Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

May 16, 2024 BCC Agenda Date/Item: ___________

Board of County Commissioners
Clackamas County

Approval of a Revenue Intergovernmental agreement with Oregon Health Authority for participation in the Alternative Payment Methodology and Advanced Care Model (APCM) Program. Estimated total value is $9,600,000 for 2 years. Funding is through Oregon Health Authority. No County General Funds are involved.

Previous Board Action/Review	Previous Agreement Approved, A1 – December 17, 2020 Briefed at Issues – May 14, 2024		
Performance Clackamas	1. Individuals and families in need are healthy and safe. 2. Ensure safe, healthy and secure communities.		
Counsel Review	Yes	**Procurement Review**	No
Contact Person	Sarah Jacobson	**Contact Phone**	503-742-5303

EXECUTIVE SUMMARY: Oregon's Alternative Payment Methodology and Advanced Care Model (APCM) program is available for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The intent of the APCM program is to align payment for participating health centers with high quality, efficient provision of patient-centered health care to incentivize high-value services over a volume of visits. The Health Centers Division is eligible for payment for assigned Medicaid members, billing per member per month at the Beavercreek, Sunnyside, Gladstone, Sandy, Lake Road and School Based Health clinics.

RECOMMENDATION: The staff respectfully recommends that the Board of County Commissioners approve this agreement and authorize Chair Smith to sign on behalf of Clackamas County.

Respectfully submitted,

Rodney A. Cook

Rodney A. Cook
Director of Health, Housing & Human Services

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PARTICIPATION AGREEMENT

OREGON'S ALTERNATIVE PAYMENT METHODOLOGY AND ADVANCED CARE MODEL (APCM) PROGRAM

Parties:

_______________________________________ ("Health Center")

Oregon Health Authority ("OHA" or the "Authority")

January 1, 2024 ("Effective Date")

This Participation Agreement ("Agreement") describes the terms of participation in Oregon's Alternative Payment Methodology and Advanced Care Model ("APCM") program ("Program" or "APCM Program") for Federally Qualified Health Centers ("FQHCs") and Rural Health Clinics ("RHCs") and the respective obligations of the FQHCs and RHCs and Oregon Health Authority (OHA). The FQHCs and RHCs are sometimes referred to collectively as the "Health Centers". The program parameters are guided by the Oregon State Plan Amendment ("SPA") Transmittal # 12-08, Attachment 4.19-B; Methods and Standards for Establishing Payment Rates: Alternate Payment Methodology, approved on 9/12/12 by CMS and Oregon Administrative Rule (OAR) 410-147-0360, attached as **Exhibit 1**).

The intent of the APCM program is to align payment for participating health centers with high quality, efficient provision of patient-centered health care to incentivize high-value services over a volume of visits. The parties understand that the program is intended to incent a significant transition in patient-centered care and that it will likely result in a reduction in traditional, billable patient visits. At the same time, the program will likely result in an increase in non-billable engagement with the patient known as Care STEPs (Services that Engage Patients). Further, both parties agree to work together to address unanticipated challenges and concerns on the part of either party to reach mutually acceptable solutions.

ATTACHMENTS

This Agreement includes and incorporates the following:

Attachment A Oregon APCM Program Accountability Plan

Attachment A-1 Oregon APCM Accountability Plan Risk Guidelines

Attachment A-2 Patient Experience Reporting for APCM

Attachment B APCM Rate Methodology Worksheet

Attachment C APCM Care STEPs

Attachment D Reconciliation Template

Attachment E Attribution Policy

Attachment F APCM Exclusion Agreement for Wrap Cap Reimbursement

Attachment G Change-in-Scope Methodology for APCM

Exhibit 1 Oregon State Plan Amendment Transmittal #122-08, Attachment 4-19-B: Methods and Standards for Establishing Payment Rates: Alternative Payment Methodology

Exhibit 2 Oregon Administrative Rules 410-120-0000, 410-147-0120, 410-147-0140

Exhibit 3 Eligible Patient Flow-Chart (illustration)

AGREEMENT

Section 1. Definitions. Capitalized terms used in this Agreement have the following meanings unless the context requires otherwise.

"3131 Patient List" means the comma delimited spreadsheet (.csv) by which new APCM enrollments are identified and uploaded to OHA through the MMIS Provider Web Portal, sent as frequently as determined by health center.

"820 Report" means the weekly report, in standard Electronic Data Interchange (EDI) format approved by the Accredited Standards Committee (ASC) X12, received by health center from OHA that outlines all charges and payments for health center's APCM-enrolled patients.

"OHP" means one of the following Oregon Health Plan benefit packages: (1) BMH: OHP Plus (excluding those with the following PERC codes: CC, CD, CE, CF, CG, CH, CI, CJ, CK, CL, CM, CN, CO, CP, CQ, CR, H6, H7, H9, HH, HI, HJ, HK, HN, HO, HP, HQ, HR, HS, HT, HU, HV, HX, HY, and HZ); (2) BMM: Qualified Medicare Beneficiary and OHP with Limited Drug; (3) BMD: OHP with Limited Drug; and (4) CWX: Prenatal Expansion for Citizenship Waived Medical (CWM) clients, and (5) any other OHP benefit package that OHA may create that results in a PMPM Payment.

"APCM Establishing Visit" means a face-to-face interaction with the patient (including a traditional office visit, home visit, group visit, virtual, or telemedicine visit) that includes, at minimum, a medical history, problem list review, and medication and allergy review or any other medical encounter as defined in OAR 410-147-0120 that constitutes a carved-in APCM service. In the case of a virtual or telemedicine visit, the visit must be a "synchronous (live two-way interactive) video transmission resulting in real time communication." Telemedicine visits must be in accordance with OAR 410-120-1990. An establishing visit shall be provided by a Health Care Professional acting within the scope of his/her practice, certification, or licensure as defined in OAR 410-120-0000 (102) (**Exhibit 2**). To accurately track and report visits that are non-billable, Health Center must document such visits in the medical record and include them in their next quarterly Care STEPs report sent to OHA; or be able to produce and report them to OHA within 30 calendar days, upon a request from OHA. APCM establishing visits must be provided in compliance with OAR 410-147-0140 (6) and (7) (**Exhibit 2**), which prohibits Health Centers from "unbundling" services that are normally rendered during a single visit to generate multiple encounters.

"APCM Enrollment Change Report" has the meaning given in Section 5(D).

"APCM Enrollment Report" means the report sent to the Health Center by OHA to confirm initial enrollment (e.g., the Day-One List) in the health center's APCM program and provided after each additional patient list upload by Health Center.

"Advanced Care Learning Community" has the meaning given in Section 3(A).

"APCM Program" has the meaning given in paragraph 1 of this Agreement.

"APCM Steering Committee" has the meaning given in Section 3(A).

"Care STEPs" means the activities described in **Attachment C**.

"Change-in-Scope" has the meaning given in Section 4(A1).

"Day-One List" has the meaning given Section 5(A).

"Disqualifying Visit" has the meaning given in Section 5(E)(6)(a).

"Eligible Patient" has the meaning given in Section 5(B).

"Eligible PMPM Patient" has the meaning given in Section 5(C).

"Engagement Period" has the meaning given in Section 5(C).

"ER Utilization" means per patient utilization rates of the emergency room.

"FQHC" means a federally qualified health center.

"Health Care Professional" means an individual defined in OAR 410-120-0000(100).

"Health Center" means a FQHC or RHC that is an APCM program participant and party to this Agreement.

"Leaked Patient" has the meaning given in Section 5(E)(6)(a).

"Non-Engaged Closure Report" has the meaning given in Section 5(D)(5).

"Non-Engaged Patient" has the meaning given in Section 5(E)(4).

"OPCA" means the Oregon Primary Care Association.

"PDR" means the patient data report, a monthly report received by health center from OHA, which includes (among other individuals) the list of patients currently receiving the PMPM payment.

"PIP" or "Performance Improvement Plan" has the meaning given in Section 7.

"PMPM" means per-member-per-month and refers to the payments for APCM-enrolled patients.

"PPS" means Prospective Payment System.

"Primary Care Visit" means a visit in which a patient receives carved-in APCM services (e.g., non-obstetrical medical visit), which may or may not constitute an APCM establishing visit. If the provider is eligible for PPS payments, a primary care visit would result in a PPS payment.

"RHC" means a rural health clinic.

"Term" has the meaning given in Section 2(A).

"Total Cost of Care" is described in **Attachment A, Cost.**

Section 2. Term and Termination.

A. Term. The term of this Agreement shall align with CCO 2.0 and last four years (the "term") commencing January 1st, 2021 and ending December 31st, 2025 The Agreement may be terminated prior to the end of the term as described in Sections B and C. Upon expiration of the term, or earlier termination, Health Center shall be entitled to payment under the APCM program for all services satisfactorily rendered through the termination date.

B. Termination by the Health Center. Health Center may terminate this Agreement upon 30 days prior written notice to OHA.

Termination by the Authority. OHA may terminate this Agreement if Health Center fails to meet the expectations of a Performance Improvement Plan, as described in Section 7, or upon 30 days prior written notice to the health center if OHA determines that health center or health center staff, affiliates, or subcontractors commit actions that could result in a mandatory or discretionary sanction by OHA, as outlined in OAR 410-120-1400(3) and (4).

Section 3. Program Participation and Accountability.

A. Minimum Participation Requirements. Health Center agrees to (a) include all Health Center sites and all its eligible patients in the APCM program, (b) to maintain sufficient capacity to meet all its reporting requirements described in this Agreement, and (c) to participate in the Advanced Care Learning Community. The "Advanced Care Learning Community" is comprised of OPCA and health centers who meet several times per year and discuss care model transformation. The "APCM Steering Committee" consists of leadership and staff from

APCM health centers who volunteer to make collective decisions. In addition, the APCM Steering Committee and OPCA provide guidance, leadership, and strategic counsel to OHA on policy issues and practice transformation strategies impacting the program.

B. Accountability for Program Participation. By participating in the APCM program, Health Center agrees to the requirements outlined in the APCM program accountability plan, **Attachment A**. The accountability plan reflects the mutual agreement of health center, OHA, and OPCA on program requirements with respect to quality, access, cost and utilization, and population health equity. In order to track and review Health Center participation, the Health Centers agree to produce and submit quarterly data to OPCA and OHA in accordance with **Attachment A**. No Health Center shall transmit any personally identifying information, personal health information, or other information subject to HIPAA or the HITECH Act to OPCA in complying with this Section 3(B) or otherwise.

