

# Transformation Plan Element #3

## Alternative Payment Methodologies

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### **Transformation Plan Guidance and Technical Assistance**

Oregon Health Authority's technical assistance is designed to provide Coordinated Care Organizations (CCOs) with guidance on specific areas each plan should address; examples of approaches and outcomes that can help inform discussions and strategies as the CCO develops its plan; other resources and additional technical assistance available to CCOs; and staff assistance to answer specific questions through an assigned OHA contact. Please call or email your OHA Transformation Plan contact if you need assistance with a particular subject or item.

### **Overview**

As part of Oregon's health care transformation, CCOs must find innovative ways to provide efficient and effective care to Medicaid enrollees. To identify efforts and plans to do this, the CCO Transformation Plan must; (1) describe the CCO's current utilization of alternative payment methodologies that align payment with health outcomes; (2) describe the alternative payment methodologies to be implemented; and (3) describe the milestones and timelines to move to full implementation of payment reform.

### **Background**

Health care today is rewarded by the volume of services provided rather than by the value of the services provided. Providers whose primary concern is keeping people healthy are in effect penalized through a predominately fee-for-service payment system for not delivering extra services. Policies which further exacerbate this trend include the undervaluation of preventive services, as well as the overvaluation of non-preventive services; non-payment to physicians for services required to provide patient-focused, care coordination; and the provision of incentives for volume of services without regard to quality of care or resource utilization.<sup>1</sup>

### ***Alternative Payment Methodologies***

CCO's are expected to use alternative payment methodologies (APMs) for provider compensation, in accordance with the principles of equity, accountability, simplicity, transparency, and affordability or cost containment. CCOs will have the flexibility to choose which APMs they implement. APMs will be evaluated for their effectiveness in meeting the goals outlined above. The state, through its Transformation Center, will offer technical assistance and implementation tools for a "starter set" of promising APM models to develop value-based purchasing models. Promising APM models may include:

- Patient-Centered Primary Care Home (PCPCH) payments;
- Bundled payments, including case rates, fee-for-service (FFS) with risk-sharing, and episode payments;
- Risk and gain-sharing arrangements between health plans and their providers;
- Service agreements aligning incentives for specialty and primary care physicians;
- Quality bonuses or other performance incentives; and
- Accountable Care Organization (ACO) models.

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These different payment systems have different effects on individual cost factors. According to Harold Miller, Executive Director of the Center for Healthcare Quality and Payment Reform, total per capita health care costs are driven by:

- The prevalence of health conditions in the population;
- The number of “episodes of care” they require per condition;
- The number and types of health care services a person receives in each episode;
- The number and types of processes, devices and drugs involved in each service; and finally,
- The cost of each individual process, device, and drug.

#### *Current Payment Systems*

However, multiple payment systems exist and some have the potential to control health care costs and increase quality of care. There are six methods of provider reimbursement, which have been traditionally utilized within the healthcare system.<sup>2</sup>

- **Fee-For-Service** – The most common way of paying for health care services today is the fee-for-service system, under which a predetermined amount is paid for each discrete service provided. Fee-for-service payment puts the provider at risk for the number and cost of processes within each service, but there is no limit on the number of services, and providers get paid regardless of quality or outcomes.
- **Per Diem** – A provider is paid a set amount per patient for each day that patient is in the provider’s care. All services rendered during that day are covered under the set amount.
- **Episode-of-care** – A single provider is paid a set amount for all services rendered (by that provider) during a defined “episode” of care. For example, a provider may be paid a pre-determined amount for a patient undergoing a kidney transplant. This payment would cover the surgery and all services, including follow-up, associated with that “episode.” Using this method there would typically be multiple payments for a single episode since more than one provider may treat a patient.
- **Multi-provider bundled episode-of-care** – Multiple providers are jointly paid for all services rendered during an episode of care, as defined above. Using this method there would only be a single payment made by the payers, which would cover the services rendered by all providers.
- **Condition-specific capitation** – One or more providers are paid a pre-determined fee to cover all services rendered for a specific condition. These payments can be either a one-time fee or on-going depending on the severity of the illness.
- **Capitation** – One or more providers are paid a regular, pre-determined fee to cover all services rendered for the continuous care of a patient. This fee covers all episodes and all conditions.<sup>1</sup>

