

Oregon's Primary Care Transformation Initiative

2018 Progress Report

Primary Care Payment Reform Collaborative

January 2019

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Executive summary

Background

The Primary Care Payment Reform Collaborative (“Collaborative”) is a legislatively mandated (Chapter 575 Oregon Laws; Senate Bill [SB] 934 [2017]) multi-stakeholder advisory body to the Oregon Health Authority (OHA). The Collaborative advises and assists OHA in the implementation of a Primary Care Transformation Initiative (“Initiative”) to:

- Use value-based payment methods that are not paid on a per-claim basis to:
 - Increase the investment in primary care
 - Align primary care reimbursement by all purchasers of care
 - Continue to improve reimbursement methods, including by investing in the social determinants of health
- Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care

SB 934 also includes strategies for the Collaborative to consider that support the implementation of the Primary Care Transformation Initiative:

- Provide technical assistance to clinics and payers in implementing the Initiative
- Aggregate the data from and align the metrics used in the Initiative with the work of the Health Plan Quality Metrics Committee
- Facilitate the integration of primary care behavioral and physical health care

The Collaborative includes 46 members representing a broad range of provider, payer and other primary care stakeholder perspectives. It is convened by the OHA Transformation Center and has been meeting since 2016. In December 2016, the Collaborative presented a set of recommendations to the Oregon Health Policy Board (OHPB) which informed SB 934.

This report is an update to the Oregon Legislature and OHPB as mandated by SB 934. It includes progress on the Initiative and recommendations on how to achieve the goals of the Initiative. The recommendations were developed by members over the course of seven Collaborative and twenty-six Collaborative work group meetings in 2018. The recommendations have been endorsed by all member organizations.

Recommendations

The Collaborative is recommending the Primary Care Transformation Initiative focus on the spread of mechanisms to strengthen Oregon’s primary care system with an emphasis on innovative payment models supported by a statewide infrastructure. The recommendations fall into the following categories: infrastructure, two complementary payment models, and implementation. These recommendations are complementary and should be considered as a whole, rather than as separate parts.

Value-based payments (VBPs), which are foundational to the Initiative, are defined as strategies used by payers to promote quality and value of health care services. The goal of VBPs is to shift from pure volume-based payment, as exemplified by fee-for-service (FFS) payments, to payments that reward providers for “value” of care, including improvements in quality, utilization and health outcomes.

Develop an infrastructure to support the Primary Care Transformation Initiative

Central to the Initiative is a multi-payer primary care payment model that aims to provide support to standardize payment methodologies, increase investment in primary care, and reduce administrative burden for payers and providers. A strong infrastructure is critical to success of this transformative work. The Collaborative urges the Oregon Legislature to support the creation of a statewide infrastructure to:

- Provide payer and provider technical assistance;
- Monitor participating payers and providers (including through reporting mechanisms and practice eligibility oversight); and
- Oversee and coordinate evaluation of the Initiative.

Adopt complementary multi-payer payment models

Two complementary payment models — a primary care payment model, and a primary care and behavioral health integration payment model — are central to the Collaborative’s recommendations for the Initiative. While many payers and providers have been working together over the years to identify and implement alternative ways to invest in and pay for primary care, the Collaborative’s recommendation of these two multi-payer payment models seeks to facilitate and hasten the adoption of innovative payment mechanisms across Oregon.

Primary care payment model

The multi-payer primary care payment model recommended by the Collaborative supports the implementation of the Oregon Patient-Centered Primary Care Home (PCPCH) model of care and fosters alignment of payment methodologies. The payment model aims to standardize payment methodologies and reduce administrative burden for payers and providers. It is the Collaborative’s intent that all payers and providers adopt this model.

The payment model aligns with the Centers for Medicare and Medicaid Services’ (CMS) Comprehensive Primary Care Plus (CPC+) advanced primary care medical home payment model, in which Oregon participates. The payment model extends the CPC+ framework to all payers in Oregon and to non-CPC+ clinics, including pediatric practices, federally qualified health centers and rural health clinics.

The Collaborative recommends all health care payers that provide coverage in Oregon implement an aligned payment model with the four following components:

1. *Advanced primary care infrastructure (APCI) payments (per-member, per-month [PMPM] payments)*
These are risk-adjusted, population-based PMPM payments that sustainably support a high-functioning primary care system.
2. *Performance-based incentive payments*
These are payments for performance on priority accountability measures, such as population-based quality metrics and utilization.
3. *Fee-for-service (FFS) payments*
FFS is the traditional health care payment model for most payers.
4. *Comprehensive primary care payments (CPCPs) (prospective, up-front payment)*
These are prospective, population-based PMPM or lump sum payments calculated from historical FFS payments for a defined set of primary care services.

All clinics participating in the payment model must be recognized as a PCPCH by OHA and utilize federally certified electronic health record (EHR) technology in the clinic. Clinics with 1,000 or more patients are required to participate in at least two of the three VPB components of the payment model. All clinics meeting the criteria and expectations will be eligible to participate in the payment model within three years of its implementation following a phased-in schedule.

To ensure success of the Initiative, all health care payers that provide coverage in Oregon are expected to implement the model; be accountable for shared and equitable VBP investment; implement the model broadly across populations and practice types; and share data. The recommendations also include VBP targets. The VBP targets align with categories in the Health Care Payment Learning and Action Network (HCP LAN) framework and include both category-specific targets and targets for all VBPs to primary care combined. The targets are intended to be aspirational but achievable and will be re-evaluated and refined by the Collaborative over time based on experience and evaluation evidence.

Primary care and behavioral health integration payment model

Integrating behavioral health services with primary care is a foundational tenet of Oregon's health transformation efforts. The Collaborative's three recommendations below comprise a payment model that supports primary care and behavioral health integration. The payment model seeks to address finance and payment barriers through fostering alignment of payment and performance methodologies.

1. *Health plan contracting structure*
Payers, providers and other contracting entities (such as independent practice associations) should work together to develop contractual mechanisms with integrated primary care clinics where all services delivered at the clinic are included in the same contract with the health plan.

2. *Improved access to integrated behavioral health care for patients*

Payers should remove pre-authorization requirements for behavioral health services delivered in an integrated primary care clinic, as with other primary care services. Payers should remove double co-pays for patients who see a primary care provider and behavioral health clinician on the same day. Payers should remove policies that reject two payments for services provided on the same day by a primary care provider and behavioral health clinician.

3. *Sustainable payment approach*

Payers should provide population-based payments to integrated primary care clinics that meet PCPCH behavioral health integration standards. In addition to population-based (PMPM) payments, payers should reimburse primary care providers and behavioral health clinicians working in a clinic with integrated health care for an agreed-upon set of FFS codes with no pre-authorization requirements.

Gain stakeholder support for implementation and coordination of the Initiative

The Collaborative is recommending the spread of mechanisms to support primary care transformation, with an emphasis on innovative payment models supported by a statewide infrastructure. This effort requires support and coordination. Outlined below are the requests the Collaborative makes of each stakeholder to ensure progress.

Oregon Legislature

- Support the development of a statewide infrastructure with sustainable funding so stakeholders can successfully implement and evaluate the Initiative. This infrastructure is foundational for success, and the Collaborative urges the Oregon Legislature to consider this a priority for implementing these recommendations.
- Facilitate the establishment of a structure and framework to support the spread of aligned value-based payments in primary care, while avoiding codifying details of the Collaborative's payment model recommendations that could impede flexibility to learn from and build on work underway.
- Amend Section 4(3) and Section 7 of SB 934 (2017) to include all payers in Oregon, not just those participating in a national primary care medical home payment model (CPC+).

All health care payers that provide coverage in Oregon

- Adopt, implement and report on all the payment model strategies outlined in this report.
- In the spirit of transparency and to foster alignment, share pay-for-performance value-based payment model structures in a public reporting process. This would not include detailed information that could put payers at risk of violating anti-trust law.

All primary care providers in Oregon

- Adopt, implement and report on the payment model strategies outlined in this report, including participation in value-based payments models with the payers with which their clinic contracts, now or in the future.
- Apply for and maintain clinic PCPCH recognition from OHA.