C. APCM Program Development. The APCM Steering Committee, in partnership with OHA and OPCA, will have the opportunity to further develop APCM program methodology, consider programmatic expansion, and evaluate program effectiveness. Program changes identified or recommended by the APCM Steering Committee or other Health Center will not amend or alter the program or this agreement unless agreed to in writing by OHA. In addition, a Health Center has the option to work directly with OHA regarding unique circumstances that may warrant an exception to program methodology. OHA will respond to Health Center in writing within 90 days indicating the result of the Health Center's proposal and rationale behind the decision, if applicable. A Health Center may appeal the decision in accordance with OAR 410-120-1560.

D. OPCA Role and Notice. OHA and participating health centers acknowledge that OPCA is involved in the APCM program to help maintain programmatic consistency, identify issues with and improve implementation of program objectives, avoid unintended consequences, and support the APCM Steering Committee. The APCM Steering Committee and Health Centers agree to work collectively with OHA and OPCA to address unintended consequences of program implementation, adjusting details of this Agreement as needed.

Section 4. APCM Program Rates and Payment.

A. APCM Rate Calculation. Health Center, with the help of OPCA, will work with OHA to complete a financial and patient member month analysis to compute Health Center's APCM rates in accordance with the methodology outlined in **Attachment B**. There will be a "wrap-cap" APCM rate paid for all OHP patients assigned to Coordinated Care Organizations (CCOs), as well as an "open-card" rate paid for fee-for-service (FFS) patients for whom OHA would historically pay the full Prospective Payment System (PPS) rate directly to the Health Center.

A1. APCM Rate Adjustment. The APCM rates, once established, will be adjusted annually by the Medicare Economic Index (MEI) in compliance with Federal statute governing the PPS. When a participating Health Center that is already on the APCM has a PPS change-in-scope, approved by the Authority in accordance with OAR 410-147-0362 (Change in Scope of Services), the Authority shall initiate a corresponding rate change to the Health Center's APCM rates to be effective the same date as the PPS rate change. The methodology is outlined in detail in **Attachment G**. There is nothing in this Agreement intended to prevent a health center from pursuing a change in scope of services as described in OAR 410-147-0362.

B. Payment Methodology. The Authority agrees to pay Health Center its PMPM payments each month. OHA shall pay a prorated daily PMPM amount for individuals added or deleted from Health Center's APCM program during a given month.

C. Included and Excluded Services. The APCM rates are PMPM rates paid to a Health Center for patients established through a primary care visit, as defined in a Health Center's established PPS rate calculation. School Based Health Center (SBHC) patients and services are also included in the program and payment calculations. Behavioral health, dental, and obstetrical services (prenatal and deliveries) are excluded initially from the APCM rate and program. However, as described in Section 3(C), health centers may work through the APCM Steering Committee on feasibility and methodologies for including these initially excluded (carved-out) services in the future. See **Attachment F** for included and excluded service codes.

D. Open Card. Open-card patients also referred to as FFS patients are included in the APCM program, and a unique Open-card rate is established.

E. Quarterly and Annual Reconciliation with Annual Adjustment. Health Center will complete the quarterly reconciliation comparing revenue earned under the APCM program with revenue it would have earned under traditional PPS, in accordance with the SPA guidance, **Attachment D**, and OARs 410-147-0360 and 410-147-0460. This reconciliation is intended to assure that the APCM revenue is at least as much as the PPS payments would have provided for the same time period. OHA will complete an annual payment reconciliation for the calendar year of Health Center's program participation where quarterly reports show APCM payments at a lesser amount than what PPS would have provided. A participating Health Center is not required to return dollars in excess of PPS payments, as determined by the calculation; however, a Health Center will be reimbursed on or before December 31st of the subsequent calendar year by OHA for any amount below the PPS payment level based on the annual payment reconciliation completed by OHA. Health Centers are required to report all payments of amounts reflected on an Explanation of Benefits (EOB) and payments received for the provision of health services to OHP members, including capitation and any and all payments received by the Health Center from private insurance or any other coverage, including, but not limited to: Medicare MCO supplemental payments; Medicare Advantage Managed Care Organizations (MCO); any third-party resource (TPR); and total payments for all services submitted to the CCOs including laboratory, radiology, nuclear medicine, and diagnostic ultrasound and excluding any bonus or incentive payments.

Section 5. APCM Program Eligible Patients.

A. Day-One List. Health Center shall prepare and upload a "Day-One" patient list, which is the list of patients for which the Health Center is eligible to be reimbursed an APCM rate effective the first month of Health Center's participation in the APCM program (the "Day-One List") if the patients are eligible for the Oregon Health Plan and not enrolled with a separate participating Health Center. Health center uploads their Day-One List through the MMIS Provider Web Portal.

B. Eligible Patient. An eligible patient is an OHP member with an OHP Plus benefit plan (indicated in MMIS as BMH, BMM, BMD, and CWX benefit plans), excluding the Cover All Kids (CAK) population (listed in MMIS with OHP Plus, but identified with the following PERC codes: CK; CL; CM; CN; CO; CP; or CR) and the Healthier Oregon (HOP) population (listed in MMIS with OHP Plus, but identified with the following PERC codes: CC, CD, CE, CF, CG, CH, CI, CJ, CQ, H6, H7, H9, HH, HI, HJ, HK, HN, HO, HP, HQ, HR, HS, HT, HU, HV, HX, HY, and HZ). Qualified Medicare Beneficiaries (QMB) and Citizenship Waived Medical (CWM) members are not eligible patients.

In order to be an eligible patient included on the Day-One list, or confirmed thereafter on the APCM Enrollment Report and added to health center's APCM program (each "eligible patient"), a patient must:

1. Have a valid OHP ID number; and
2. Have been provided a face-to-face medical encounter (office visit) in the prior 18 months at the Health Center (or, in the period following the creation of the Day-One List, have been provided an APCM establishing visit within a 12-month look back period). Health Centers are prohibited from using an 18-month look back for an APCM establishing visit after the "Day-One" patient list is loaded through the MMIS Provider Web Portal.
3. After the Day-One List, Health Center shall use a 12-month look back for an APCM establishing visit.
4. Be attributed to Health Center after adjusting for attribution and leakage (e.g., patients overlapping with other FQHCs, RHCs, or primary care providers). See "Leakage", Section 5(E)(6) below.
5. Leaked patients, as described in Section 5(E)(6) below, may only be re-enrolled into Health Center's APCM program as an eligible patient after the final leakage date of service indicated on the APCM Enrollment Change Report, and effective the date that Health Center provides a face-to-face visit, as described in Section 5(B)(2).

C. Patient Engagement. An eligible patient, as defined in Section 5(B),who is included on Health Center's APCM Enrollment Report as successfully enrolled remains an eligible patient for which Health Center receives a PMPM payment (an "Eligible PMPM Patient") so long as: (a) the patient maintains OHP coverage as an "eligible patient" as defined in Section 5(B), (b) the Health Center provides the patient with at least one visit or Care STEP every

eight quarters (such eight-quarter period referred to as the "Engagement Period"), and (c) patient has not become a "Leaked Patient", as defined in Section 5(E)(6)(a) below.

D. OHA Reports. OHA will provide the following reports to a participating Health Center until such time that OHA notifies Health Center in writing that a particular report will no longer be provided:

1. A monthly Patient Data Report (PDR) which includes, among other data, the list of patients currently APCM-enrolled with the Health Center.
2. An APCM "Enrollment Report" following OHA's receipt of the Day-One List and each subsequent list of eligible patients thereafter showing the result of the 3131 Patient List upload and reason codes for individual patient enrollment or lack of enrollment;
3. An 820 report, which lists all the charges and payment details for Health Center's APCM-enrolled patients. Health Centers that contract with an EHR vendor received these reports from their EHR contractor. OHA has limited ability to produce alternative payment reports to the system generated 820report.. These alternative payment reports do not contain all the information needed for the reconciliation process.
4. A monthly APCM "Enrollment Change Report," which indicates patients who were served by other primary care providers in a 6-month look back period (as outlined in Section 5(E)(6)(b)),
5. A quarterly "Non-Engaged Closure Report" (NECR) notifying Health Center of closing enrollments due to lack of engagement in the prior eight quarters from the last quarterly Care STEPs report submitted.

All enrollment closures will be documented on an APCM Enrollment Change Report (ECR) or a Non-Engaged Closure Report (NECR) and provided to a Health Center prior to being finalized.

E. PMPM Payment Stops; Adding and Removing Patients.

1. Adding Patients. After the date of the Day-One List, a Health Center may add new patients to its APCM program by uploading a completed 3131 Patient List to the MMIS Provider Web Portal. Patients may be added via the 3131 Patient List after the Health Center has provided the patient with an APCM establishing visit (which includes a billable medical encounter). New patients become eligible patients for PMPM if they obtain OHP, as defined in Section 5(B), and are APCM-enrolled in the MMIS within 12 months of receiving the APCM establishing visit (which includes a billable medical encounter) and are attributed to the Health Center. New eligible PMPM patients will be confirmed by OHA on the APCM Enrollment Report and added to the Health Center's PDR.

2. Losing or Obtaining OHP Coverage. Patients who have been provided with an APCM establishing visit (which includes a billable medical encounter) in the last 12 months at the Health Center, but who were previously not covered by OHP, may be added to the APCM patient list report (3131 Patient List) effective the date of the APCM establishing visit. Once on the APCM patient list, PMPM payments will begin on the first day the patient obtains OHP and only be issued for timeframes that the APCM-enrolled patient qualifies as an eligible patient (e.g., has OHP coverage, as defined in Section 5(B)).

3. List Management. Health Center shall maintain changes to its APCM patient list, which includes but is not limited to removing people who the Health Center knows have died, moved out of area, are no longer eligible patients, as defined in Section 5(B), or who have been dismissed by the Health Center.

4. Non-Engaged Patient. An eligible patient must receive at least one visit or Care STEP during each engagement period (eight quarters). If an otherwise eligible PMPM patient does not receive at least one visit or Care STEP during an engagement period, the PMPM payment with respect to such patient will stop as of the day after the end of the eighth quarter. After a patient is dis-enrolled through the Non-Engaged Closure Report (NECR), the Health Center must provide an APCM establishing visit to re-enroll a patient in the APCM program. OHA will only run the NECR for eligible PMPM patients each quarter. Patients who are not covered by OHP will not be included in the NECR. The non-engaged patient removal process is outlined in **Attachment E.**

5. Appeals Request. OHA will consider an "Appeals Request" for non-engaged closures when the Health Center provides evidence that an establishing visit, office visit, or Care STEP occurred within the prior eight quarters, as outlined in **Attachment E**.