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#### ***Oregon's Payment System***

Payment systems for health care in Oregon are currently in a state of transition, but fee-for-service and capitation have been the dominant methods. While it is well-known that fee-for-service payments put the provider at risk for the number and cost of processes within each service, they do not limit the number of services. Therefore providers get paid regardless of quality or outcomes. Supplemental systems such as prior authorization and pay-for-performance (P4P) have been created to address these problems with fee-for-service payment, but they can lead to a level of micromanagement of providers that is inefficient and can deter innovation, while leaving undisturbed the major disincentives in the underlying payment system.

Capitation models of payment are designed to control the number of episodes of care as well as the cost of individual episodes in that a single payment to cover all of the services patients need during a specific period of time, regardless of how many or few episodes of care the patients experience. However, the amount of the payment is the same regardless of how sick or how well patients are, which provides incentive to avoid patients who have multiple or expensive-to-treat conditions, and it puts providers at risk of financial difficulty or bankruptcy if they take on large numbers of such patients. Newly formed CCOs contracted with Oregon's Medicaid program are operating under a global budget that is meant to shift payment away from capitation and toward payment for outcomes.

#### ***Requirement for CCOs to Use Alternative Payment Methodologies***

To encourage higher quality and more efficient delivery of Medicare and Medicaid services, CCOs will be required to use alternative payment methodologies. Using these methodologies will result in providers needing to embrace the huge culture change of shifting from being rewarded for the treatment of sick people to being rewarded for good outcomes. Alternative payment methodologies include methodologies that support the following objectives:

- Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;
- Hold organizations and providers responsible for the efficient delivery of care;
- Reward good performance or create shared responsibility across sites of care and provider types;
- Create incentives for the prevention, early identification and early intervention of conditions that lead to chronic illnesses;
- Provide person-centered planning in the design and delivery of care, and use of patient-centered primary care homes; and
- Incentivize coordination across provider types and levels of care

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### *CCO RFA Requirement for Alternative Payment Methodologies*

#### Section 5 - Payment Methodologies that Support the Triple Aim

A.5.1. Demonstrate how Applicant's payment methodologies promote or will promote the Triple Aim and in particular, how the Applicant will:

- Provide comprehensive coordination or create shared responsibility across provider types and levels of care and creates incentives for using such delivery systems such as PCPCHs;
- Provide financial support, differentially based on the tier level achieved, to PCPCHs for meeting the PCPCH standards;
- Align financial incentives for evidence-based and best emerging practices.

#### ***Patient-Centered Primary Care Homes***

Because Patient-Centered Primary Care Homes are an integral component of the CCO delivery system model, all CCOs must use recommended payment methods to reward traditionally undercompensated activities performed by those practices. This could be tier-based enhanced payments for the CCOs population in the PCPCH - \$2, \$4, \$6 PMPM plus additional PMPM for managing complicated patients (similar to Affordable Care Act payments). More information about how clinics are recognized and specific qualifications for tiers is available online at: [www.PrimaryCareHome.oregon.gov](http://www.PrimaryCareHome.oregon.gov) and noted in the "Resources" section below.<sup>4</sup>

#### **References/Resources**

- [www.innovations.cms.gov](http://www.innovations.cms.gov)
- [www.chqpr.org](http://www.chqpr.org)

#### **Required Components of Transformation Plan for Alternative Payment Methodologies**

1. Describe current benchmark of payment systems employed by CCO and provide an analysis of how these methodologies and the incentives they create impact cost and quality.
2. Describe new payment systems that will align payments with outcomes and control the cost of care.
3. Provide detailed implementation plan for new payment systems including milestones and timelines. Milestones and timelines will be included in the July 1 2013 contract amendment.