All contracting entities in Oregon

- Support all primary care clinics to transition to the PCPCH model of care and to the VBP model components outlined in this document.

Oregon Health Authority

- Continue to serve as convener of the Collaborative with dedicated resources.
- Align agency value-based payment policies to support the work of the Collaborative and participate in the implementation of the Initiative.
- Collaborate with the Department of Consumer and Business Services to develop a report on progress of Initiative strategies.
- Support necessary infrastructure to facilitate success (see Infrastructure recommendation).

Department of Consumer and Business Services

- Align agency value-based payment policies to support the work of the Collaborative and participate in the implementation of the Initiative.
- Collaborate with OHA to develop a report on progress of Initiative strategies.

Next steps

Looking ahead to 2019, there are several key areas of focus for the Collaborative.

Metrics

The Metrics Sub-workgroup of the Collaborative started working in 2018 to identify a set of measures for the Initiative and will resume this work in early 2019. These measures will be included in the performance-based incentive payment component of the primary care payment model and as part of the overall evaluation of the Initiative, and they will be aligned with the work of the Oregon Health Plan Quality Metrics Committee.

Implementation of recommendations

The Collaborative will focus on developing strategies to implement the recommendations in this report.

Collaborative membership

OHA will explore options to improve and enhance participation for members (for example, establishing a leadership steering committee and adding new work groups).

Initiative evaluation

Oregon Health & Sciences University Center for Health Systems Effectiveness (CHSE) is developing options for the Collaborative's consideration to evaluate the Initiative.

Collaborate with stakeholders

The Collaborative will continue to seek opportunities to build upon and leverage health system transformation efforts across Oregon through alignment with other stakeholders.

Supporting Organizations

The following organizations support the recommendations in this report.





**Hagan Hamilton
Insurance Solutions**



**Integrated Behavioral
Health Alliance**





OCHIN



**OHSU
Family Medicine
at Richmond**





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Introduction

The Primary Care Payment Reform Collaborative (“Collaborative”) is a legislatively mandated (Chapter 575 Oregon Laws; Senate Bill [SB] 934 [2017]) multi-stakeholder advisory body to the Oregon Health Authority (OHA). Per SB 934, the Collaborative is to advise and assist OHA in the implementation of a Primary Care Transformation Initiative (“Initiative”) to:

- Use value-based payment methods that are not paid on a per-claim basis to:
 - Increase the investment in primary care
 - Align primary care reimbursement by all purchasers of care
 - Continue to improve reimbursement methods, including by investing in the social determinants of health
- Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care

SB 934 also includes strategies for the Collaborative to consider that support the implementation of the Primary Care Transformation Initiative:

- Provide technical assistance to clinics and payers in implementing the Initiative
- Aggregate the data from and align the metrics used in the Initiative with the work of the Health Plan Quality Metrics Committee
- Facilitate the integration of primary care behavioral and physical health care.

The Collaborative includes 46 members representing a broad range of provider, payer and other primary care stakeholder perspectives; membership categories are defined in statute. In addition, there are three work groups: Payment Improvement and Alignment, Behavioral Health Integration, and Metrics and Evaluation. There were seven Collaborative meetings and twenty-six work group meetings in 2018.

This report is an update on the progress of the Initiative and represents the Collaborative’s work during the past 12 months. The Collaborative is recommending the Primary Care Transformation Initiative focus on the spread of mechanisms to strengthen Oregon’s primary care system with an emphasis on innovative payment models supported by a statewide infrastructure. The report includes recommendations to the Legislature and Oregon Health Policy Board (OHPB) in the following areas: infrastructure, payment models and implementation.

The Collaborative is convened by the OHA Transformation Center and has been meeting since 2016. The Collaborative will continue to convene through 2027.

Recommendation: statewide infrastructure

The Collaborative recommends strategies to implement the Initiative, as directed by the Oregon Legislature in SB 934. Central to these strategies is a multi-payer primary care payment model that aims to standardize payment methodologies, increase investment in primary care, and reduce administrative burden for payers and providers.

Implementation of these strategies requires a statewide infrastructure to:

- Provide payer and provider technical assistance (TA);
- Monitor participating payers and providers (including through reporting mechanisms and practice eligibility oversight); and
- Oversee and coordinate evaluation of the Initiative.

This infrastructure is foundational for success of the Initiative, and the Collaborative urges the Oregon Legislature to support the implementation of these strategies through the creation of a statewide infrastructure. The infrastructure should be sustainable and equitably financed through a shared utility model by all participants. This infrastructure would build upon the work of the Patient-Centered Primary Care Home (PCPCH) program and the OHA Transformation Center. In addition, it would leverage and avoid duplication of existing TA supports already implemented across the state. The specifications for the infrastructure require further development, but broadly it is intended to:

- Provide TA to practices and payers that supports primary care transformation activities, such as PCPCH recognition, Comprehensive Primary Care Plus (CPC+) milestones, value-based payments, and electronic health record functionality. TA activities should be data-driven; include expertise that is applicable to all populations; and leverage and avoid duplication of existing supports already implemented across the state. TA should be informed by previous learnings in Oregon, evidence-based and emphasize delivery mechanisms identified as effective by providers. It should focus on peer-to-peer, on-the-ground assistance to foster better care, better health, lower costs, and improve the work life of primary care clinicians and teams.
- Provide a common portal for data collection and aggregation to minimize administrative costs and maximize timeliness of reporting and reliability of data. Oregon's Clinical Quality Metrics Registry and the CPC+ data aggregation solution may be leveraged for this purpose in the future. In addition to collecting and aggregating data from providers, data policies and infrastructure should support access to data needed by payers and providers to fully participate in value-based payment arrangements.
- Provide a standardized process for identifying eligible clinics to participate in the value-based payment models.
- Evaluate whether the Initiative achieved its legislatively mandated (SB 934) goals of:

- Increased investment in primary care (without increasing costs to consumers or increasing the total cost of health care);
- Improved reimbursement methods, including by investing in the social determinants of health; and
- Aligned primary care reimbursement by purchasers of care.

Recommendation: payment models

Two complementary payment models are central to the Collaborative’s recommendations for the Initiative. The first is a primary care payment model that expands the CPC+ program, which encourages movement toward paying for value and away from FFS payments. The second is a payment model specifically focused on behavioral and physical health integration in primary care.

Payment model recommendation: primary care

This document outlines a multi-payer primary care payment model for the Initiative that supports the implementation of the Oregon PCPCH model of care and fosters alignment of payment methodologies. The payment model aims to standardize methodologies and reduce administrative burden for payers and providers. Increased investment in primary care is a key component of the Initiative (as mandated by SB 934), but it is not a requirement for implementation of each of the payment model components.

Value-based payments are foundational to this payment model. VBPs are defined as strategies used by payers to promote quality and value of health care services. The goal of VBPs is to shift from pure volume-based payment, as exemplified by FFS payments, to payments that reward providers for “value” of care, including team-based care, asynchronous care, and improvements in quality, utilization and health outcomes.

The Collaborative believes that implementation of this payment model requires a statewide infrastructure to deliver payer and provider support, monitoring, technical assistance and evaluation. This infrastructure would build upon the work of the PCPCH program and the OHA Transformation Center. In addition, it would leverage and avoid duplication of existing technical assistance supports already implemented across the state. This infrastructure is foundational for success and is a priority underlying the Collaborative’s recommendations.

Alignment with Comprehensive Primary Care Plus (CPC+)

This payment model aligns with the Centers for Medicare and Medicaid Services’ (CMS) CPC+ advanced primary care medical home payment model, a five-year demonstration program (2017–2022). Fourteen payers and over 150 primary care clinics participate in CPC+ in Oregon. This proposed payment model extends the CPC+ framework to all payers in Oregon and to non-CPC+ clinics, including pediatric practices, federally qualified health centers and rural health clinics.

