonus	Retrospective	All attributed members	Upside	Financial and Quality	Yes	Operational
Primary Health of Josephine County	PCPs	FFS with PMPM for non-visit functions (case management)	Prospective	All attributed members	N/A	N/A	N/A	Operational
PacificSource Community Solutions CCO -- Columbia Gorge Region	PCPs	Partial capitation with quality incentive (withhold)	Prospective	All attributed members	Upside and downside	Financial and quality	Yes	Operational
PacificSource Community Solutions CCO --	Behavioral Health (outpatient	Partial capitation with quality	Prospective	All attributed members	Upside and downside	Financial and quality	Yes	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Columbia Gorge Region	mental health and SUD)	incentive (withhold); also some shared risk for non-capitated services						
PacificSource Community Solutions CCO -- Columbia Gorge Region	SUD residential services	Partial capitation	Prospective	All attributed members	Upside and downside	Financial and quality	Not specified	Operational
PacificSource Community Solutions CCO -- Columbia Gorge Region	Dentists	Partial capitation	Prospective	All attributed members	Upside and downside	Financial only	No	Operational
PacificSource Community Solutions CCO -- Columbia Gorge Region	NEMT	Partial capitation	Prospective	All attributed members	Upside and downside	Financial and quality	No	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
PacificSource Community Solutions CCO – Central Oregon	PCPs	Partial capitation with quality incentive (withhold)	Prospective	All attributed members	Upside and downside	Financial and quality	Yes	Operational
PacificSource Community Solutions CCO – Central Oregon	Acute care hospitals	Partial capitation with quality incentive (withhold)	Prospective	All attributed members	Upside and downside	Financial and quality	Not specified	Operational
PacificSource Community Solutions CCO – Central Oregon	Behavioral Health (outpatient mental health and SUD)	Partial capitation with quality incentive (withhold); also some shared risk for non-capitated services	Prospective	All attributed members	Upside and downside	Financial and quality	Yes	Operational
PacificSource Community Solutions CCO – Central Oregon	SUD residential services	Partial capitation with quality incentive (withhold)	Prospective	All attributed members	Upside and downside	Financial and quality	Not specified	Operational
PacificSource Community Solutions CCO – Central Oregon	Dentists	Partial capitation	Prospective	All attributed members	Upside and downside	Financial only	No	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
PacificSource Community Solutions CCO – Central Oregon	NEMT	Partial capitation with quality incentive (withhold)	Prospective	All attributed members	Upside and downside	Financial and quality	No	Operational
Trillium Community Health Plan	PCPs	Partial Capitation with quality incentive (withhold) and PMPM case management payments, plus shared savings	Prospective (capitation) and PMPM Case Management payment Retrospective (withhold return and shared savings)	All attributed members	Upside and downside	Financial and quality	Not specified	Operational
Trillium Community Health Plan	Specialist physicians	FFS with quality incentive (withhold on physician, Rx and hospital claims creates shared risk pool)	Retrospective	Only if services received	Upside and downside	Financial only	No	Operational
Trillium Community Health Plan	Specialists	Case rate for back care	Not specified	Only if services received	Upside and downside	Financial only	No	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Trillium Community Health Plan	ED physicians	Partial capitation with quality incentives (withhold) and case rate	Prospective (capitation) Retrospective (case rate)		Upside and downside	Financial only	No	Operational
Trillium Community Health Plan	Dentists	Partial capitation with quality incentives (withhold)	Prospective	All attributed members	Upside and downside	Financial and quality	Not specified	Operational
Trillium Community Health Plan	Behavioral Health	Partial capitation and case rates with quality incentives (withhold on BH claims) and PMPM case management payments	Prospective (capitation) and PMPM Case Management payments Retrospective (case rate)	All attributed members (capitation) Service received (case rate)	Upside and downside	Financial and quality Quality incentives for behavioral health integration with PCPs	Not specified	Operational
Trillium Community Health Plan	Hospitals	FFS with quality incentives (withhold)	Retrospective	Only if services received	Upside only	Financial and quality	Not specified	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Umpqua Health Alliance	PCP	FFS plus risk withhold plus Pay-For-Value (P4V)	Prospective and Retrospective	Both FS and attributed members on P4V	Upside and downside	Financial and Quality	Based on CCO Quality Metrics	Operational
Umpqua Health Alliance	PCP	PCPCH Payment for tier status	PMPM Prospective	Attributed panel	Upside only	PCPCH tier status	PCPCH tier status	Operations
Umpqua Health Alliance	Specialists	FFS plus risk withhold plus P4V	Prospective and Retrospective	FFS plus supplemental RVU payment	Upside and downside	Financial and Quality	Yes, community standards of care and CCO metrics where applicable.	Operational and Under development
Umpqua Health Alliance	Sole Community Hospital	FFS plus risk withhold plus Pay-For-Value (P4V)	Prospective and Retrospective	Services Rendered plus P4V component	Upside and downside	Financial and Quality	Yes, community standards of care and CCO metrics where applicable.	Operational and Under Development
Umpqua Health Alliance	Chemical Dependency	FFS plus risk/quality withhold	Prospective and Retrospective	Services Rendered plus P4V component	Upside and downside	Financial and Quality	CCO Quality Metrics used where applicable.	Operational and Under Development
Umpqua Health Alliance	Mental Health	FFS plus risk/quality withhold	Prospective and Retrospective	Services Rendered plus P4V component	Upside and downside	Financial and Quality	CCO Quality Metrics used where applicable.	Operational and Under Development

