

Robert Wood Johnson Foundation Payment Reform Evaluation Project

Transforming Payment for Oregon's Community Health Centers through an Alternative Payment  
Methodology

Oregon Primary Care Association

**August 2015 Report**

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## Introduction and Context

This report describes the “Transforming Payment for Oregon’s Community Health Centers through an Alternative Payment Methodology” project supported by the Robert Wood Johnson Foundation in Oregon. The Oregon Primary Care Association (OPCA) serves as the applicant organization and principal convener and facilitator of this endeavor, which aims to transform the payment methodology for the state’s community health centers (CHCs)<sup>1</sup>. The Alternative Payment Methodology (APM) is intended to offer an alternative to the encounter-based Prospective Payment System (PPS) for Medicaid patients in CHCs by using a per-member-per-month (PMPM) payment for primary care aligned with patient-centered care, rather than the face-to-face, visit-centered care implicitly encouraged by prospective payment.

The momentum for the APM grew out of Oregon’s participation in the earlier Safety Net Medical Home Initiative, a national demonstration project aimed to help CHCs become patient-centered primary care homes (PCPCHs). The CHCs realized that the primary care home vision could not be achieved fully without a shift away from volume-driven, visit-based payment. The primary care homes were organized around team-based care, and fully actualizing the advanced care model (ACM) would not occur under fee for service (FFS). The patient-centered care of the ACM requires population health management, identifying the prevalence of and managing chronic health conditions, and coordinating care over time and across multiple settings – a model not supported by the predominant PPS payment structure. The additional pre-visit planning and panel management inherent in the PCPCH was not consistent with visit-based payment.

The APM has been in place since March 2013 in three CHCs: the Virginia Garcia Memorial Medical Center, Mosaic Medical Health Center, and the Oregon Health Sciences University Richmond Clinic. In July 2014 four additional CHCs (Coastal Family Health Center, the CHCs of Benton and Linn Counties, Multnomah County Health Department, and Yakima Family Farm Workers), and a rural health center [OHSU Scappoose] went live, with the two phases combined to form the Alternative Payment and Care Model project (APCM)<sup>2</sup>. To our knowledge, the Oregon project is the first in the nation to implement a PMPM-based payment alternative to the prevailing PPS method for Medicaid patients in community health centers<sup>3</sup>. The APM also supports Oregon’s coordinated care organizations (CCOs), the latter catalyzed by a \$1.9 billion grant from the Centers for Medicare and Medicaid Services (CMS) to the state

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<sup>1</sup> All Community Health Centers (CHCs) participating in Phase I of the APM project are Federally Qualified Health Centers, and one of the five Phase II clinics (OHSU-Scappoose) is a Rural Health Center (RHC). For FQHCs and RHCs not participating in APM, the standard CMS payment method for both these types is an all-inclusive prospective payment system (PPS) rate per visit. See, for example, CMS: FQHC/RHC Q&As related to January 1, 2015 PPS changes. [http://www.azahcccs.gov/commercial/Downloads/FQHC\\_RHC\\_QAs.pdf](http://www.azahcccs.gov/commercial/Downloads/FQHC_RHC_QAs.pdf) Accessed June 20, 2015.

<sup>2</sup> Oregon Primary Care Association. Alternative Payment and Care Model. <http://www.orpca.org/initiatives/alternative-care-model> Accessed May 4, 2015

<sup>3</sup> Transforming Payment for Oregon’s Community Health Centers through an Alternative Payment Methodology. Full Proposal Narrative to Robert Wood Johnson Foundation. Proposal ID 9377.

of Oregon. Several interviewees remarked on the importance of the CMS grant, especially the provision of substantial funds for system transformation on the payment and delivery sides. The CCOs in Oregon are the successors to the Medicaid managed care organizations, and are subject to CMS spending targets for the state Medicaid program that require reducing the cost curve by two percentage points below the rate of projected global spending growth. In fiscal year (FY) 2013 the rate of increase was 4.4 percent, and the target rate for FY 2014 and beyond is 3.4 percent<sup>4</sup>. The state ultimately intends to apply value-based payment methodologies to two other major purchaser groups: state employees and teachers.