The payment model was further informed by the following:

- Collaborative recommendations to the OHPB (December 2016)
- Payer and provider case studies (spring 2017)
- Collaborative and payment work group discussions

- Collaborative Behavioral Health Integration work group proposed payment model
- American Academy of Family Physicians Advanced Primary Care Alternative Payment Model
- Health Care Payment Learning and Action Network (HCP LAN) Primary Care Payment Model Whitepaper (2017)
- *Primary Care Spending in Oregon* reports (February 2016, 2017 and 2018)

Primary Care Payment Model

All health care payers that provide coverage in Oregon will implement an aligned payment model for primary care clinics that meet requirements and expectations (see below). The four components of the payment model are designed to support transformation of primary care that should result in more comprehensive, patient-centered care; accountability for clinical and patient satisfaction outcomes; and interventions that reduce total cost of care. Payers will adopt this payment model across all lines of business to the greatest extent possible.

1. Advanced primary care infrastructure (APCI) payments (per-member, per-month [PMPM] payments)

These are risk-adjusted, population-based PMPM payments that sustainably support a high-functioning primary care system, including key elements such as risk-stratified care management, care coordination, integrated clinical pharmacy, and non-visit-based care.

The monthly PMPM payment supports traditionally non-encounterable or non-billable services. CPC+ defines this payment as: *“non-visit-based payment meant to augment staffing and training in support of population health management and care coordination.”*

Certain populations, including but not limited to pediatrics, geriatrics or socially complex patients, may require a population-appropriate risk adjustment methodology.

The Collaborative proposed a behavioral health integration (BHI) payment model that includes a PMPM for population-based BHI in primary care (see page 30). Those population-based BHI payments would be included in this component of the payment model.

These payments align with HCP LAN category 2A.

2. Performance-based incentive payments

These are payments for performance on priority accountability measures, such as population-based quality metrics and utilization. Incentives should provide sufficient compensation to promote improvement or achievement of benchmarks. The accountability measures will be aligned across payers, be determined by consensus, and align with other statewide measures as appropriate (for example, Health Plan Quality

Metrics measure set, PCPCH Core and Quality measure set for PCPCH Standard 2.A., behavioral health metrics such as those adopted by the Collaborative).

In CPC+, CMS models this payment method on traditional Medicare with a prospective PMPM payment that is recouped from providers if practices do not meet targets. CPC+ payers align with the CMS approach in various ways.

These payments align with HCP LAN category 2C.

3. FFS payments

FFS is the traditional health care payment model for most payers. This model includes payments for standard primary care office visits. It may also pay for value-added, encounterable patient benefits compared to standard primary care, such as mental health, substance use disorders, health behaviors, office procedures and minor surgeries.

Behavioral health services billing codes. The Collaborative has recommended a set of billing codes that support BHI in primary care and other policies regarding health plan contracting structure and BHI access (see page 31).

The Collaborative encourages payers to reduce conversion factors for an aligned, common set of evaluation and management payment codes and replace the reduced FFS amount with comprehensive primary care payments. This shift from FFS payment to partial capitation of primary care payment provides practices with additional flexibility, thus enabling them to transform the delivery of care.

These payments align with HCP LAN category 1.

4. Comprehensive primary care payments (CPCPs) (prospective, up-front payment)

These are prospective, population-based PMPM or lump sum payments calculated from historical FFS payments for a defined set of primary care services. These payments can be used by the clinic to budget for both billable and non-billable work and services.

CPCPs can provide clinics additional flexibility in how they provide care to patients in the practice to better meet their care needs. This should include providing care outside of the traditional office visit, such as telemedicine, e-visits, text messages, community or home visits, or group visits. CPCPs may facilitate contracting innovation around some of the structural and access recommendations of the Collaborative.

CPCP strategies may be used for more advanced PCPCHs, as is the case with CPC+ (that is, Track 2 CPC+ clinics). Therefore, not every clinic may be eligible for this payment type. In Year 1 of the Initiative, the Collaborative will use eligibility criteria to define which clinics are considered sufficiently advanced with an adequate patient population to effectively participate in this component of the payment model.

These payments align with HCP LAN category 4B.

Contracting Entity Accountability

The Collaborative acknowledges that transformation activities require implementation at the individual clinic level while payers and providers contract with health systems, independent practice associations (IPAs) and medical groups. To support consistency in payment methods within contracts and to foster alignment throughout the system, contracting entities are expected to:

- Use incentive payments to support sustainable primary care transformation at the clinic level to support and sustain the PCPCH model of care and to foster better care, better health, lower costs, and improve the work life of primary care clinicians and teams;
- Support all primary care clinics to transition to the PCPCH model of care and to the VBP model components outlined in this document;
- During the transitional period, or when new clinics are added to the contracting entity, contracting entities will uniquely identify practices that are at different levels of participation, or readiness to participate, in the payment model through billing mechanisms (for example, use of National Provider Identifier);
- Ensure transparency in the distribution of VBP payments and incentive payments to the PCPCH (clinic) level; and
- Move toward aligning provider compensation with VBP models. Provider compensation should support advanced primary care (for example, team-based care), include quality factors, and not depend solely on productivity measured by relative value units (for example, face-to-face visits).

Clinic Accountability

The recommendations below focus on transformation and accountability at the clinic level. The Collaborative believes that expanding the model to all clinics would ideally result in more consistency across the health system and, ultimately, support increased accountability for total cost of care.

Participation criteria

All clinics participating in this payment model must meet the following criteria:

- Be recognized as a PCPCH by the OHA; and
- Utilize federally certified electronic health record (HER) technology in the clinic.

Clinics with 1,000 or more patients

Clinics with 1,000 or more total patients calculated across all payers that meet both of the criteria above are required to participate in at least two of the three non-FFS VBP components of the primary care payment model described above.

Clinics with fewer than 1,000 total patients

Clinics with fewer than 1,000 total patients calculated across all payers that meet both criteria above may, but are not required to, participate in any of the non-FFS VBP components of the primary care payment model described above.

The Collaborative will convene payers, providers and health systems to explore implementing mechanisms to combine data and/or services by region or service area to help represent higher patient populations and leverage resources, thus facilitating the use of more advanced components of this payment model for these smaller clinics.

Expectations of participating clinics

To ensure payments support high-value primary care functions and capabilities that will improve quality and total cost of health care, participating clinics are expected to:

- Be willing to contract with a variety of payers that appropriately serve the clinic's patient population and community, including Medicaid coordinated care organizations (CCOs);
- Have the capability to report data for the agreed-upon performance measures (in development) on an ongoing basis through federally certified EHR technology or a shared portal;
- Commit to prioritizing clinic achievement of benchmarks or improvement targets for agreed-upon performance metrics;
- Agree to submit a document forecasting how the clinic plans to spend the APCI, performance-based incentive payments, and CPCP dollars to support advanced primary care in the clinic, and provide a report related to the PCPCH standards and measures that are supported by this initiative;
- Agree to participate in applicable Collaborative technical assistance activities to support the Initiative goals;
- Agree to participate in a Primary Care Transformation Initiative evaluation; and
- Empanel patients to a primary care provider and communicate this information with payers.

Participation timeline

All clinics meeting the criteria and expectations above will be eligible to participate in the payment model within three years of its implementation. To align with the intent of including non-CPC+ eligible clinics in the payment model, the following phase-in schedule is recommended:

- Year 1: Clinics and contracting entities participating in the CPC+ Track 2 advanced primary care program

- Year 2: Track 1 CPC+ clinics and contracting entities; and non-CPC+ clinics designated as federally qualified health centers, rural health clinics, and pediatric clinics, including contracting entities
- Year 3: All other non-CPC+ clinics and contracting entities

This timeline does not preclude payers from phasing in clinics earlier than outlined above. Payers may set member attribution thresholds agreed upon by the Collaborative for certain components of the overall payment model outlined in this document.

Data reporting

Participating clinics will report specific measures to payers and/or the Collaborative.