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Umpqua Health Alliance	Mental Health	Capitation	Prospective	PMPM payment based on historical 'mental health' premium (pre-transformation) based on all CCO patients	Upside and downside	Financial and Quality	CCO Quality Metrics used where applicable.	Operational and Under development
Umpqua Health Alliance	Dental	Capitation	Prospective	PMPM payment based on historical 'dental health' premium (pre-transformation) based on all CCO patients.	Upside and downside	Financial and Quality	CCO Quality Metrics used where applicable.	Operational and Under development

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Umpqua Health Alliance	Community Programs	Block Program Funding	Prospective and Retrospective	Block Funding for specific Quality related programs usually for at-risk CCO plan population subsets or specific CCO Metrics.	Upside and downside	Quality	Based on CCO Quality Metrics	Operational and Under development
Western Oregon Advanced Health	PCP	Partial capitation with P4P	Prospective	All attributed members	Upside and downside	Financial and quality	Yes	Operational
Western Oregon Advanced Health	Physical therapists	Case rate based on diagnoses	Retrospective	Only if service received	Upside and downside	Financial	No	Pilot
Western Oregon Advanced Health	Urgent care	Partial Capitation	Prospective	All attributed members	Upside and downside	Financial	No	Operational
Western Oregon Advanced Health	PCP, hospital and OB	P4P for CCO Incentive Pool	Retrospective	Only if service received	Upside only	Quality	Yes	Operational
Western Oregon Advanced Health	SUD	Partial capitation	Prospective	All attributed members	Upside and downside	Financial	No	Operational

CCO	Providers Covered	Payment Model*	Payment type: Retrospective or Prospective?	Payments: For all attributed members or only if service received?	Risk: Upside risk only? Upside and downside risk?	Payment targets: Financial only? Quality only? Financial and quality?	Quality targets: Are population health metrics included?	Implementation progress: Under development? Operational?
Willamette Valley Community Health	Provider Networks	Capitation with full risk for physical health services and P4P	Prospective	All attributed members	Upside and downside	Financial and quality	Yes	Operational
Willamette Valley Community Health	Dentists	Partial Capitation	Prospective	All attributed members	Upside and downside	Financial	Yes	Operational
Willamette Valley Community Health	Behavioral Health	Partial Capitation	Prospective	All attributed members	Upside and downside	Financial	Yes	Operational
Yamhill Community Care Organization	All providers	FFS with P4P	Retrospective	N/A	Upside	Quality	Yes	Operational
Yamhill Community Care Organization	Qualifying PCPCHs	Partial Capitation	Prospective	All attributed members	Upside and downside	Financial	No	In development

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Alternative Payment Models

Will Brake
Director, Provider Network
Transformation Services

What - AllCare APM Models

Specialty	County	# of Providers	Members	Model
Primary Care / Peds	Josephine	61	18,288	Capitation and Performance Incentive / Shared Savings Payments
Primary Care / Peds	Jackson	134	19,327	Fee for Service and Performance Incentive / Shared Savings Payments
Primary Care / Peds	Curry	7	838	Fee for Service and Performance Incentive / Shared Savings Payments
Specialists	All Counties	221		Fee for Service and Performance Incentive / Shared Savings Payments
Behavioral Health Agencies	All Counties	5		Capitation & Fee for Service and Performance Incentive / Shared Savings Payments
Dental Care Organizations	All Counties	5		Capitation and Performance Incentive / Shared Savings Payments
Hospitals / SNF / Surgery Centers	All Counties	8		Fee for Service and Performance Incentive / Shared Savings Payments
Non Emergent Medical Transportation	All Counties	1		Capitation and Performance Incentive / Shared Savings Payments
	Total	**442**	**38,453**	

Members assigned to PCP APM participants 74.67%

Why – How was Model Chosen?