6. Leakage.

a) A "Leaked Patient" is a patient who is included in Health Center's APCM program but whose APCM enrollment ends due to the patient receiving a "Disqualifying Visit." A disqualifying visit is one primary care visit by another Oregon Medicaid enrolled provider that qualifies for PPS payments or at least two primary care visits by another provider that does not qualify for PPS payments. PMPM payments to a Health Center will stop with respect to a leaked patient, as of the date of the earliest disqualifying visit, for each of the two scenarios.

b) Each month, OHA runs a claims algorithm that looks back six months at all primary care claims billed for APCM-enrolled patients to identify leaked patients and provide Health Center with notice of disenrollment due to leakage. This is the monthly APCM Enrollment Change Report (ECR). The ECR includes the leaked patient's recipient ID, APCM start date and new end date (that will be input to stop PMPM payments effective the day before the disqualifying visit), date of service of the disqualifying visit, and leakage type (e.g. FQHC, RHC, tribal organization or other). OHA shall recoup from the Health Center any PMPM payments received on account of leaked patients after the disenrollment date. PMPM payment adjustments will be indicated on the Health Center's 820 Report. OHA shall collect such repayments from future payments to Health Center. This reattribution process is outlined in **Attachment E.**

c) Health Center may only add a leaked patient back onto its APCM patient list as a newly eligible patient in accordance with subsection B above, but in no event shall the restart date be sooner than the "Final Leakage DOS" on the APCM ECR.

d) OHA shall not make any enrollment changes to Health Center's APCM program for the first three months of Health Center's participation in the APCM program.

e) Health Center may request a review of an enrollment change due to leakage to indicate that the disqualifying visit was the result of Health Center's referral to the other primary care provider or the visit relates to a specialty service. Such review requests must be made within 30 days of the date that the triggering APCM Enrollment Change Report was sent, be in an excel format, and include the following information:
   i. Recipient ID of the referred patient;
   ii. Service or condition that caused referral;
   iii. Provider's specialty or type that saw the referred patient; and
   iv. Name of provider/organization that saw the referred patient.

   OHA will notify Health Center of its decision on reconsideration within 60 days of the request.

Section 6. Quality.

A. Health Center agrees to report CCO measures for the Health Center's APCM eligible OHP patients. Failure to submit the list of required measures and improvement targets by the agreed upon deadline may trigger a Performance Improvement Plan (PIP) as described in Section 7. (See **Attachment A** for the full list of required measures and improvement target values.)

B. The CCO aggregate performance average (CCO average), when available, will serve as the target value for each quality metric. OPCA will communicate and update target values each July to reflect annual averages in the prior calendar year, which are published annually in OHA's CCO Metrics Report (CCO Metrics on Oregon.gov).

C. If a participating Health Center does not meet the CCO averages as described in **Attachment A** and **Attachment A-1**, as applicable (as may be amended from time to time), OHA and Health Center, with the assistance of OPCA in Health Center's discretion, will agree on a Performance Improvement Plan, as described in Section 7.

D. Health Centers must also report their performance on two Patient Experience measures as described in **Attachment A** and **Attachment A-2**.

Section 7. APCM Accountability Plan Risk Guidelines

A. If Health Center does not meet CCO averages as required, OHA and Health Center agree to begin a Performance Improvement Plan (PIP). Health centers are encouraged, though not required, to inform OPCA of the activation of a PIP.

B. The PIP will require the selection of focus measures for improvement, which will be selected through a collaborative process between the involved parties. Targets for improvement are also selected via a collaborative discussion between OHA and Health Center. The “Minnesota Method” will be utilized to establish target values.

C. The PIP may include process requirements such as documentation of clinic QI process and analysis of patient complexity to identify barriers to improvement. If a Health Center enters a PIP, it will have an additional four quarters to meet improvement targets set therein. If a Health Center does not meet the minimum requirements for access or quality improvement as agreed to under a PIP, then the Health Center will be at risk for a PMPM rate reduction or, in some cases, termination from the APCM program as described in **Attachment A** and **Attachment A-1**.

This Agreement may only be amended by a writing identified as an amendment and signed by both parties on signature lines intended for that purpose. An exchange of emails or other informal communication will not act to amend the terms and conditions of this Agreement. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. This Agreement (together with Attachments and Exhibits) constitutes the entire agreement and understanding between the parties with respect to its subject matter and supersedes any prior agreement or understanding. This Agreement shall be effective as of the Effective Date.

Health Center Signature

By: ______________________________ Date: ____________________
Name:
Title:

Oregon Health Authority Signature

By: Rusha Grinstead Date: 4/24/2024
Name: Rusha Grinstead
Title: Health Policy and Program Manager

Attachment A: Oregon APCM Accountability Plan

Oregon APCM Program Accountability Plan

Early in the APCM program, the state of Oregon, OPCA, and the three pilot Health Centers agreed on the following aims and shared goals as the overarching vision for APCM.

Aim of the APCM Initiative as articulated by OPCA: To align payment with an efficient, effective, and emerging care model that lowers overall costs while improving quality, access, and health equity for all.

Shared Goals: State Medicaid and the OPCA met on June 26, 2014 and confirmed the following shared goals for the APCM initiative.

- Progress toward achieving OHA's Triple Aim: Better health, better care, lower costs
- Ability to demonstrate that the APM and APCM initiatives have had a positive impact
- Budget neutrality as defined by the same amount paid to the Health Center per active patient, per year, compared to the rate setting year
- Ability to clarify the new care model(s) needed in Health Centers
- Positive feedback from key stakeholders
- A basis to justify continuation of the APCM
- Ideally, this and all health reform initiatives will be looked at for their impact on global costs

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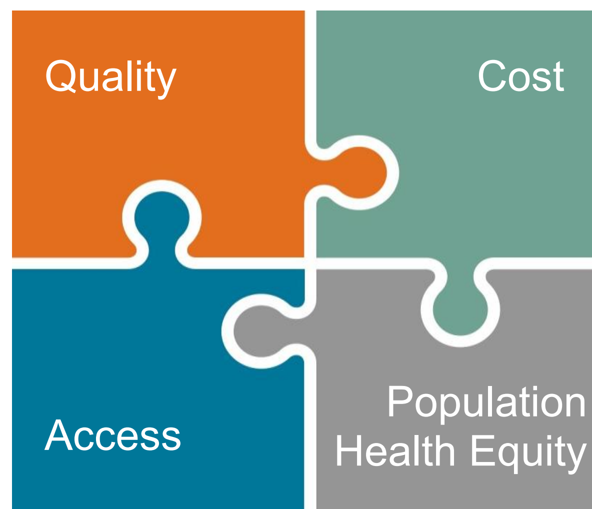
Metrics and Accountability Strategy

OHA, OPCA and all then-participating Health Centers met on April 18th, 2017 and agreed to an accountability plan entailing an explicit measurement strategy that frames Health Centers' accountability to OHA for APCM program participation. By agreeing to participate in the APCM program, the Health Center agrees to submit data to OHA and OPCA and participate in the required process workgroups that advance operationalization of developmental reporting requirements. The APCM Accountability Plan components are represented as the following 'four quadrant' framework:



Population Health Equity

1. Health Centers will engage in segmentation, which is a process where Health Centers identify a population and use a tool to learn more about bio—psychosocial needs.

Cost

1. OHA, OPCA, and Health Centers agree that defining and tracking total cost and utilization is an important and complex effort of the program. Currently, total cost and utilization data is not consistently available to participating Health Centers.

2. OHA, OPCA and Health Centers will agree to a process to clearly define what data should be tracked under the cost and utilization quadrant, including Emergency Room (ER) utilization.

3. OHA, OPCA, and Health Centers will work collaboratively to identify ways to access this data for CHCs to include Total Cost of Care and an ER Utilization metric, among others. Until there is an agreed-upon definition of Total Cost of Care, health center will not be required to positively influence Total Cost of Care or be held to metrics related thereto.

Access

1. Health Centers may use visits and/or Care STEPs, using any member of the care team, to keep a patient active in the APCM program. The APCM Care STEPs, as approved by OHA, are set forth in **Attachment C**.

   OHA will remove patients from the APCM program and will stop issuing PMPM payments for removed patients when and as described in the Agreement.

Quality

1. Metrics are decided upon by OHA in collaboration with the OPCA-APCM Steering Committee. Metrics are aligned with the Uniform Data System (UDS) and Oregon CCO measures. Health Centers report the following required CCO measures for Medicaid patients at the Health Center. The benchmarks will be the UDS or CCO averages for the previous calendar year. The reports, entitled “CCO Final Performance Report” can be found on OHA’s Office of Health Analytics website https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx.

Quality Metrics
Depression and Follow-Up Plan
SBIRT (the combined rate)
Diabetes Hemoglobin A1C Poor Control (>9.0)
Social Determinants of Health (SDoH)
Hypertension Blood Pressure Control

   CCO and quality metrics will be assessed and used as described in Section 7 of the Agreement.

2. Report two Patient Experience measures as outlined in **Attachment A-2**.

Performance Improvement Plan Guidelines

A. Health Center is expected to meet CCO averages on at least three of five metrics over four consecutive quarters. In cases where there are only four metrics with benchmarks, a Health Center must meet at least two of four metrics over four consecutive quarters. Failure to do so may result in a Performance Improvement Plan, as described in Section 7 of the Agreement.

B. Accountability Consequences

   - State Medicaid, the OPCA, and then participating Health Centers met on April 18, 2017 and committed to aligning APCM accountability with a trajectory towards Value-Based Pay (VBP) in Oregon. The following

details are actions and consequences that OHA will use if a Health Center does not meet the minimum requirements for access or quality improvement as agreed to under a Performance Improvement Plan.

C. Access consequences

- The APCM Leadership Committee (replaced by the APCM Steering Committee in 2020) convened in 2018 to review the impact of the eight-quarter cut-off rule and develop a recommendation for OHA and OPCA to address outstanding access concerns and measure transformation investment.

D. Quality consequences

- OHA may reduce the rates of a participating Health Center if it fails to meet expectations of a Performance Improvement Plan after four consecutive quarters. In some cases, OHA reserves the right to remove Health Centers from the program.

- The timeline for a four-quarter quality measure review period started on January 1st, 2019 (Q1 2019) for existing APCM Health Centers. Starting with Phase 6, a Health Center that is new to the APCM program will have a one-year (four-quarter) lag between its APCM Program start date and its first quarter of quality metrics review period.