- SB 934 mandates the Collaborative to align with the work of the Health Plan Quality Metrics Committee; therefore, measures will be informed by the Health Plan Quality Metrics Committee final measure set¹ and other statewide performance measures (for example, CPC+ metrics, PCPCH core and quality measure set for PCPCH standard 2.A., and behavioral health metrics adopted by the Collaborative).
- The agreed-upon measures for the Initiative will be aligned across payers and should leverage measures that are agreed to by CPC+ participants.
- Data for agreed-upon measures should be reported by clinics on an agreed-upon schedule (for example, biannually) and should be used to guide technical assistance activities.
- Agreed-upon measures will be tied to performance-based incentive payments for clinics.
- A goal of the Initiative is to have data collection linked to an EHR or uploaded through a common portal to minimize administrative costs and maximize timeliness of reporting and reliability of data. Oregon’s Clinical Quality Metrics Registry (CQMR) may be leveraged for this purpose in the future.

Payer accountability

To ensure success of the Initiative, all health care payers that provide coverage in Oregon are expected to implement the model; be accountable for shared and equitable VBP investment; implement the model broadly across populations and practice types; and share data.

Specifically, payers are expected to:

- Implement the payment model as outlined in this document and report organizational implementation status/progress to the Collaborative. The information will be included

¹ Health Plan Quality Metrics Committee Draft 2019 Aligned Measures Set
<http://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Meeting%20Documents/DRAFT-2019-Aligned-Measures-Set.pdf>

in the annual legislatively mandated Primary Care Transformation Initiative report to the Oregon Legislature and the Oregon Health Policy Board.

- Support and participate in the aggregation and reporting of data for agreed-upon measures submitted by clinics.
- Align with the attribution principles described in this document.
- Implement, to the greatest extent possible, the payment model to all appropriate product lines in the health plan's business.

Attribution principles

Payers, purchasers, providers and patients will adopt the following principles for patient attribution to ensure more effective VBP-based investment in primary care. The intent of these principles is to foster alignment and transparency on methodology, and to ensure outcome metrics associated with VBPs accurately reflect a clinic's patient population.

1. Payers will adopt policies such as lower patient cost sharing, transformation in benefit design, and educational efforts to encourage patient choice of a primary care provider.
2. Payers, providers and patients will work together to develop and implement strategies to ensure that patients who want to identify their primary care providers can, and this patient choice will be prioritized for attribution, regardless of business line of coverage for those patients.
3. Payers, providers and patients should work collaboratively to ensure accuracy and agreement about patient attribution. Payers will ensure providers have clear and actionable information about patients assigned to them and providers will ensure the accuracy of the claims data they submit that support the attribution process. This information should be shared by payers at least quarterly.
4. Payers will use the same approach for attribution for performance measurement and financial accountability.
5. Payers will prioritize primary care providers and preventive care visits when analyzing claims or encounter data for attribution, and may consider other factors such as geographic location, family selection of primary care provider, and past claims.
6. Payers will use other claims-based evaluation and management visits if patient input cannot be obtained and preventive care visits cannot be used, and link those visits with primary care provider types. At least 24 months of claims-based data should be used, if available.
7. Payers will define which providers would be eligible to take on accountability for patients at the beginning of the performance period, and share this information with providers in advance. Identify clearly who can serve as primary care providers (for example, could recommend all providers in recognized PCPCHs).
8. To support payer alignment and ensure accurate attribution — which allows for proper VBPs being made to a provider or clinic — providers agree to work in good faith with

payers to ensure billing practices allow for submission of complete claims data to payers.²

9. The Collaborative will consider alignment across payers at level of attribution (clinic vs. individual provider).

Improving investment in primary care: VBP categories and target goals

The HCP LAN published an alternative payment model framework with discrete categories intended to reflect the continuum of VBPs (Figure 1). This framework has been widely adopted by national and state organizations to measure VBP use.

The purpose of including targets is to accelerate transformation, increase investment in primary care and its infrastructure, and move toward value and away from a fee-for-service system. At the same time, the Collaborative wants to apply lessons learned over time and needs latitude to adjust targets as well as any associated reporting requirements. The Collaborative also recognizes that practices and payers are at different stages of evolution and wants to provide flexibility, while also imparting a sense of urgency. These considerations and the vision embodied in SB 934 inform the approach outlined below.

The VBP targets align with categories in the HCP LAN framework and include both category-specific targets and targets for all VBPs to primary care combined. The targets are intended to be aspirational but achievable and will be re-evaluated and refined by the Collaborative over time based on experience and evaluation evidence.

The targets and ranges provide flexibility within the HCP LAN framework, while also ensuring increasing investment in primary care transformation through the VBP components of the primary care payment model. The categories and targets were informed by CPC+, the HCP LAN framework and the 2016 Collaborative recommendations to the OHPB.

All health care payers that provide coverage in Oregon will be required to report on progress toward meeting these targets for primary care payments. For years two to four, payers will set and report individual annual improvement targets for the three VBP components of the payment model. Achieving these VBP targets is dependent on payers, purchasers, providers and patients adopting the patient attribution strategies described in the preceding section of this document.

Payers must develop and offer to clinics the components of the payment model that demonstrate their intent to meet the minimum targets in primary care payments and

²Billing practices should consistently utilize the CMS claim form fields and definitions to ensure accurate attribution of members at the participating clinic level. For example, CMS 1500 box 32 should properly reflect the Service Facility Location information to include name, address and National Provider Identifier of the site the services were delivered.

investments aligned with LAN categories “2A” and “2C or higher” (categories are outlined in Table 1 and Figure 1). “Category 2C or higher” includes multiple HCP LAN categories to allow payers flexibility in how they meet the target.

Payers also will report payments aligned with each primary care payment model component separately, even if those dollars are included in a contract with other HCP LAN categories. In early 2019, the Collaborative will develop the specifications for how each target will be calculated. The intent of the targets in Table 2 below is to capture and track over time the penetration of each of the payment model components (via the percent of dollars in each payment model component relative to total payer spending in primary care). The footnotes associated with Table 1 and Table 2 explain the difference between how the targets are calculated.

The Collaborative recommends “Year 1” begin in 2020 and “Year 4” be no later than 2024.

Table 1: Primary care VBP targets out of all primary care spending, by Payer, for HCP LAN Categories 2A and 2C or higher*

	Year 1	Year 2	Year 4
Primary care VBP targets out of all primary care spending, by Payer, for HCP LAN Categories 2A and 2C or higher**	40%	55%	75%

*Includes 3A VBPs with Shared Savings, 3B VBPs with Shared Savings and Downside Risk, and 4A Condition-Specific Population Based Payments. VBPs with downside risk are generally best suited for clinics that can take on more financial risk (that is, large, health system-based clinics). In addition, for the purposes of this table, VBP spending is calculated in accordance with the following guidance from the HCP LAN 2018 Alternative Payment Models Survey (<http://hcp-lan.org/workproducts/APM-survey.pdf>): “Plans should report the total dollars paid, which includes the base payment plus any incentive, such as fee-for-service with a bonus for performance, fee-for-service and savings that were shared with providers, etc.”

Table 2: Primary care VBP targets out of all primary care spending, by payer, by primary care payment model component**

Primary Care Payment Model Component	Year 1	Year 2	Year 4
Fee-For-service (FFS) with no link to quality and value – not a VBP		TBD by payer	25% (max)
Advanced primary care infrastructure (ACPI) payments <ul style="list-style-type: none"> Typically, this investment is through up-front PMPM payments, supporting non-billable team-based care These payments to clinics will not be at risk 	10%	TBD by payer	Target range: greater than 10%-40%
Performance-based incentive payments <ul style="list-style-type: none"> Payments for performance on agreed-upon accountability measures, such as population-based quality metrics and utilization 	5%	TBD by payer	Target range: greater than 5%-10%
Comprehensive primary care payments (CPCP) <ul style="list-style-type: none"> Up-front payments (typically PMPM), based on historical spending in primary care Accompanied by decreased FFS rates 		TBD by payer	Target range: 10-25% or greater

**For the purposes of this table, VBP spending means the ACPI payment, performance-based incentive payment, and/or CPCP only.

