Lessons from Collecting Two Cycles of APM Data in Oregon's APCD



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Presentation Today

- Background on Oregon's collection of APM data
- High level results from 2016 submission
- Lessons learned from qualitative interviews
- Next steps on APM data collection
- Future policy directions



Background Information



History of APM data collection in Oregon

- First discussions with carriers July 2015
- First data submitted in September 2017

"Mandatory Reporters shall submit separate information for each line of business and payment arrangement category held with each billing provider or organization, and shall differentiate spending on primary care from spending on non-primary care."



History of APM data collection in Oregon

- Current lines of business reported:
 - Commercial, not subject to ERISA
 - Medicare Advantage plans
 - PEBB/OEBB plans



Use Cases



Why Capture APMs?

- Measure spread of the CCO model and total statewide spending on health care
- Improve data completeness for measuring healthcare spending
- Measure penetration and quality of APM arrangements
- Benchmark to recognize payers at the forefront of APM adoption



2016 Data

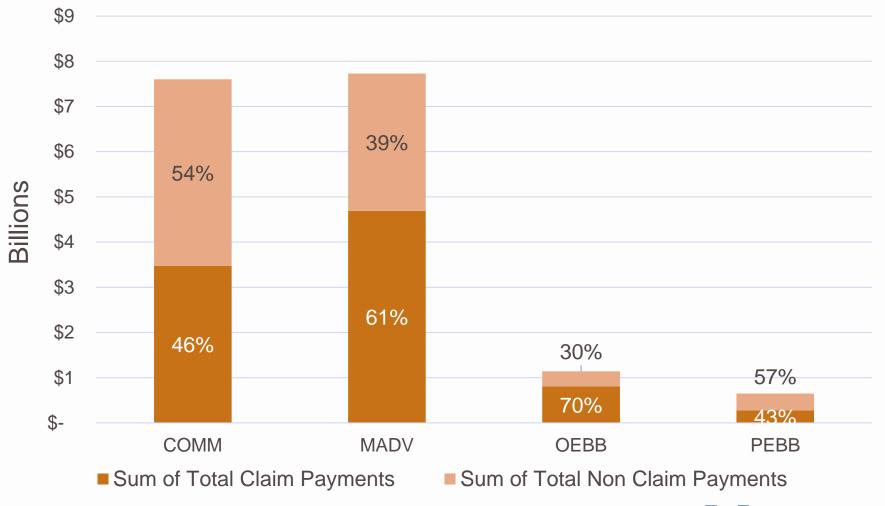


Making sense of the data – summary stats

- 19 reporters submitted APM data in 2017
- Total payments for all lines of business: \$4.56B paid in claims and \$2.75B paid in non-claims
 - 38% of total payments were non-claims-based
- Primary care payments for all lines of business: \$584M paid in claims and \$484M in paid nonclaims
 - Primary care was 14.6% of all payments

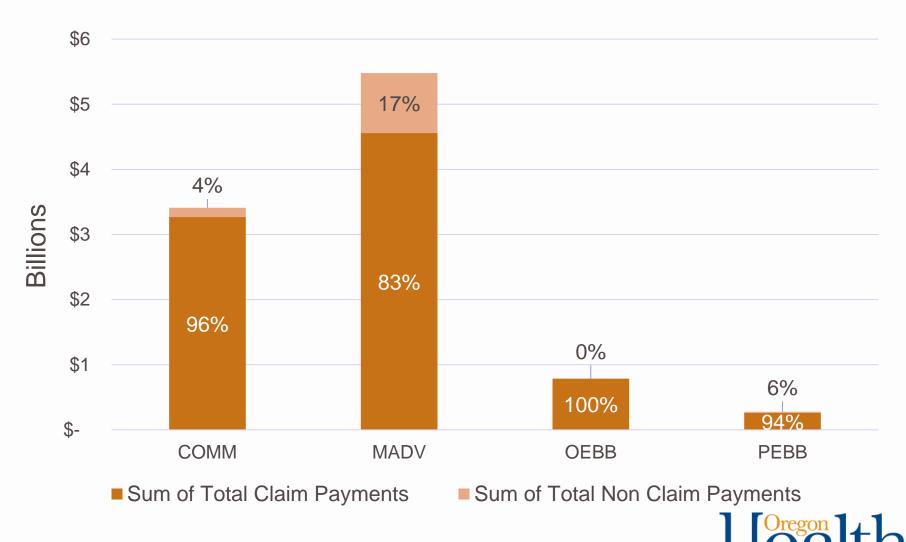


Making sense of the data #1 – by LOB





Making sense of the data #2 – by LOB



Conversations with carriers about the data

- Primary care designation proved challenging.
- Operationalizing the inclusion criteria was not done uniformly.
- Treatment of withholds and recoupments not consistent.
- Rows represent various permutations of providers.



Next Steps



Possible changes in file structure

\$	8		
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
	Α	Α	Α
	Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for health information technology investments)	APMs with Shared Savings (e.g., shared savings with upside risk only)	Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
		APMs with Shared Savings	
	В	and Downside Risk	В
	Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	Pay-for-Performance (e.g., bonuses for quality performance)		С
			Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
Figure 1: The Updated APM Framework		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality



Changes in mandatory reporters

- Oregon's fifteen CCOs are required to report APMs to APAC starting September 2019.
- OHA has worked with four CCOs to voluntarily submit data in 2018.



Changes in specifications

- Instructions specific to CCOs
- Clarification about at which level payments are to be reported
- Instructions for national carriers
- Clarification about complex payment arrangements



Future challenges

 Cannot cleanly analyze PMPMs paid to PCPCH clinics/providers



APM current and future policy directions

- Primary Care Spending Report
- Measure value-based-payment (VBP) requirements embedded in CCO 2.0
- Measure spread of VBP uptake across and within each line of business



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