Attachment A-1: Oregon's APCM Accountability Plan Risk Proposal
June 2018

Framework and Process for the Risk Model:

Together with clinics and the Oregon Health Authority, OPCA convened to discuss the idea of attaching accountability for outcomes, first by articulating a shared list of guideposts for the agreement, including the following:

- We are seeking meaningful accountability and to avoid the ultimate consequence of termination from the program. However, the state must be able to take concrete consequences to their leadership.
- The state requires that the proposal must remain revenue neutral. They have no additional dollars for upside risk arrangements.
- The solution should protect against constrained access and poor-quality performance, but also include a process that can drive improvement.
- The solution should include accountability for access and quality. However, accountability for each should be separate. In other words, penalties for poor quality should not be tied back to billed visits.
- The agreement should be cautious about tying financial accountability to outcomes in the absence of adequate risk adjustment for patient complexity.

With these guideposts in place, we agreed to target accountability for quality metrics, and to consider tying financial consequences for poor performance. To honor the premise that we wanted the process to drive quality improvement, we agreed to a phased approach to assessing penalties for poor quality performance. The following represents the framework and process for our risk model.

- TRIGGER PERIOD: Clinics report quality measures quarterly as outlined in the Accountability Plan. If a clinic does not meet established targets on at least three out of five measures over four consecutive quarters, they will trigger the next phase: the Performance Improvement Plan (PIP) period.

- PIP PERIOD: Health Centers and OHA will negotiate a PIP for the next four quarters, which includes expectations for improvement. Both parties agree to use the CCO methodology for setting improvement targets and tracking performance for measures that fall below the statewide average. The CCO methodology is based on the Minnesota Department of Health's Quality Incentive Payment System and is outlined under OHA's Improvement Targets Brief.

- ACCOUNTABILITY (or penalty) PERIOD: If the health Center has failed to meet expectations outlined in the PIP agreement over the course of four quarters, they will enter the accountability, or penalty period. During this period, the clinic will be penalized with a rate reduction spanning between 2% and 3.5% of their PMPM rates to the state, depending on how many targets are missed. If the clinic's margin between PPS equivalency and their APM payments is less than the penalty, the margin will be the maximum penalty so that the clinic is not paid less than PPS equivalency. Following is the penalty calculation.

APCM Revenue 'Rate Reductions' during Accountability Periods

Measures NOT MET	% Payment reduction
2 or less	0.0%
3	2.0%
4	2.75%
5	3.5%

A Health Center remains in the accountability or penalty period until they sustain four consecutive quarters of performance where they meet or exceed the CCO or UDS average on at least three measures each quarter.

- PROBATION PERIOD: Once the Health Center sustains four quarters of meeting or exceeding the CCO average, they are off the penalty period, and they then return to the trigger period.

Attachment A-2: Patient Experience Reporting for APCM

The Oregon Health Authority (OHA) wants to ensure patients remain satisfied with their care from Health Centers participating in the APCM program. To establish a sight line into patients' experiences, OHA is requiring APCM Health Centers to report Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to OHA as part of the Quality Quadrant of the APCM Accountability Plan. The details for doing so are below.

- **How:** Health Centers will use the combined 'Quality Quadrant' template provided by OPCA. This template will contain multiple tabs, with one of them designated for Patient Experience data.
- **What**: Two questions will be included on the Patient Experience tab of the template. Both required questions (below) are taken from the CAHPS Adult 3.0 survey and will reflect the results for the Health Center's entire patient population. The two questions are considered 'report only' and are not held to a performance standard.
  - CAHPS Q6 under the Access Domain: In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?
  - CAHPS Q18 under the Care Domain: Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?
- **When:** Health Centers are expected to report new data on an annual basis, at a minimum.

Ideally, data collection methods will eventually be standardized across the APCM program, so that the results are comparable to each other. In the meantime, Health Centers are expected to make a good faith effort and to continue working with OPCA and OHA to come into alignment around the data collection methods used, frequency of surveying, and the lookback period for CAHPS Q6.

If CCO requirements change, either party may re-open this agreement to re-establish alignment.

Attachment B: APCM Rate Methodology Worksheet

CHC Revenue Request Template

Wrap Cap Data Request Template - Insert Health Center Name
For 12 Month Period: Insert Rate Setting Period

	MCO Payments	Wrap & Reconciliation Payments	Total Payments	Visits	*Effective Rates per Visits*
Payments for Managed Care Patients			$ -		#DIV/0!
Less OB payments			$ -		#DIV/0!
Less dental payments			$ -		#DIV/0!
Less mental health payments					#DIV/0!
Less Cover All Kids					
subtotal	$ -	$ -	$ -	0.00	#DIV/0!
Less services not included in PPS rate	$ -	$ -	$ -	-	-
Total Applicable Payments For MCO Patients	-	-	-	-	#DIV/0!

		Patients	Visits	*Visits Per Patient*
1	Total			#DIV/0!
2	Less Dental Only			#DIV/0!
3	Less Mental Health Only			#DIV/0!
4	Less OB Only			#DIV/0!
5	Less Dental/Mental Health/OB Only			#DIV/0!
6	Less Full Year Open Card			#DIV/0!
7	Less Dental/Mental Health/OB Only Open Card			#DIV/0!
8	Less Partial Year Open Card Patients			#DIV/0!
	Less Cover All Kids			0
	Medicaid Managed Care For APM	-	-	#DIV/0!
	PPS RATE			
	Effective Date			

	State Payments	Total Payments	Visits	*Effective Rates per Visits*
Payments for Open Card Patients				#DIV/0!
Less OB payments				#DIV/0!
Less dental payments				#DIV/0!
Less mental health payments				#DIV/0!
Less Cover All Kids				
subtotal	$ -	$ -	$ -	#DIV/0!
Less CAWEM (does not include CAWEM+)	$ -	$ -		
Less MED (Qualified Medicare Beneficiaries)				
Less OEW payments associated with applicable visits		$ -		
Less services not included in PPS rate	$ -	$ -	-	
subtotal	$ -	$ -	-	#DIV/0!
Total Applicable Payments for Open Card Patients	-	-	-	#DIV/0!

For OPCA to Fill Out	**Amount Paid**	**Valid Claims Total**	**Revenue Per Visit**
State Claims File - Open Card Data (Medical Only) for (INSERT Rate Setting Period)			

Member Month Methodology Template

	Patients		Member Months	***Analysis*** *Ave MMs*	*Patients Proportions*	*MM Proportions*
Total Patients				#DIV/0!		
Total Managed Care Patients			-		#DIV/0!	#DIV/0!
Total Full Year Open Card Patients			-		#DIV/0!	#DIV/0!
Less Dental Only Patients			-			#DIV/0!
Less Mental Health Only Patients			-			#DIV/0!
Less OB Only Patients			-			#DIV/0!
Less Combo Dental, MH, OB Only Patients			-			#DIV/0!
Total Non-Medical for Managed Care and Open Card			-			#DIV/0!
Used Other FQHC					#DIV/0!	#DIV/0!
Used Non FQHC					#DIV/0!	#DIV/0!
Used BOTH Other FQHC, Non FQHC					#DIV/0!	#DIV/0!
Care Providers for Managed Care and Open Card		0	0		#DIV/0!	#DIV/0!
Total Managed Care	-		-	#DIV/0!		
Less Dental Only Patients						
Less Mental Health Only Patients						
Less OB Only Patients						
Less Combo Dental, MH, OB Only Patients						
Total Non-Medical Patients for Managed Care	-		-			
Used Other FQHC		-	-			
Used Non FQHC		-	-			
Used BOTH Other FQHC, Non FQHC		-	-			
Total Patients Utilizing Other Primary Care Providers for Managed Care		-	-			
Applicable to Wrap Cap (Managed Care)	-		-			
Total Full Year Open Card				#DIV/0!		
Less Dental Only						
Less OB Only						
Less MH Only						
Less Combo Dental, MH, OB Only						
Full Year Open Card Total Non-Medical	-		-			
Used Other FQHC						
Used Non FQHC						
Used BOTH Other FQHC, Non FQHC						
Total Patients Utilizing Other Primary Care Providers for Open Card		-	-			
Full Year Open Card Member Months	-		-	#DIV/0!		
Total Partial Year Open Card				#DIV/0!		
Less Dental Only						
Less OB Only						
Less MH Only						
Less Combo Dental, MH, OB Only						
Partial Year Open Card Total Non-Medical		-	-			
Partial Year Open Card Member Months		-	-	#DIV/0!		
Managed Care Member Months	-		-	*Used for Proposed Wrap Cap*		
Full Year Open Card Member Months	-		-			
Partial Year Open Card Member Months		-	-			
Open Card Member Months	-		-	*Used for Open Card Rate*		

APCM Rates Template

(Insert Health Center Name)		
Calculation of FQHC APM Rates		
(Insert Rate Setting Period)		
	Current MCO Only	APM
Total For Wrap Cap Calculation		$ -
Total Member Months	-	-
Proposed Wrap Cap		*#DIV/0!*
Trended for MEI to 7/1/2020 (1.8%)		***#DIV/0!***
Open Card Applicable Revenue		$ -
Open Card Applicable Member Months		-
Proposed Open Card Rate		#DIV/0!
Trended for MEI to 7/1/2020 (1.8%)		**#DIV/0!**

APCM Care STEPs Report

***Care** and **S**ervices **T**hat **E**ngage **P**atients*

In the Alternative Payment Methodology and Advanced Care Model (APCM) program, collaboratively developed by the Oregon Health Authority, Oregon Primary Care Association and participating Oregon Federally Qualified Health Centers and Rural Health Centers, patient access to health care is no longer defined only by the traditional face-to-face office visit.

The goal of the Care STEPs documentation system is to demonstrate the range of ways in which Health Center teams are providing access to services and value to patients. Care STEPs data are collected and submitted quarterly so OHA can better understand the non-billable and non-visit-based care and services being delivered as the Patient-Centered Primary Care Home (PCPCH) model advances under APCM.

A Care STEP is a specific direct interaction between Health Center staff and the patient, the patient's family, or the patient's authorized representative(s) through in-person, digital, group visits, or telephonic means. There are currently 18 Care STEPs, grouped into four categories: 1) New Visit Types, 2) Education, Wellness and Health Promotion, 3) Coordination and Integration, and 4) Reducing Barriers to Health. The definitions and guidance on when to document each Care STEP is provided below.