New investments in primary care should be VBPs. ACPI payments and performance-based incentive payments may reflect new investments in primary care for payers, as these payment model components are not based on historical FFS payments and support primarily non-billable primary care team activities. CPCP and FFS payments reflect current dollars spent in primary care for all payers, as the CPCP model component is based upon historical FFS spending.

Challenges

Oregon is often on the forefront of health system transformation and is currently leading the nation in primary care payment reform efforts. In recent months, Colorado, California and Delaware have introduced or passed legislation modeled after SB 934 to develop a state primary care payment reform collaborative and track spending on primary care by health plans and other payers. Paving the way is not without challenges, and the Collaborative has identified several potential obstacles to implementing this work:

- There is currently no statewide infrastructure that would support payers and providers participating in the payment model, including a process for identifying eligible clinics that are interested in participating in the payment model. The Collaborative believes finding a way to materially support these efforts is critical.

- Data collection and reporting is arduous for payers and providers as there is no shared portal or EHR solution. Payers participating in CPC+ are working on a shared data aggregation solution through Q Corp/HealthInsight and there may be opportunity to leverage these efforts. In addition, some non-CPC+ payers already participate in the HealthInsight data portal.
- Technical assistance for payers and providers is necessary to implement this payment model. There are few identified financial resources to support technical assistance, and as noted above, finding support for this work is critical. The Collaborative will be discussing options and channels for technical assistance, as required by SB 934.
- Some payers have established VBPs that may conflict with implementing the payment model components outlined in this document. The Collaborative acknowledges the challenge of developing a payment model that is flexible but also adheres to the legislative intent of SB 934.
- There is concern that some practices in Oregon may not be ready and/or willing to adopt the most advanced payment methodologies, which will have implications for achieving the targets.
- Alignment of accountability metrics across payers is a challenge due to variability in payer business practices and priorities.
- CPC+ is an evolving primary care payment model, and the Collaborative should maintain the flexibility to modify the payment model to best meet the needs of Oregonians. In addition, because CPC+ is focused on the adult population, there may be limited capacity to consider the differences of how value-based payments impact pediatric populations.
- Efforts should be made to align this work with CPC+ milestones, both in terms of content and by considering how to potentially utilize a “milestone approach” to guide clinic performance and maturation over time.
- SB 934 requires payers with health plans in Oregon to increase their health care expenditures allocated to primary care, but it does not address reducing health care expenditures in other areas (for example, specialists, hospitals, pharmaceuticals) to offset the increase.
- Some payers and providers disagree with the methodology used to determine primary care expenditures in the *Primary Care Spending in Oregon* report. This methodology is primarily defined in statute and cannot be changed without legislative action.
- Implementing health plan contracting structure changes is complex and would need to be implemented over time.

- Figure 1: HCP LAN APM Framework





Alternative Payment Models

THE APM FRAMEWORK



Health Care Payment Learning & Action Network

This Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations.

			
CATEGORY 1 FEE FOR SERVICE - NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE - LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION - BASED PAYMENT
	A	A	A
	Foundational Payments for Infrastructure & Operations <small>(e.g., care coordination fees and payments for HIT investments)</small>	APMs with Shared Savings <small>(e.g., shared savings with upside risk only)</small>	Condition-Specific Population-Based Payment <small>(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</small>
	B	B	B
	Pay for Reporting <small>(e.g., bonuses for reporting data or penalties for not reporting data)</small>	APMs with Shared Savings and Downside Risk <small>(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</small>	Comprehensive Population-Based Payment <small>(e.g., global budgets or full/percent of premium payments)</small>
	C		C
	Pay-for-Performance <small>(e.g., bonuses for quality performance)</small>		Integrated Finance & Delivery Systems <small>(e.g., global budgets or full/percent of premium payments in integrated systems)</small>
		3N	4N
		Risk Based Payments NOT Linked to Quality	Capitated Payments NOT Linked to Quality

Payment Model Recommendation: Primary Care Behavioral Health Integration

In December 2016, the Collaborative presented the following recommendations to the OHPB:

Payers should develop value-based primary care payment models that support primary care behavioral health integration to improve health for all populations. The Collaborative should identify, elevate, and remove system and regulatory barriers for integration at the payer level through payment reform. Billing/coding assistance and technical assistance on successful integration strategies should be available to providers to ensure payment for primary care behavioral health integration.

The Collaborative recommends that mental health and substance use carve-outs that impact behavioral health services be invisible to service recipients and providers and not impact access to, delivery of, and payment for care. If this is not possible, the Oregon Health Authority (OHA) should evaluate the elimination of carve-outs.

These recommendations informed legislation enacted in 2017 ([Senate Bill 934](#)) requiring the Collaborative to advise and assist OHA in the implementation of a Primary Care Transformation Initiative. The legislation requires the Collaborative to “*facilitate the integration of primary care behavioral and physical health care*” as part of the Initiative.

Over the past two years, the Collaborative has identified specific finance and payment barriers to integration, including:

- Contracting structures that may result in restricted access to services; double co-payments and confusion for patients and families; and administrative burden for providers (for example, the delegation or “carve-out” of the total behavioral health services benefit to a separate organization);
- Inconsistent benefit coverage across payers;
- Provision of and lack of coverage for preventive behavioral health; and
- Variation in how primary care practices provide integrated behavioral health care, and a lack of standard accountability measures.

This document is a proposed solution to address these identified barriers. Its focus is on licensed behavioral health clinicians and primary care providers practicing in an integrated primary care clinic. The Collaborative is focused on primary care transformation and reimbursement. Specialty care and inpatient hospital services are not within the scope, except to the extent to which these topics impact the goals of the Initiative.

Payment model to support primary care and behavioral health integration

The three recommendations below comprise a payment model that supports primary care and behavioral health integration. The payment model seeks to address finance and payment barriers through fostering alignment of payment and performance methodologies.

Payers and providers will adopt all three components as an implementation strategy for the Primary Care Transformation Initiative.

- **Health plan contracting structure**

Payers, providers and other contracting entities (such as independent practice associations) should work together to develop contractual mechanisms with integrated primary care clinics where all services delivered at the clinic are included in the same contract with the health plan. Primary care providers and behavioral health clinicians at the same clinic should be included in the same contract and network and undergo the same credentialing process. The Collaborative acknowledges the challenges of changing contracting structures and therefore recommends the following timeline:

- Year 1: Develop a plan to modify contracting structure. The Collaborative will rely on lessons learned from Year 1 to develop a structure for Years 2 and 3.
- Year 2: Report on progress toward implementation of modified contracting structure
- Year 3: Implement modified contracting structure

- **Improved access to integrated behavioral health care for patients**

Payers should remove pre-authorization requirements for behavioral health services delivered in an integrated primary care clinic, as with other primary care services. This aligns with federal parity requirements.

Payers should remove double co-pays for patients who see a primary care provider and behavioral health clinician on the same day.

Payers should remove policies that reject two payments for services provided on the same day by a primary care provider and behavioral health clinician.

- **Sustainable payment approach**

Payers should provide population-based payments to integrated primary care clinics that meet at least one of the following set of standards:

- Patient-Centered Primary Care Home Measure 3.C.3 (Figure 2)
- Integrated Behavioral Health Alliance (IBHA) Recommended Minimum Standards for PCPCHs Providing Integrated Health Care (Figure 3)

Population-based payments should sustainably support key elements of behavioral health integration in primary care that are not typically paid for under FFS mechanisms, such as same-day brief consultations; preventive behavioral health; warm hand-offs between the primary care provider and the behavioral health clinician; behavioral

health clinician participation in pre-visit planning and team huddles; consultations between primary care and behavioral health clinicians; and care coordination and communication, especially outside the primary care clinic, including with specialists, schools, teachers, community services, etc.

An example of a population-based payment is a risk-adjusted PMPM payment based either on level of behavioral health integration (for example, PCPCH measure 3.C.3 and IBHA standards) or on meeting benchmarks for population penetration, access, quality, patient experience, or other outcomes.