The AllCare APM Models were developed over a 2 year period. We utilized the following process:

- We convened an APM committee specific to the discipline (PCPs for Primary Care, Behavioral Health Agencies for BH, etc.).
- We explored multiple models for each discipline and selected the model that best aligned compensation and quality of care.
- In addition, these committees developed their performance incentive measures and methodologies.
- Criteria included the triple aim, alignment with OHA, improved access, increased prevention and patient centered care.

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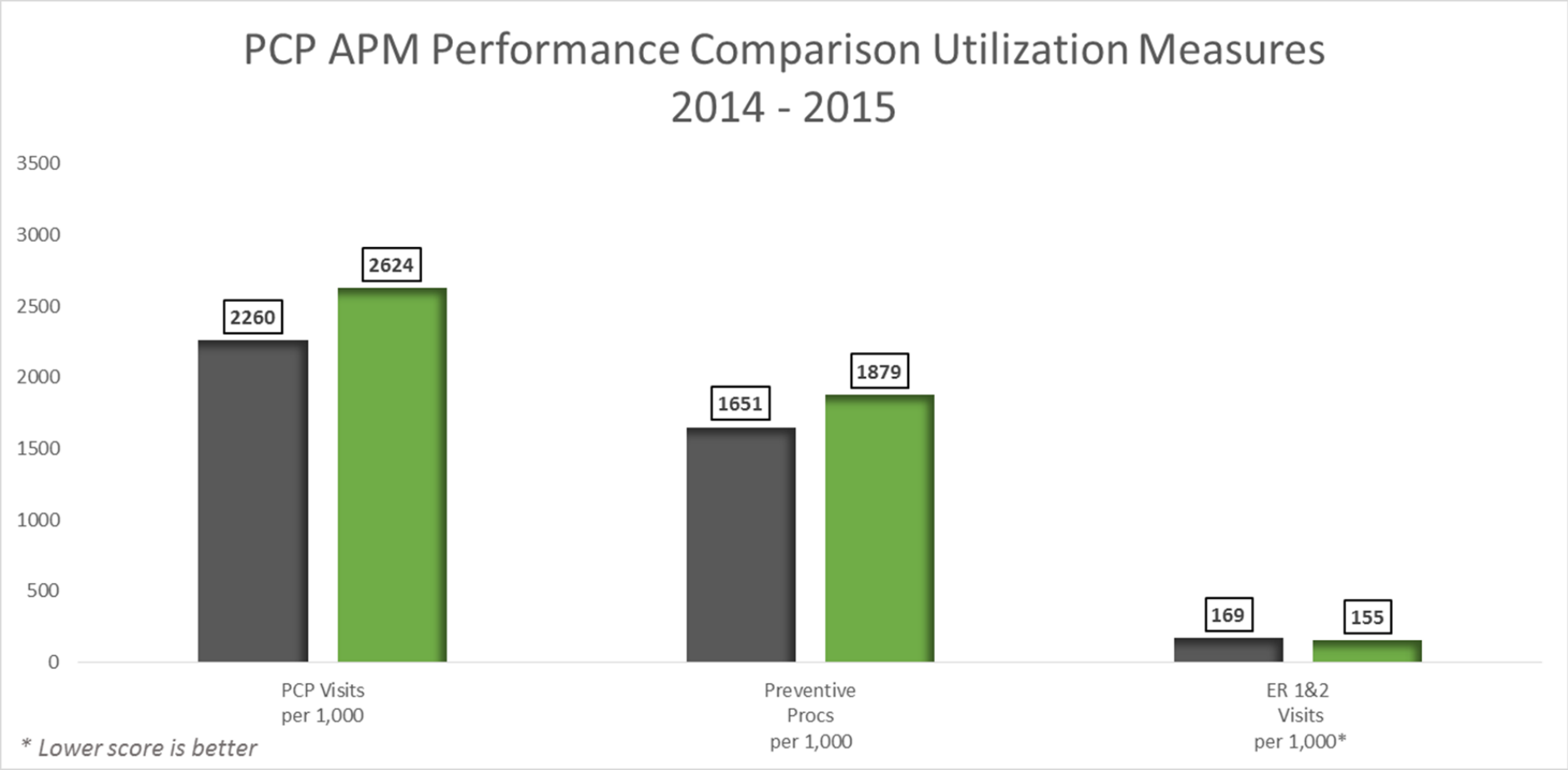
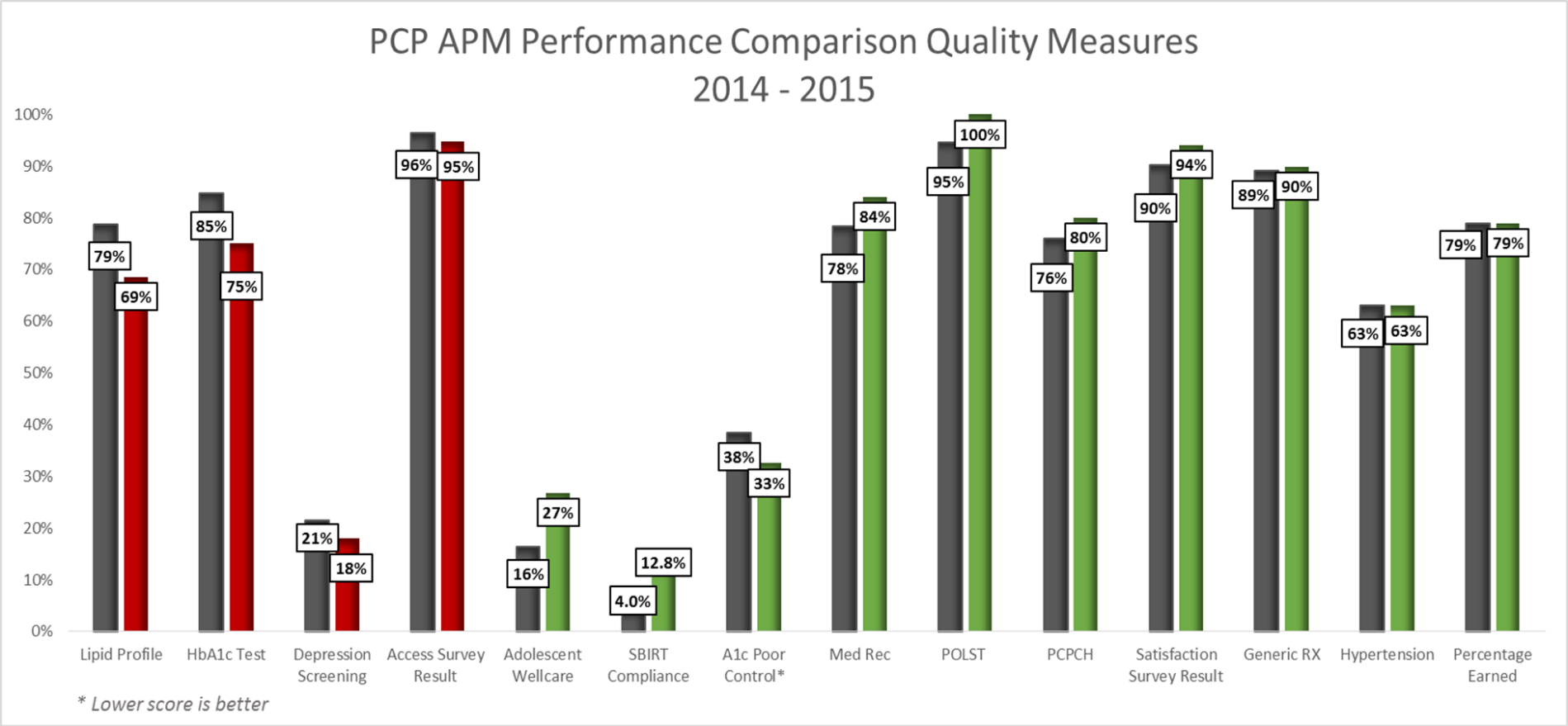
Results – APM Outcomes



Results – APM Outcomes

PCPs Improved on 75% of the APM Measures from 2014-2015



Results – Response from Providers

- Our providers are:
  - More engaged in value-based care
  - More engaged with AllCare CCO
  - More supported by AllCare CCO

- Our CCO staff have formed better partnerships with our network providers & agencies

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Results - Top 10 Lessons Learned

1. Involve the right people – thought leaders
2. Engage providers in the process
3. Set timeframes and manage to them
4. Keep it simple, especially in year one
5. Train early with a focus on coding and documentation
6. Modify the measures as necessary
7. Validate the data
8. Respond in a timely manner to provider questions about the data
9. Be as transparent as possible
10. Many providers want to achieve 100% of the measures

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Next Steps

Where are we going?

- Continue to modify the measures in collaboration with our providers and agencies
- Explore payment methodologies that further incentivize providers to improve the cost and quality of care
- Increase our focus on the social determinates of health
- Maximize support to our providers in meeting their goals
- Implement innovative approaches to our care delivery model

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