If more than one Care STEP is conducted during a single interaction with a patient, document all Care STEPs that correspond with the services provided to the patient. For example, a nurse is conducting gaps in care outreach to patients with diabetes who are due for an HbA1c test. The nurse initiates a telephone call with the patient and discusses the patient's gaps in care. The patient would like to come to the clinic to complete the lab test but does not have the money for bus fare. The nurse helps to arrange transportation for the patient. During this call, the nurse asks the patient about their top concerns in managing their diabetes and the patient discloses sometimes running out of money to buy groceries. The nurse creates a referral for the patient to the local food pantry and creates a plan to follow up with the patient the following week to see if the patient was able to access the local food resource services. In this call, the nurse should document the completion of three Care STEPs: 1) Gaps in Care Outreach, 2) Transportation Assistance, and 3) Accessing Community Resource/Services.

New Visit Types		
Care STEP	**Definition**	**Use**
Online Portal Engagement	Patient and/or family communicate with members of the care team using a web portal application within the electronic health record system that allows patients to connect directly with their provider and care team securely over the internet.	This Care STEP should be counted when a message is sent from the patient or the patient's care team sends a message to them.
Health and Wellness Call	Health Center provider or qualified health professional[1] speaks to the patient or family/representative over the telephone about health and/or wellness status to discuss or create care plan, treatment options, and/or health promotion activities (with the exception of tobacco cessation or maternity case management[1])	This Care STEP should be counted when Health Center staff member speaks with patient or family/representative about health and/or wellness status AND discusses or creates care plan OR discusses treatment options OR discusses health promotion activities. Standard clinical operations such as appointment reminders and calls supporting other administrative processes should not be recorded.

[1] Tobacco cessation and maternity case management are excluded from this category because these types of telephone calls are billable encounters, if they include all of the same components of a face-to-face visit, in accordance with OAR 410-147-0120 Section 4. Retrieved from http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html.

New Visit Types		
Home Visit (non-billable)	Health Center staff visits the patient's home for reasons unrelated to assessment, diagnosis, treatment, or Maternity Case Management. Non-billable home visits include but are not limited to: A community health worker visiting patient's residence to support the family or a clinical pharmacist visiting to assist with medication management and reconciliation.	This Care STEP should be counted upon completion of the home visit as defined in the definition section.
Home Visit Encounter	Health Center staff conduct a billable home visit. The Division considers a home visit for assessment, diagnosis, treatment, or Maternity Case Management as an encounter [2].	This Care STEP should be counted when a Health Center provider or other qualified health professional conducts a billable home visit at a patient's residence or facility for assessment, diagnosis, treatment, or Maternity Case Management.
Advanced Technology Interactions	This Care STEP includes telemedicine encounters, as well as other types of interactions supported by technologies not historically used for providing health care, such as text messaging or the use of smartphone applications for remote patient monitoring or other health promotion activities.	This Care STEP should be counted when: 1) A patient consultation takes place via videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a medical practitioner located in a distant site and the client being evaluated and located in an originating site that is a billable telemedicine encounter according to OAR[3] OR when a non-billable interaction between a member of the health care team and the patient using videoconferencing takes place.

[2] Details relating to billable home visit encounters can be found in OAR 410-147-0120, section 10(n) and can be accessed at: http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html.

[3] Details relating to billable telemedicine encounters can be found in OAR 410-130-0610 and accessed at: http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_130.html.

New Visit Types		
		2) Health Center staff uses a non-traditional technology, such as text messaging or smartphone application, to interact with patients regarding their health and wellness status OR discuss their care plan or treatment options OR provide health promotion based on the patient's health status or risk factors. Outreach efforts where the patient does not reply may not be counted.

Education, Wellness and Health Promotion		
Care STEP	**Definition**	**Use**
Care Gap Outreach	Health Center staff identifies gaps in care for their empaneled patient and speaks with patient or family/representative to help them access the appropriate health promotion, preventive or chronic disease management care and services.	This Care STEP should be counted when Health Center staff has spoken in-person or over the phone with patient or family/representative regarding gaps in care.
Education Provided in Group Setting	Patient attends an education group related to health promotion activities (such as parenting/pregnancy classes, health fairs, and teaching kitchens/healthy cooking classes) provided by Health Center staff or affiliated group.[4]	This Care STEP should be counted when the Health Center verifies that the individual patient attended the education class/event provided by the Health Center or affiliated group. Verification may come from the patient.
Exercise Class Participant	Patient attends an exercise class (such as a low-impact walking group, yoga, Zumba, or Tai Chi) provided by the Health Center or affiliated group.[4]	This Care STEP should be counted when the Health Center verifies that the individual patient attended the exercise class/event provided

[4] The health center must have a contract, MOU or other written agreement with the affiliated group to establish access for health center patients in order to count services provided by the affiliated group in this Care STEP category.

Education, Wellness and Health Promotion		
		by the Health Center or affiliated group. Verification may come from the patient.
Support Group Participant	The patient attends a support group for people with common experiences and concerns, who provide emotional and moral support for one another, hosted by the Health Center or affiliated group.[4]	This Care STEP should be counted when Health Center staff have verified patient attended a support group hosted by their Health Center or referred to by the health center. Verification may come from the patient.
Health Education Supportive Counseling	Services provided by a physician or other qualified health care professional[5] to an individual or family, in which wellness, preventive disease management, or other improved health outcomes are attempted through discussion with patient or family. Wellness or preventive disease management counseling will vary with age and risk factors and may address such issues as family problems, social circumstances, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter.	This Care STEP should be counted when Health Center staff engages in the activities described in the definition.

[5] Qualified health professional is any health care professional providing services within their scope of practice, either under their own licensure, or working under the supervision requirements of an overseeing provider's license. Definition retrieved from OAR 410-147-0120 Section 11, http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html.

Coordination and Integration		
Care STEP	**Definition**	**Use**
Coordinating Care: Clinical Follow-up and Transitions in Care Setting	Health Center staff speaks with patient or family/representative regarding the patient's recent care at an outside health organization (ER, hospital, long-term care facility, etc.) to: 1) Arrange a follow-up visit or other Care STEP at the Health Center, or 2) Speaks with patient to update care plan and educate on preventive health measures, or 3) Assists patient with a transition in their care setting.	This Care STEP should be counted when Health Center staff have verified the patient received or needs to receive health services from a different provider, and completed 1, 2, or 3 listed in the definition section.
Coordinating Care: Dental	During primary care visit, patient and Health Center staff identify that patient has dental health care needs and coordinate with dental professionals by assistance with dental appointment set-up or follow up with patient about dental health care needs.	This Care STEP should be counted when Health Center staff have confirmed that the primary care provider set up a dental appointment and/or has followed up with the patient about their dental health care needs.
Behavioral Health and Functional Ability Screenings	Health Center staff facilitates the completion of standardized screening tools that assess patient's needs or status relating to behavioral health, functional ability, and quality of life to organize next steps in a care plan. Screening tools include behavioral, mental health, developmental, cognitive, or other functional screening tools, either through interview or patient self-administration of a screening form.	This Care STEP should be counted when completion of the screening process has been initiated to support care and service planning in collaboration with the patient.
Warm Hand-off	Health Center provider or health professional conducts a face-to-face introduction for the patient to a provider or health	This Care STEP should be counted when the patient is successfully introduced to the

Coordination and Integration		
	professional of a different health discipline (e.g. primary care physician introduces patient to a behavioral health consultant or community health worker).[6]	second provider or health professional.

Reducing Barriers to Health		
Care STEP	**Definition**	**Use**
Social Determinants of Health Screening	Health center staff facilitate the completion of a Social Determinants of Health screening questionnaire with the patient, either through interview or patient-self administration of a screening form.	This Care STEP should be counted when the screening process has been initiated to support care and service planning in collaboration with the patient.
Case Management	Case management is a process in which a provider or another qualified health care professional[7] is responsible for direct care of a patient and, additionally, for coordinating, managing access to, initiating, and/or supervising other health, social, or other kinds of services needed by the patient. To use this Care STEP category, the Health Center must be able to identify who the assigned case manager is in the patient health record.	This Care STEP should be counted, once a case manager is assigned to the patient, for all interactions where the case manager directly interacts with the patient or family/representative relating to direct care, coordination of care, managing patient's access to care or initiation and/or supervision of other health care services needed by the patient.

[6] Based on the SAMHSA-HRSA Center for Integrated Health Solutions definition of a Warm Handoff. Retrieved from http://www.integration.samhsa.gov/glossary#w.

[7] Qualified health professional is any health care professional providing services within their scope of practice, either under their own licensure, or working under the supervision requirements of an overseeing provider's license. Definition retrieved from OAR 410-147-0120 Section 11, http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html.

Reducing Barriers to Health		
Accessing Community Resource/Service	Patient or family/representative is educated on available resources in their community based on a presenting need (such as assisting with immigration paperwork, finding domestic violence resources, obtaining legal services, medication assistance program registration, financial assistance, donations including clothing, infant supplies, medical equipment, prostheses, assistance finding employment, education opportunities, shelter) AND Health Center staff refers or connects the patient to the resource/service.	This Care STEP should be counted when Health Center staff educates the patient and/or family on available resources AND refers/connects the patient to the resource.
Transportation Assistance	Health Center provides direct assistance to a patient by a staff member or contractor to arrange or provide transportation resources and services to reduce access barriers for the patient.	This Care STEP should be counted after staff identify patient has an access barrier in the realm of transportation AND delivers the resource/service that will reduce the transportation barrier.