The Collaborative's primary care payment model includes two different components with PMPM payments (see page 18). Population-based PMPM payments to support behavioral health integration could be included in either of these two components of the payment model.

In addition to population-based (PMPM) payments, payers should reimburse primary care providers and behavioral health clinicians working in a clinic with integrated health care for an agreed-upon set of fee-for-service (FFS) codes (Figure 4) with no pre-authorization requirements. Payers are encouraged to adopt a broad interpretation of which providers can bill for these codes within the scope of practice defined by provider licensing boards. The set of billing codes could be included in the FFS or CPCP component of the primary care payment model recommended by the Collaborative (see page 18). The codes will be reviewed by the Collaborative annually.

The different payment mechanisms described above can support various members of the integrated health care team, who can provide behavioral health services in ways that meet the unique needs of populations in clinics and communities across Oregon. The Collaborative recognizes that the FFS vs. PMPM payment ratio for behavioral health will likely change over time and Collaborative participants will work together to learn and spread best practices as behavioral health integration payment models are implemented.

FIGURE 2

Source: Oregon Health Authority Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide

<http://www.oregon.gov/oha/HPA/CSI-PCPCH/Documents/TA-Guide.pdf>

CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE

Standard 3.C – Behavioral Health Services

Measure 3.C.3 - PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.

3.C.3 Specifications

Clinics meeting 3.C.3 must have an on-site licensed behavioral health provider (MD, PhD, PsyD, PMHNP, LCSW, LPC, LMFT) trained to work in a primary care¹ setting delivering a broad array of comprehensive evidence-based behavioral health services for mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks and conditions, stress-related physical symptoms, preventive care, and ineffective patterns of health care utilization.

On-site behavioral health services should be available for enough hours each week to adequately address the needs of the clinic's patient population and meet the specifications for 3.C.3 described below.

In clinics meeting 3.C.3 a behavioral health provider is available for same-day open access services include warm hand-offs, brief assessments and interventions for patients and families, consultations to primary care clinicians and other care team members, and participation in pre-visit planning and daily huddles.

At clinics meeting 3.C.3 physical and behavioral health providers use the same medical record system and participate in collaborative treatment planning and co-management via case conferences, consults, pre-visit planning and/or daily huddles.

PCPCH utilizes universal behavioral health screening, care coordination, and panel management to monitor the behavioral health needs and outcomes of the PCPCH patient population. PCPCH utilizes written protocols for referrals to appropriate specialist(s) and hospitalization if clinically indicated.

PCPCH identifies the psychiatric care needs of their population, determines viable psychiatric consultation strategies and provider options, and develops a care model that includes these services.

Note: Clinics may use telehealth services that align with standards set by the American Telemedicine Association to meet this measure.

<http://thesource.americantelemed.org/resources/telemedicine-practice-guidelines>.

¹ Core Competencies for Behavioral Health Providers Working in Primary Care. <http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf>

FIGURE 3

**Integrated Behavioral Health Alliance
Recommended Minimum Standards for Patient-Centered Primary Care Homes (PCPCH) Providing Integrated Health Care IBHA concepts developed by expert consensus—November 2015**

Minimum Standard*	Specifications
Integrated behavioral health services are provided as part of routine care at the PCPCH including licensed Behavioral Health Clinician(s) (BHC) delivering an array of services onsite. BHC as defined in ORS 414.025.	BHC(s) provides care at the PCPCH with a ratio of 1 FTE BHC for every 6 FTE of Primary Care Clinicians (PCC). For example, a practice with 4 FTE PCC would need to have .67 FTE of a BHC (approximately 26.5 hours/week). For rural practices with behavioral health clinician shortages, integrated services may be provided virtually as long as other standards are met.
Integrated BHC provides a broad array of comprehensive evidence-based behavioral health services.	BHC services should be applicable to the PCPCH patient population served, including care for: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks and conditions, stress-related physical symptoms, preventive care, and ineffective patterns of health care utilization per ORS 414.025.
Integrated BHC provides same-day open access behavioral health services.	Same-day open access services include warm hand-offs, brief assessments and interventions for patient and families, consultations to primary care clinicians and other care team members, and participation in pre-visit planning and daily huddles. Same-day open access services are provided in real-time at the point of care when behavioral health issues are identified at the PCPCH. On average, at least half of the BHC’s hours at the practice each week must be available for same- day open access services.
Primary care clinicians, staff, and BHC utilize shared medical records and have a mechanism in place for collaborative care planning and co-management of patients.	Primary care clinicians, staff, and BHC document clinically relevant patient information in the same medical record system and participate in collaborative treatment planning and co-management via case conference consults, pre-visit planning and/or daily huddles.
BHC is an integrated part of the primary care team.	Primary care clinicians, staff, and BHC utilize shared physical space and the BHC participates in practice activities such as team meetings, daily huddles, pre-visit planning, and quality improvement projects.
PCPCH utilizes a population-based approach to delivering and coordinating integrated behavioral health services.	PCPCH utilizes universal behavioral health screening, care coordination, and panel management to monitor the behavioral health needs and outcomes of the PCPCH patient population. PCPCH utilizes written protocols for referrals to appropriate specialist(s) and hospitalization if clinically indicated.
The integrated team includes psychiatric consultative resources.	PCPCH identifies the psychiatric care needs of their population, determines viable psychiatric consultation strategies and provider options, and develops a care model that includes these services.

* Adapted from AHRQ *Professional Practices in Behavioral Health and Primary Care Integration* 2015 <http://integrationacademy.ahrq.gov/>

FIGURE 4
Fee-for-Service billing codes to support integrated health clinics*

Codes	Description	Examples
Health and behavior codes, including, but not limited to: 96150–96154	Assessment/intervention of diagnosed medical conditions referred by medical providers.	Diabetes, hypertension, obesity, asthma, chronic pain, developmental delay, disruptive behavior in early childhood, sleep and eating problems, neuropsychiatric symptoms related to major neurocognitive disorder with behavior disturbance (dementia).
Preventive medicine counseling codes, including, but not limited to: 99401–99404; 99411–99412	Assessment and intervention of subclinical biopsychosocial concerns for the purpose of reducing risk factors and promoting behavior change.	Family problem, divorce, child behavior problem, attachment issues, child self-regulation, adjustment to loss of functioning after a CVA/MI or other medical change, grief issues commonly seen in older adults.
Care management of psychological, behavioral, emotional, and social concerns including, but not limited to: 99492–99494; 99484	BH care management codes created specifically to support integrated behavioral health.	Facilitating patients to addiction services, contact with a teacher or coordinating special education services with the school. Facilitating referral to child mental health provider.
Alcohol and/or substance use including, but not limited to: 99406–99407 (Medicare G0397); 99408–99409 (Medicare G0396)	Screening and brief interventions for substance use concerns.	Tobacco, alcohol or other drug use.
Behavioral health screening and health risk assessment including, but not limited to: 96110; 96127; 96160–96161	Screening and risk assessments for behavioral health concerns.	Brief emotional/behavioral assessment, child social-emotional and behavioral health screening tools, developmental screenings, suicide risk assessment, depression, postpartum depression screenings, and substance use disorders screenings.

<p>Psychiatric diagnostic evaluation and psychological testing including, but not limited to: 90791; (96101; 96103)¹</p>	<p>Diagnostic procedures to differentiate and diagnose DSM-5 conditions.</p>	<p>Major depressive disorder, PTSD, schizophrenia, etc. Psychodiagnostic assessment of emotionality, intellectual abilities, personality, psychopathology, major neurocognitive disorder, minor neurocognitive disorder, and substance use disorders.</p>
<p>Psychotherapy including, but not limited to: 90839; 90832; 90834; 90837; 90840; 90846–90847; 90849; 90853; 90875</p>	<p>Psychotherapy for diagnosed DSM-5 mental health diagnoses, including individual and group therapy, and psychotherapy in crisis situations.</p>	<p>Major depressive disorder, generalized anxiety disorder, schizophrenia, oppositional defiant disorder, attention deficit hyperactivity disorder, parent management training such as parent child interaction therapy, child and parent psychotherapy, psychotherapy plus medication management for moderate to severe psychiatric or neuropsychiatric illness, and substance use disorders.</p>

*These codes are intended to support continued transformation for integrated health clinics without being overly proscriptive. This list should be consistent with the most current CPT codes, which change over time.¹ The use of these codes must align with claims and regulatory requirements. Further, it should be noted that some codes on this list require a pairing with a medical diagnosis code. The Primary Care Payment Reform Collaborative will review this list annually and make recommendations for revisions.