Attachment D: Reconciliation Template

Alternative Payment Methodolgy (APM) Reconciliation		
For the Period :		
PAYMENTS		
From the State		
820 Payments:		
OPEN CARD Client Capitation		
MANAGED CARE Client Wrap Payments		
Subtotal		$ -
Fee for Service Payments:		
Cawem, QMB, etc.		
Carve Outs		
Incorrect claims (MH/OB)		
Subtotal		$ -
From MCOs / CCOs		
Capitation Payments		
Fee for Service Payments		
Subtotal		$ -
From Medicare / Commercial Payers		
Capitation Payments		
Fee for Service Payments		
Subtotal		$ -
Total Payments..		**$ -**

EXCLUDED PAYMENTS		
From the State		
820 Payments:		
Unrecovered 820 Payments		
Fee for Service Payments:		
Prenatal / OB		
Dental		
Mental Health		
Services for Clients NOT enrolled in APM		
Clinic Sites/Services not in Scope		
Subtotal		$ -
From MCOs / CCOs		
Fee for Service Payments: (received for clients excluded from APM)		
Prenatal / OB		
Dental		
Mental Health		
Capitation Paid		
Services for Clients NOT enrolled in APM		
Clinic Sites/Services not in Scope		
		$ -
From Medicare / Commercial Payers		
Fee for Service Payments		
Prenatal / OB		
Dental		
Mental Health		
Services for Clients NOT enrolled in APM		
Clinic Sites/Services not in Scope		
		$ -
Total Excluded Payments..		**$ -**
NET Payments for APM Clients (Total Payments less Excuded Payments)...		**$ -**

ENCOUNTERS

		Open Card	Mgd.Care
	Total Medicaid Encounters		
Less Encounters for	Prenatal / OB		
	Dental		
	Mental Health		
	Clinic Sites not in Scope		
	Encounters for clients NOT on 820		
	CAWEM / QMB		
	Other (explain) ______________		
		0	0
	Net APM Encounters	0	0
	Clinic PPS Rate	$ -	
	PPS Equivalent Amounts......	$ -	$ -
	Total PPS Equivalent Amount........................		$ -
	NET Payments for APM Clients.....................		$ -
Difference from Actual APM Payments...................................			$ -

Key:
Are the blue highlighted cells above for which Health Center staff need to enter a value

APCM Attribution Policy

Reviewed and amended by OPCA, OHA, and CHCs on April 18th, 2017

Intent and Overview:

The Oregon Health Authority (OHA) must prevent duplicate payments from occurring due to APCM enrolled members receiving services from other primary care providers in the Oregon Medicaid delivery system. The details of the re-attribution methodology, titled "Re-attribution to Other Primary Care Providers and the Enrollment Change Report Cycle", are covered under section 1 below.
Beginning Q2 2019, OHA will also take action to stop per-member-per-month (PMPM) payments for members who were not engaged at the APCM Health Center in the prior eight quarters to assure payment is made for engaged patients. The details of this other attribution methodology, titled "Removal of Non-engaged Patients", are covered under section 2 below.

Section 1: Re-attribution to Other Primary Care Providers and the Enrollment Change Report Cycle

OHA will monitor monthly all claims for enrolled members, using a six-month lookback to reassign members and close the APCM enrollment effective the day prior to when members accessed other primary care providers.

After OHA closes a member's APCM enrollment, APCM Health Centers may re-enroll them on the date of service (DOS) of their next billable visit if the service occurred after the member's final visit with the outside primary care provider. All enrollment changes executed by the OHA will be reported to the APCM organization at least 14 days before the change occurs.

All Health Centers joining the APCM Program will receive a three-month grace period where the OHA will not make enrollment changes. The grace period will cover claims for dates of service during the first three months of APCM participation.

The attribution timeline is a rolling six-month look-back that shifts forward one month each month. For example, the March 2024cycle will look at claims for dates of service between September 1st, 2023 to February 29th, 2024. The April 2024 cycle would shift forward to look at claims for dates of service between October 1st, 2023 and March 31st, 2023. Please see the figure and table below.

Re-attribution to Other Primary Care Providers and the Enrollment Change Report Cycle

Enrollment Change Report Cycle

Attribution Cycle	Look-Back DOS Begins	Look-Back DOS Ends	Closure Date
July 2023	01/01/2023	06/30/2023	08/07/2023
August 2023	02/01/2023	07/31/2023	09/11/2023
September 2023	03/01/2023	08/31/2023	10/09/2023
October 2023	04/01/2023	09/30/2023	11/13/2023
November 2023	05/01/2023	10/31/2023	12/11/2023
December 2023	06/01/2023	11/30/2023	01/08/2024
January 2024	07/01/2023	12/31/2023	02/12/2024
February 2024	08/01/2023	01/31/2024	03/11/2024
March 2024	09/01/2023	02/29/2024	04/08/2024
April 2024	10/01/2023	03/31/2024	05/13/2024
May 2024	11/30/2023	04/30/2024	06/10/2024
June 2024	12/01/2023	05/31/2024	07/08/2024

Re-attribution to Other Primary Care Providers Process

Identifying Leakage and End-Dating APCM Enrollments

1. OHA will review primary care claims during the look-back period each month.
   a. At the beginning of each month, the attribution cycle will produce the patients that leaked out to primary care providers in the prior six months (six-month look-back period). OHA will determine the type of leakage:
      i. FQHC/RHC/Tribal organizations, OR
      ii. Other primary care providers
2. FQHC/RHC/Tribal Organization
   a. APCM patient will be end-dated on the day before the earliest leakage DOS.
   b. Patients with a primary care visit at a different FQHC/RHC/Tribal organization will be end-dated after **one visit** on the day prior to the DOS.
3. Other Primary Care Providers
   a. Patients receiving primary care services from a different provider (that is **not a FQHC/RHC/Tribal Organization**) will be end-dated when **two or more visits** within the look-back period occur.
   b. The end date will be the day before the earliest leakage visit DOS within the six-month look-back period.

Reporting Enrollment Changes to APCM Organizations

1. OHA will document all changes made to an APCM organization's PMPM patient roster.
2. Before enrollment changes are completed, OHA will send the Enrollment Change Report (ECR) through secure email to the APCM organization.
3. PMPM payments will be recouped for the timeframe that was removed from the patient's APCM enrollment **IF** that timeframe had already been paid.
4. PMPM recoupments will be reported on the APCM organization's 820 report and will only recoup from future payments.
5. ECR will indicate:
   a. Patient's Recipient ID
   b. Patient's APCM start date and 'new' end date
   c. The date-of-service (DOS) of each visit with a different primary care provider
   d. Leakage Type: FQHC/RHC/Tribal Organization **OR** Other Primary Care Provider **OR** Both Types

Restarting PMPM Payments for End-dated APCM Patients

a. The APCM organization can re-enroll the patient with an effective date after the final leakage DOS on the ECR **AND after** a new visit is registered.
b. The APCM organization shall not re-enroll the APCM patient on a date prior to the final leakage DOS on the ECR.
c. If sections (a) and (b) are satisfied, the date of re-enrollment should be the date the APCM organization re-established the patient through a billable encounter or Care STEP.

Appeals Request Process for Re-attribution to Other Primary Care Providers

OHA will consider a request for appeal of an enrollment closure when the APCM Health Center indicates the outside primary care visit occurred due to a referral to the other primary care provider, or the leakage

visit was a specialty service. Health Centers may use Care STEPs data as evidence of continuous engagement when re-attribution was caused due to a referral or specialty service. The appeals must be submitted in an excel format. It is expected that the Health Center will review each patient's status, and confirm closure should not have taken place, before including the patient on the appeal submission.

1. APCM organization will notify the OHA within 30 days of the ECR send date.
2. APCM organization will include the ECR and indicate within the report:
   a. Recipient ID of referred patient.
   b. Service or condition that caused referral.
   c. Type or specialty of provider patient was referred to.
   d. Name of the provider or organization patient was referred to.
3. The OHA will research the alleged leakage visit and make a final decision within 60 days of receipt of review request.
4. If the patient being appealed has a service or condition that caused the referral listed as "unknown," the health center must provide a visit or CareSTEP date that occurs **after** the leakage date.

<u>Attribution Between APCM Health Centers</u>

1. Patients moved from one APCM Health Center's list are available for enrollment by a new Health Center on the day following the end date with the previous APCM Health Center.
2. Functionality is currently available under the eligibility screen on the MMIS Provider Web Portal to view a patient's APCM enrollment status and determine which Health Center the patient is enrolled with.

Section 2: Removal of Non-engaged Patients

Following the submission of each APCM Health Center's Care STEPs Report, OHA will query the Medicaid Management Information System (MMIS) to determine the patients who did not have a visit in the prior eight quarters. For example, for the Q2 2019 Care STEPs Report, OHA will look for a visit at the Health Center between Q3 2017 to Q2 2019. For members who did not have a visit in this timeframe, OHA will then determine the members that did not receive a Care STEP in the same eight quarters from the Health Center they are enrolled with.

OHA will close enrollment for members who were not engaged through a visit or a Care STEP in the past eight quarters with the APCM Health Center. The end date will be the last day of the previous quarter (e.g. 6/30/2019).

Health Centers may re-enroll the member effective the date they re-establish care as defined in the APCM New Patient Engagement Procedure in 'Attachment C'.

Removal of Non-engaged Patients Sample Timeline

Attribution Cycle	Care STEPs Report Due Date	Engagement Range	Enrollment End Date	OHA Date of Closure
Q2 2020 Report	7/31/2020	Q3/2018 – Q2/2020	6/30/2020	9/1/2020
Q3 2020 Report	10/31/2020	Q4/2018 – Q3/2020	9/30/2020	12/1/2020
Q4 2020 Report	1/31/2021	Q1/2019 – Q4/2021	12/31/2020	3/1/2021
Q1 2021 Report	4/30/2021	Q2/2019 – Q1/2021	3/31/2021	6/1/2021
Q2 2021 Report	7/31/2021	Q3/2019 – Q2/2021	6/30/2021	9/1/2021
Q3 2021 Report	10/31/2021	Q4/2019 – Q3/2021	9/30/2021	12/1/2021
Q4 2021 Report	1/31/2022	Q1/2020 – Q4/2021	12/31/2021	3/1/2022
Q1 2022 Report	4/30/2022	Q2/2020 – Q1/2022	3/31/2022	3/1/2022

Year	Quarter	Month Year	CareSTEPs Due	CareSTEPs Look Back	NECR Due	Closure Date
	1	Jan-21	Q4 - Jan 31st			
2021	1	Feb-21			Feb 28th	
	1	Mar-21				12/31/2020
	2	Apr-21	Q1 - Apr 30th			
2021	2	May-21			May 31st	
	2	Jun-21				3/31/2021
	3	Jul-21	Q2 - Jul 31st			
2021	3	Aug-21			Aug 31st	
	3	Sep-21				6/30/2021
	4	Oct-21	Q3 - Oct 31st			
2021	4	Nov-21			Nov 30th	
	4	Dec-21				9/30/2021
	1	Jan-22	Q4 - Jan 31st			
2022	1	Feb-22			Feb 28th	
	1	Mar-22				12/31/2021
	2	Apr-22	Q1 - Apr 30th			
2022	2	May-22			May 31st	
	2	Jun-22		Look Back Period - 8 quarters		3/31/2022
	3	Jul-22	Q2 - Jul 31st			
2022	3	Aug-22			Aug 31st	
	3	Sep-22				6/30/2022
	4	Oct-22	Q3 - Oct 31st			
2022	4	Nov-22			Nov 30th	
	4	Dec-22				9/30/2022
	1	Jan-23	Q4 - Jan 31st			
2023	1	Feb-23			Feb 28th	
	1	Mar-23				12/31/2022
	2	Apr-23	Q1 - Apr 30th			
2023	2	May-23			May 31st	
	2	Jun-23				3/31/2023
	3	Jul-23	Q2 - Jul 31st			
2023	3	Aug-23			Aug 31st	
	3	Sep-23				6/30/2023
	4	Oct-23	Q3 - Oct 31st			
2023	4	Nov-23			Nov 30th	
	4	Dec-23				9/30/2023
	1	Jan-24	Q4 - Jan 31st			
2024	1	Feb-24			Feb 28th	
	1	Mar-24				12/31/2023
	2	Apr-24	Q1 - Apr 30th			
2024	2	May-24			May 31st	
	2	Jun-24				3/31/2024

Removal of Non-engaged Patients Process

Care STEPs Report Submissions

1. OHA will file all quarterly Care STEPs reports and insert data in access database.
2. Care STEPs reports are always submitted one month after the close of the calendar quarter.

Query for a Visit at the APCM Health Center

1. A query will search the MMIS claims database for a billed visit for each member attributed to the APCM Health Center in the prior eight quarters.
2. A list will be produced displaying the members who did not have a visit.

Query for a Care STEP at the APCM Health Center

1. Using the list of members without a visit in the prior eight quarters, OHA will then query the Care STEPs report database.
2. The query will search for the select member who also did not have a Care STEP within the prior eight quarters.
3. Within 30 days of Care STEPs report submission, a list will be produced displaying non-engaged members within the prior eight quarters.

Non-Engaged Closure Report

1. OHA will generate the Non-engaged Closure Report (NECR) and send to the APCM Health Center prior to closing the enrollments.
2. NECR will display the following data elements.
   a. Recipient ID
   b. APM Effective Date (start date)
   c. 'New' APM End Date

Appeals Request Process for Non-Engaged Patient Removal Closures

OHA will consider a request for review of an enrollment closure when the APCM Health Center indicates that there was a billable visit or Care STEP within the prior eight quarters. It is expected that the Health Center will review each patient's status, and confirm closure should not have taken place, before including the patient on the appeal submission.

1. APCM Health Center will notify OHA within 30 days of the NECR send date.
2. If the APCM Health Center believes a Care STEP occurred, the Health Center must resubmit a new Care STEPs report and attach documentation showing the following in an Excel format, including:
   a. Recipient ID.
   b. Date of the Care STEP.
   c. Name of provider/staff who delivered the Care STEP.
   d. Type of provider/staff who delivered the Care STEP.
   e. Name of the Care STEP category that was provided.

3. If the APCM Health Center believes a billable visit occurred, the Health Center must submit documentation in an Excel format of the visit such as an Explanation of Benefits (EOB) or remittance advice, that includes at a minimum:
    a. Recipient ID.
    b. Date of service.
    c. Claim ICN.
    d. Rendering provider NPI.
    e. Rendering provider name.

Section 3: Administrative Review Request

OHA will consider an Administrative Review Request that falls outside of the ECR and NECR appeals cycles. A Health Center may submit a request to review potential missing payments for patients that are enrolled in their APCM program. This request will only be considered for a 12-month look back period from the date of submission. For example, if a request is submitted in September of 2023, OHA will only review payment from October of 2022 to September 2023, encompassing a total of 12 months. This request must include the following and submitted in an excel format:

1. An APCM eligible Recipient ID

2. Beginning date of missing payments

3. End date of missing payments

OHA will review and send a response to the Health Center within 60 days.
If a request is sent and any patients listed are found not APCM eligible, OHA will deny the request. The Health Center may review the list and submit a new Administrative Review Request within 30 days from receiving the response from OHA. A participating Health Center may only submit a request once every calendar year.

Attachment F: Excluded Codes

Oregon Alternative Payment Methodology and Advanced Care Model (APCM)
Exclusion Agreement for Wrap Cap reimbursement

On March 1, 2013, three Oregon Community Health Centers voluntarily entered into an agreement with the Oregon Health Authority (OHA) to participate in an Alternative Payment Methodology and Advanced Care Model (APCM) program to adjust traditional PPS payment for Health Centers to a capitated equivalent. Each program participant signed a participation agreement with the OHA which guides implementation and agreements for the program.

Since that date, many details have evolved in partnership between OPCA, APCM clinics and OHA. This document is intended to outline agreements around services that are excluded from the wraparound capitation, or "Wrap Cap", paid by the OHA for each active Oregon Health Plan (OHP) patient of a program Health Center. As is noted at the end of the document, the scope of services included in capitation received from the managed care organization may differ and is guided by the Health Center's agreement with the Managed Care Organization (MCO) or Coordinated Care Organization (CCO).

The participating Health Center is responsible for assuring revenue associated with carved-out services is excluded from the APCM rate development and must be documented or included as back up to the clinic's APCM rate worksheet. It is also the responsibility of participating Health Centers to ensure that submissions for supplemental wraparound only include the encounters and payments for the carved-out services (Dental, Mental Health, Addictions OB, and Maternity Case Management).

Policy Agreements: In developing the model on a broad level, the following agreements were reached with respect to included services, and the following language is captured within the MOU:

- ***Included Services****: The APCM rate is a capitated, per member per month rate paid to the Health Center for Health Center Services as defined in the Health Center's established PPS rate calculation (and defined by Federal law). Mental health, addictions, dental health, maternity case management, and obstetrical services (prenatal and deliveries) are excluded initially from the rate and program.*
- ***Open Card****: Open Card (fee-for-service) clients are included in the APCM program, and a unique Open Card APCM rate is established.*
- ***School based health:*** *School based health clinic patients and primary care services will be included under wrap cap for those patients.*

Implementation Agreements: In operationalizing the APCM program, the Oregon Health Authority, OCHIN, OPCA and APCM clinics have worked collaboratively to assure that systems are properly prepared to accept claims and issue payments for those services that are outside of the wrap cap, and to suppress claims for those services that are included within capitation. In developing those systems, several more detailed issues have been addressed related to inclusions/exclusions:

Scope of Primary Care Services (INCLUDED): Those services included in the primary care PPS rate should be included in the capitation, except OB/Prenatal excluded codes.

OB/Prenatal Care (EXCLUDED): OB/Prenatal Care is excluded from capitation and must be demonstrated to be excluded from the rate developed for each clinic. OB/prenatal codes to be excluded are listed in the Carved-Out Medical Care Codes table.

Mental Health and Addictions Services (EXCLUDED): Claims which have a mental health diagnosis code as the primary diagnosis are excluded. Services provided to a patient with a primary physical health diagnosis, and a secondary mental health diagnosis are NOT excluded.

Inpatient Care (EXCLUDED): Inpatient care, with the exception of a newborn visit in the hospital is excluded.

Dental Health (EXCLUDED): Dental health services are excluded, including all procedure codes beginning with D.

Attachment G: Change-in-Scope (CiS) Methodology for APCM

1. When a participating Health Center on the APCM has an Authority approved PPS change-in-scope, in accordance with OAR 410-147-0362 (Change in Scope of Services), the Authority shall initiate a corresponding rate change to the FQHC or Rural Health Clinic's APCM rates.
    a. Health Center shall provide any supporting financial or member data requested by the Authority to initiate the APCM rate change process.
    b. Failure to provide supporting documentation may delay or prevent the APCM rate change, or the APCM rate change effective date.
    c. If a Health Center has undergone a PPS rate change-in-scope (CiS) before their participation in the APCM, causing a rate change to occur within the rate setting period or before their go-live date; the proportional adjustment will be included for rate calculation purposes as determining the Health Center's APM Day-One rate.
2. In accordance with the agreement between the Authority, participating Health Centers, and the OPCA, the Authority will process and change APCM rates based on the Incremental APCM Change-in-Scope Method outlined below in Figures 1A and 1B.
3. The effective date for the APCM rate change shall correspond with the effective date for the PPS rate, because of the PPS change-in-scope.
4. The Authority shall use financial and enrollment data from the PPS rate change and existing Authority data sources to establish the variables required for an APCM rate change, including:
    a. Change-in-Scope costs.
    b. APCM percentage of Change-in-Scope costs.
    c. Member months.
    d. Medicare Economic Index (MEI) percentage.
    e. Current APCM rates.
5. Within 90 days of the PPS change-in-scope, the Authority shall send a rate letter confirming the APCM rate changes and effective date.

Figure 1A. Incremental Change-in-Scope Methodology for APCM Managed Care Rate		
CiS Costs	$8,610,116	APCM applicable costs from the PPS CIS worksheet
APCM %	80.9%	Medical CCO visit % in scope change year
APCM Portion	$6,968,167	CIS cost times APCM% (a x b)
Member Months	286,920.5	From OHA MMIS data warehouse for CIS time period (Wrap Cap MMs)
Wrap Cap APCM %	91.4%	% of APCM members in CCOs in reporting period
Wrap Cap APCM Portion	$6,368,904	APCM portion for CCO members (c x e)
Incremental Cost PMPM	$22.20	Trended costs divided by member months (f / d)
MEI Factor	1.4%	MEI for 2018
Trended Incremental Cost	$22.51	Cost PMPM times MEI (g * (1 + h))
Current APCM Rate	$23.23	2018 APCM rate
APCM Wrap Cap Rate from Incremental Methodology	***$45.74***	Incremental cost PMPM + APCM Rate (j + i)

Figure 1B. Incremental Change-in-Scope Methodology for APCM Open Card Rate		
CiS Costs	$8,610,116	APCM applicable costs from PPS CIS worksheet
APCM %	80.9%	Medical CCO visit % in scope change year
APCM Portion	$6,968,167	CIS cost times APCM% (a x b)
Member Months	24,678	From OHA MMIS data warehouse for CIS time period (Open Card MMs)
FFS APCM %	8.6%	% of APCM members in FFS in reporting period
FFS APCM Portion	$599,262	APCM portion for FFS members (c x e)
Incremental Cost PMPM	$24.28	Trended costs divided by member months (f / d)
MEI Factor	1.4%	MEI for 2018
Trended Incremental Cost	$24.62	Cost PMPM times MEI (g * (1 + h))
Current APCM Rate	$40.04	2018 APCM rate
APCM Open Card Rate From Incremental Methodology	***$64.66***	Incremental cost PMPM + APCM Rate (j + i)

Exhibit 1

Oregon State Plan Amendment ("SPA") Transmittal # 12-08, Attachment 4.19-B;
Methods and Standards for Establishing Payment Rates: Alternate Payment Methodology,
(approved on 9/12/12 by CMS and OAR 410-147-0360)

Transmittal # 12-08
Attachment 4.19-B
Page 9-a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: ____OREGON______________
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FQHC & RHC Alternate Payment Methodology

Payments to FQHCs will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. The APM will be effective on or after the date the clinic has signed an agreement with the Division. Those FQHCs & RHCs that do not choose the APM will continue to be paid under the Prospective Payment System (PPS) methods.