¹ In 2019, CPT codes 96101 and 96103 will expand into a larger set of new codes. The American Psychological Association descriptions for the 2019 codes can be found at <https://www.apapracticecentral.org/reimbursement/testing-codes/codes-descriptions.pdf>

Reporting requirements

Clinics receiving enhanced payment for providing integrated care should report behavioral health integration measures to CCOs and commercial health plans and/or the Collaborative. The Collaborative recommends payers and providers consider alignment with the measures proposed by the Integrated Behavioral Health Alliance.³

Challenges

Oregon is often on the forefront of health system transformation and is currently leading the nation in primary care payment reform efforts. Paving the way is not without challenges, and the Collaborative has identified several potential obstacles to implementing this work.

- Implementing the health plan contracting structure changes and eliminating double copays as proposed in this document are often complex and may need to be implemented over time.
- Collaborative members acknowledge that some behavioral health services, such as psychological testing, may still require pre-authorization.
- Health and behavior billing codes require a companion medical condition diagnosis code. Pediatric patients often do not have a medical condition diagnosis code; therefore, these codes cannot be fully utilized by this population for the intended use under an integrated behavioral health setting.
- When moving from strictly FFS payments to value-based payments for behavioral health, such as population-based PMPM payments, it will be important to establish clarity around which services/codes are paid via FFS, and which are supported through population-based payments. This is a technical assistance need for payers and clinics.
- Behavioral health provider credentialing varies by payer, and in some cases it does not align with the statutory definition of behavioral health clinician used in Oregon. For example, some health plans, such as Medicare Standard, do not reimburse for billable services provided by a licensed professional counselor or licensed marriage and family therapist credential.
- Some independent practice associations may not yet represent behavioral health clinicians, and therefore would not be able to include these providers in their contracts with payers.

Recommendations are informed by the following:

- Collaborative recommendations to the OHPB (December 2016)

³ See the measures here <http://www.pcpci.org/sites/default/files/IBHA%20Measures%20Document%202018.final%20draft.pdf>.

- Payer and provider case studies (spring 2017)
- Collaborative and BHI work group discussions
- Collaborative Payment Improvement and Alignment Work Group proposed payment model
- Oregon Revised Statute (ORS) [414.025](#)
- PacificSource pilot project on alternate payment models to support BHI (OHA funded)
- CareOregon Integrated Behavioral Health in Primary Care Sustainability Funding program
- Survey results from Collaborative payer members about behavioral health billing code alignment
- Melek et al. (2018) *Potential economic impact of integrated medical-behavioral healthcare*.

Recommendation: Implementation

Over the last decade, Oregon's health system transformation has been a multi-stakeholder effort. The successful implementation of the Primary Care Transformation Initiative strategies rely on a similar approach and require collaboration, partnership and commitment.

The Collaborative is recommending the spread of mechanisms to support primary care transformation, with an emphasis on innovative payment models supported by a statewide infrastructure. This effort requires support and coordination. Outlined below are the requests the Collaborative makes of each stakeholder to ensure progress.

Oregon Legislature

- Support the development of a statewide infrastructure with sustainable funding so stakeholders can successfully implement and evaluate the Initiative. This infrastructure is foundational for success, and the Collaborative urges the Oregon Legislature to consider this a priority for implementation of these recommendations.
- Facilitate the establishment of a structure and framework to support the spread of aligned value-based payments in primary care, while avoiding codifying details of the Collaborative's payment model recommendations that could impede flexibility to learn from and build on work underway.
- Amend Section 4(3) and Section 7 of SB 934 (2017) to include all payers in Oregon, not just those participating in a national primary care medical home payment model (CPC+).⁴

All health care payers that provide coverage in Oregon

- Adopt, implement and report on all the payment model strategies outlined in this report.
- In the spirit of transparency and to foster alignment, share pay-for-performance value-based payment model structures in a public reporting process. This would not include detailed information that could put payers at risk of violating anti-trust law.

⁴ SECTION 4 (3) A coordinated care organization that participates in a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a, that includes performance-based incentive payments for primary care, shall offer similar alternative payment methodologies to all patient centered primary care homes identified in accordance with ORS 413.259 that serve members of the coordinated care organization.

SECTION 7. An insurer offering a health benefit plan, as defined in ORS 743B.005, that reimburses the costs of services provided by a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a, that includes performance-based incentive payments for primary care, shall offer similar alternative payment methodologies to reimburse the costs of services provided by patient centered primary care homes identified in accordance with ORS 413.259 that serve beneficiaries of the health benefit plan.

All primary care providers in Oregon

- Adopt, implement and report on the payment model strategies outlined in this report, including participation in value-based payment models with the payers with which their clinic contracts, now or in the future.
- Apply for and maintain clinic PCPCH recognition from OHA.

All contracting entities in Oregon (*defined as a health system, medical group, or other provider organization that provides medical services through one or more clinics or facilities which are grouped together for payer contracting purposes.*)

- Support all primary care clinics to transition to the PCPCH model of care and to the VBP model components outlined in this document.

Oregon Health Authority

- Continue to serve as convener of the Collaborative with dedicated resources.
- Align agency value-based payment policies to support the work of the Collaborative, and participate in the implementation of the Initiative.
- Collaborate with the Department of Consumer and Business Services to develop a report on progress of Initiative strategies.
- Support necessary infrastructure to facilitate success (see Infrastructure recommendation).
- Ensure PCPCH recognition criteria align with and support the Initiative strategies.
- Consider how to improve the PCPCH behavioral health integration standard (in partnership with the PCPCH Standards Advisory Committee) and how to best communicate clinic-level behavioral integration information with payers.

Department of Consumer and Business Services

- Align agency value-based payment policies to support the work of the Collaborative, and participate in the implementation of the Initiative.
- Collaborate with OHA to develop a report on progress of Initiative strategies.

Next steps for 2019

Looking ahead to 2019, there are several key areas of focus for the Collaborative.

Metrics: Measure set scope and intent

Scope

The Metrics Sub-workgroup of the Collaborative started working in 2018 to identify a set of measures for the Initiative and will resume this work in early 2019. These measures will be included in the performance-based incentive payment component of the primary care payment model and as part of the overall evaluation of the Initiative. The measure set will be informed by and aligned with other statewide metric sets such as the Health Plan and Quality Metrics (HPQM) set, CPC+ measures and PCPCH Measure 2.A core and menu metrics. The work group is not developing new measures.

Intent

The measures are intended to be part of the foundational infrastructure necessary to support the implementation of the Initiative strategies. This infrastructure should support a standardized method for clinics to report the measure data, such as a common portal for data collection and aggregation to minimize administrative costs and maximize timeliness of reporting and reliability of data.

To foster alignment and reduce administrative burden, this measure set is intended to be a menu from which payers and providers should collaborate to select clinic-reported measures for performance-based incentive payments.

The measures will evaluate both quality and utilization, incentivizing payers and providers. The measures will be categorized into six domains of health care services, which align with the HPQM domains. These include:

1. Prevention/early detection
2. Chronic disease and special health needs
3. Acute, episodic and procedural care
4. System integration and transformation
5. Patient access and experience
6. Cost/efficiency

Future work

The Metrics and Evaluation Work Group will finalize the measure set and develop detailed recommendations on specifications, benchmarks, improvement targets and risk adjustments for each measure. These recommendations will then be shared with the Collaborative to obtain member support. Technical specifications will align with HPQM, National Quality Forum, HEDIS,

PCPCH program or other applicable sources. These recommendations will be presented to the Collaborative in 2019 for further input.