The APM will convert the clinic's current PPS rate into an equivalent Per Member Per Month (PMPM) rate using historical patient utilization and the medical only cost base rate for the specific clinic. The base rate is determined as illustrated**:**

- If a clinic PPS rate = $100/medical encounter;
- The clinic served 5000 Medicaid patients at an average of 3.0 encounters/patient, for total Medicaid medical visit revenue of $1,500,000 (excluding dental and mental health revenue).
- APM rate is based on $ 1,500,000 / 5000 = $300 per patient, per year.
- The clinic's PMPM: $300/12 = $25 PMPM.

The conversion of the clinic's PPS rate to a PMPM includes estimates of the number of Fee-For-Service beneficiaries that will be served by the clinic as well as the average number of encounters/visits that will be delivered.

The APM will be adjusted annually by the MEI as published in the Federal Register.

The interim PMPM rate is not actuarially certified as it pertains to the FFS population and may not result in final payment to the center.

On a quarterly basis, these estimates will be reconciled to actual utilization data in order to ensure that payments are made in accordance with section 1902(bb) of the Social" Security Act. To ensure that the appropriate amounts are being paid to each center, the State will perform an annual reconciliation and verify that the enhancement payments made in the previous year were in compliance with Section 1902(bb)(5)(A).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: ____OREGON_______________
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FQHC & RHC Alternate Payment Methodology

Utilization data will be pulled two quarters after the end of the year and analysis performed to determine the aggregate difference between the interim PMPM and the PPS for all FQHC & RHC services rendered within the clinic. Any enhanced payments needing to be made to bring total payments to a sum no less than the sum that would have been paid on PPS will be remitted within 120 days of the end of the year.

An adjustment will be made to a center's encounter rate if the center can show that they have experienced a valid change in scope of service. A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. As outlined in OAR 410-147-0362 a change in the scope of service will occur if: (1) the center adds, drops or expands any service that meets the definition of FQHC & RHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as defined in the State Plan Amendment.

For clients enrolled with a managed care contractor, the State will pay the center a supplemental payment in addition to the amount paid by the managed care contractor. The supplemental payments, paid in amounts necessary to ensure compliance with Section 1902(bb)(5)(A) of the SSA. The State will pay the enhancements monthly on a per-member-per-month basis.

Exhibit 2

Oregon Administrative Rule 410-120-0000 – Acronyms and Definitions

(102) “Health Care Professionals” means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.

Oregon Administrative Rule 410-147-0120**(11)**

Division Encounter and Recognized Practitioners 410-147-0120

Oregon Administrative Rule 410-147-0140**(6)(7)**
Multiple Encounters

Exhibit 3

Eligible Patient Flowchart

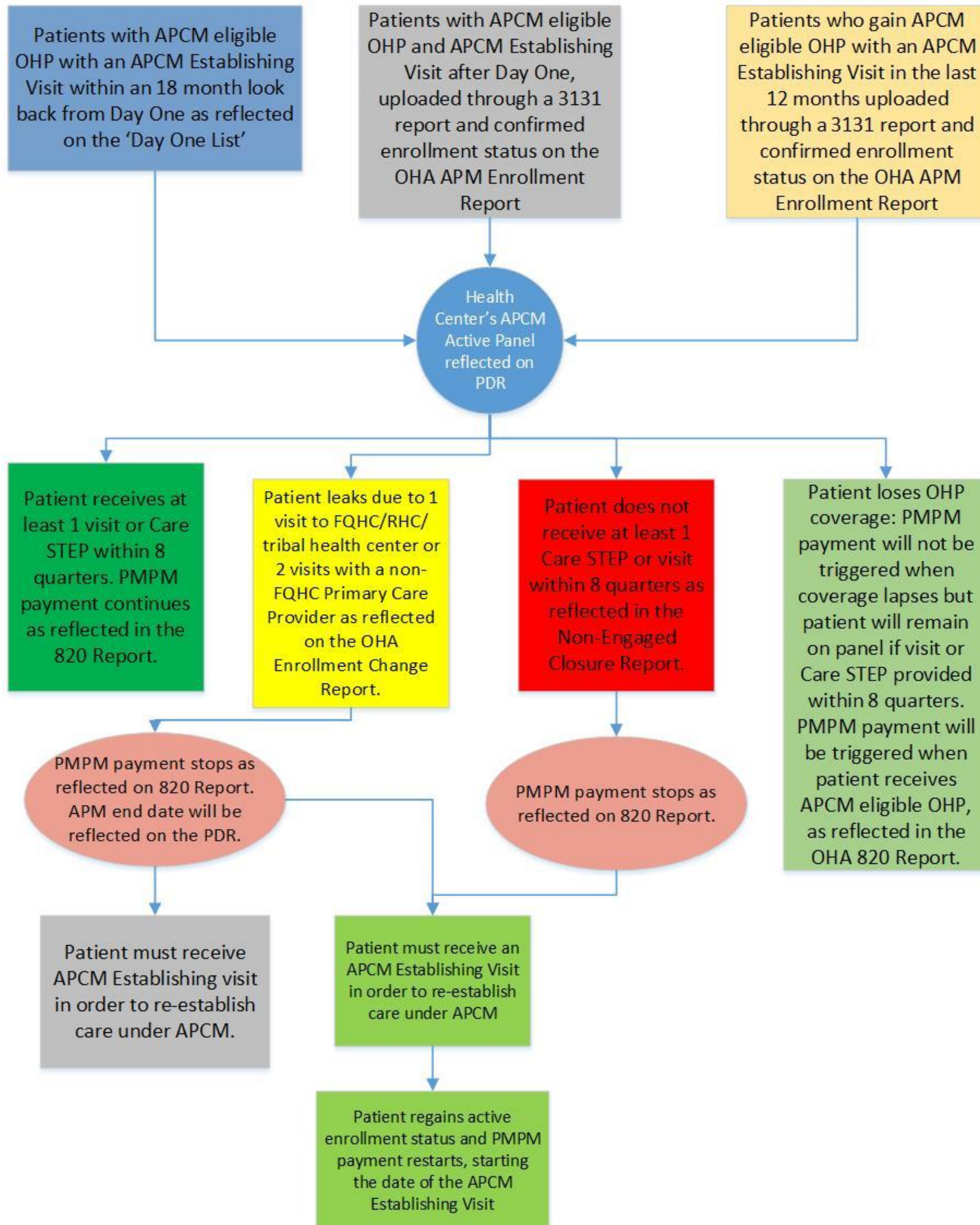


Exhibit 4

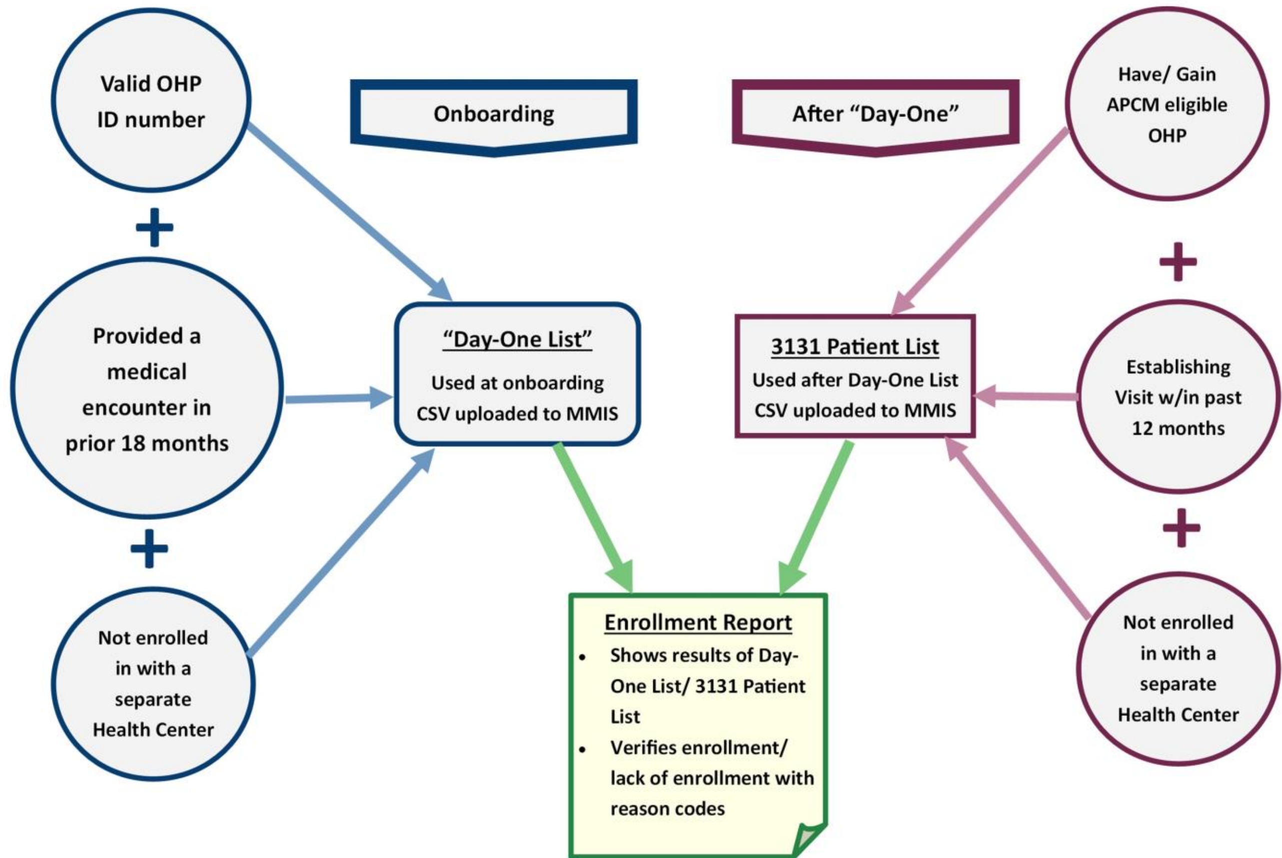


Exhibit 5