The Metrics and Evaluation Work Group (or comparable technical advisory group) will convene annually to review and make recommendations about revisions to the measure set. Recommended revisions will be informed by the Initiative evaluation, payer and provider feedback and the legislative requirements of the Initiative.

Other focus areas

Implementation of recommendations

In 2019 the Collaborative will develop strategies to implement the recommendations in this report. A new charter will reflect this focus.

Collaborative membership

Although Collaborative member engagement is strong, OHA will explore options to improve and enhance participation for members (for example, establishing a leadership steering committee). We will convene additional work groups to focus on rural and small practices, technical assistance and other areas significant to implementation of the recommendations.

Initiative evaluation

Oregon Health & Sciences University Center for Health Systems Effectiveness (CHSE) is developing options for the Collaborative's consideration to evaluate the Initiative.

CHSE's proposal will inform Oregon's capacity to evaluate the goals of the Initiative, as directed by the legislature (see page 14).

Collaborate with stakeholders

The Collaborative will continue to seek opportunities to build upon and leverage health system transformation efforts across Oregon through alignment with other stakeholders.

Collaborative members

- Carolyn Anderson, Clinical Quality Director, Mountain View Medical Center
- Dean Andretta, Chief Financial Officer, WVP Health Authority
- Gary Ashby, Health Insurance Specialist, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
- Helen Bellanca, Assistant Medical Director, Health Share of Oregon
- Tara Bergeron, Quality Improvement Specialist, Tuality Health Alliance
- Beth Black, Employee Benefit Consultant, Hagan Hamilton Insurance Solutions
- Bill Bouska, Director of Community Solutions and Government Affairs, Samaritan Health Plans, InterCommunity Health Network CCO
- Meg Bowen, Quality Director, Winding Waters Clinic
- Will Brake, Chief Operating Officer, AllCare Health
- Joy Conklin, Vice President of Practice Advocacy, Oregon Medical Association
- Dawn Creach, Health Care Consultant, Creach Consulting, LLC
- Larlene Dunsmuir, Assistant Executive Director for Professional Services, Oregon Nurses Association
- Bill Dwyer, Director of Analytics, Moda Health and Eastern Oregon CCO
- Eleanor Escafi, Assistant Director of Strategy and Execution, Network Management/Provider Partnership Innovation, Regence BlueCross BlueShield of Oregon & Cambia Health Solutions
- Randy Evans, Project Manager, Provider Networking Contracting & Provider Relations, Health Net Health Plan of Oregon Inc. and Trillium Community Health Plan
- Scott Fields, Chief Medical Officer/Chief Informatics Officer, OCHIN
- Kaye Flores, Director, Provider Network, Umpqua Health Alliance
- Ali Hassoun, Director, Public Employees' Benefit Board and Oregon Educators Benefit Board
- Robin Henderson, Chief Executive of Behavioral Health, Providence Medical Group
- Celia Higuera, Warriors of Wellness Project Manager, Oregon Community Health Workers Association
- Juliana Huff, Director of Business Intelligence, Willamette Valley Community Health
- Dale Jarvis, Principal, Dale Jarvis and Associates, LLC
- Jennifer Johnstun, Director of Health Strategy, PrimaryHealth
- Mary Kjemperud, Director of Network and Clinical Support, Jackson Care Connect and CareOregon
- Doug Lincoln, Pediatrician, Metropolitan Pediatrics
- Lynnea Lindsey, Director of Behavioral Health Services, Legacy Health
- Barbara Martin, Director of Primary Care, Central City Concern
- Ben Messner, Chief Operating Officer, Advanced Health
- Justin Montoya, Medical Director of Commercial Programs, PacificSource Health Plans
- David Norelius, Finance & Analytics Manager, Yamhill Community Care Organization
- Liz Powers, Physician, Winding Waters Clinic
- Colleen Reuland, Director, Oregon Pediatric Improvement Partnership
- Glenn Rodriguez, Physician, Oregon Academy of Family Physicians
- Deborah Rumsey, Executive Director, Children's Health Alliance
- Divya Sharma, Medical Director, Central Oregon Independent Practice Association

- Christa Shively, Senior Director of Quality and Medical Integration, Providence Health Plans
- Christi Siedlecki, Chief Executive Officer, Grants Pass Clinic
- Laura Sisulak, Strategic Advisor and Special Projects Director, Oregon Primary Care Association
- Colleen Smith, Senior Manager of Client Services, Mental Health, Family Health, Network and Housing Services, Willamette Family, Inc.
- Mindy Stadtlander, Executive Director of Medicaid and Network Services, Columbia Pacific CCO and CareOregon
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Glossary of Terms

Alternative payment model (APM): A payment structure that is not fee-for-service payment.

Behavioral health clinician: As defined in amended ORS 414.025, (a) a licensed psychiatrist; (b) a licensed psychologist; (c) a certified nurse practitioner with a specialty in psychiatric mental health; (d) a licensed clinical social worker; (e) a licensed professional counselor or licensed marriage and family therapist; (f) a certified clinical social work associate; (g) an intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or (h) any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

Behavioral Health Collaborative: A statewide multi-stakeholder effort to create a coordinated, seamless health care system that treats each individual as a whole person and not a collection of problems and diagnoses.

Comprehensive Primary Care Plus (CPC+): A five-year multi-payer advanced medical home model launched by the Centers for Medicare and Medicaid Services offering an innovative payment structure to improve health care quality and delivery. In Oregon, fourteen payers and over 150 primary care clinics are participating. CPC+ milestones can be found in the CPC Payer Partner Roadmap document: <https://www.milbank.org/wp-content/uploads/2016/11/CPC-Payer-Partner-Roadmap-final.pdf>

Contracting entity: A health system, medical group, or other provider organization that provides medical services through one or more clinics or facilities that are grouped together for payer contracting purposes.

Electronic health record (EHR), certified: An electronic health record that stores data in a structured format allowing health care providers to easily retrieve and transfer patient information and use the EHR in ways that can aid patient care. A certified EHR has been approved by the Centers for Medicare & Medicaid Services for use in promoting interoperability programs. <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html>.

Health Plan Quality Metrics Committee: Governor-appointed committee created in 2015 (Senate Bill 440) to identify health outcome and quality measures that may be applied to services provided by coordinated care organizations or paid for by health benefit plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board.

Integrated health care: As defined in amended ORS 414.025, means care provided to individuals and their families in a Patient-Centered Primary Care Home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following: mental illness; substance

use disorders; health behaviors that contribute to chronic illness; life stressors and crises; developmental risks and conditions; stress-related physical symptoms; preventive care; and/or ineffective patterns of health care utilization.

Patient-Centered Primary Care Home (PCPCH) Program: Oregon’s medical home program with over 650 participating primary care practices.

Payer: Any carrier that sells health insurance in Oregon.

Primary care provider: A physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in Oregon, whose clinical practice is in primary care.

Primary Care Spending in Oregon Report: A report for the Legislature about health care expenditures allocated to primary care by CCOs and prominent health plans. It should be noted the legislative definition of primary care used in this report — which is defined in statute — does not fully capture behavioral health integration as described in the Collaborative’s proposed payment model to support primary care behavioral health integration.

Socially complex patients: *Patients experiencing a set of co-occurring individual, family or community characteristics that can have a direct impact on health outcomes or an indirect impact by affecting a person’s access to care and/or a family’s ability to engage in recommended medical and mental health treatments.* Definition based on work of The Center of Excellence on Quality of Care Measures for Children with Complex Needs.

Triple aim: Developed by the National Institute for Healthcare Improvement, the triple aim framework serves as the foundation for organizations and communities to successfully navigate the transition from a focus on health care to optimizing health for individuals and populations. The goals are to simultaneously improve the health of the population, enhance the experience and outcomes of the patient, and reduce per capita cost of care for the benefit of communities. The quadruple aim includes the addition of improving the work life of primary care clinicians and teams.

Value-based payment (VPB): A payment structure that is not based on fee-for-services and rewards services associated with quality and cost-effectiveness rather than volume of services.