Medicaid expansion through the ACA has increased demand and revenues available to the FQHCs, with enrollment far exceeding enrollment expectations for Medicaid. For example, one interviewee noted that the clinic's uninsured population shrank from 7 percent to 3 percent after ACA implementation in Oregon. Another clinical leader observed that the APM has facilitated changes in the approach to care in order to offer increased access – more use of teams, emphasis on enabling services (non-billable “touches”) and community support. In contrast to early predictions, the new Medicaid recipients have been below-average utilizers of health services.

In the first six months of 2014, there were some delays in transformation efforts due to the new patients and the need to educate people regarding the changes caused by the ACA. Oregon experienced serious difficulties with its state-based health benefits exchange and ultimately transitioned to a federally facilitated exchange. While these problems were distracting, they seemingly had minimal impact on the APM implementation, which was focused on Medicaid members.

*Stakeholders.* In addition to the leading role of the OPCA and the Phase I and II participating clinics and their providers, several major stakeholders are driving the APM project. Former Governor Kitzhaber had been a major force in Oregon's original application for and receipt of the CMS grant, and his resignation in February 2015<sup>5</sup> created some uncertainty regarding the direction of Oregon's future efforts in health system reform. His successor, Kate Brown, who previously served as Secretary of State, has advanced the appointment of Lynne Saxton, former Governor Kitzhaber's nominee, as Director of the Oregon Health Authority<sup>6</sup>, which seemingly suggests a certain degree of continuity with the previous Governor's health care policies. One interviewee referred to the importance of educating new OHA staff regarding APM, and another clinical leader expressed concern that willingness to innovate and “play at the edges” might be diminished due to pressure on OHA and from CMS to show immediate results. The Oregon Health Authority (OHA) has responsibility for Medicaid purchasing, as well as for state employees and

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<sup>4</sup> Ibid.

<sup>5</sup> Governor John Kitzhaber announces his resignation.

[http://www.oregonlive.com/politics/index.ssf/2015/02/governor\\_john\\_kitzhaber\\_will\\_s.html](http://www.oregonlive.com/politics/index.ssf/2015/02/governor_john_kitzhaber_will_s.html) Accessed June 19, 2015

<sup>6</sup> Governor Kate Brown asks Senate to confirm Lynne Saxton as Director Oregon Health Authority March 4, 2015. <http://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=616> Accessed June 19, 2015

teachers. It works directly with OPCA and with the CHCs on billing arrangements, rules, and regulations. It also implemented information technology (IT) changes supporting those new clinic APM billing systems. OHA is required to report quarterly to legislative committees on implementation of the coordinated care model of delivery and other related matters. OCHIN, which is a large health information network in Oregon, and a team of researchers from Oregon Health Sciences University (OHSU) are conducting the state-based evaluation of the APM project<sup>7</sup>. OCHIN also is providing electronic health record and practice management support to a majority of the four pilot CHCs in the project. OPCA contracted with an expert in financial modeling and different CHC cost structures to help fashion the APM, taking into account the plethora of factors driving cost: patient case mix, Medicaid eligibility gaps, switching of patients between providers and clinics, and expected patient health services use<sup>8</sup>.

The Coordinated Care Organizations (CCOs) are another key stakeholder. Those CCOs constitute a network of providers and health plans that have agreed to provide care for physical health, behavioral, mental health, and (in some contracts) dental care for Oregon Health Plan (Medicaid) members. The CCO receives a global budget, and provider organizations (e.g., the FQHCs) contract with plans within the CCO.<sup>9</sup>The CCOs are governed by a partnership of their providers, community members, and other stakeholders in the health care organizations with financial responsibility and risk. For example, Virginia Garcia contracts with three CCOs, each comprised of multiple health plans, and is substantially involved in the governance of one of those CCOs.

Patients are directly involved in the governance of FQHCs. In fact, for FQHCs receiving Section 330 funding from the Health Resources Services Administration (HRSA), consumers receiving services and representative of the population being served must comprise at least a simple majority of the clinic's board<sup>10</sup>. Patient and family advisory councils also provide valuable input to the FQHCs.

### **Project Objective**

The intent of the APM is to encourage clinics and individual providers to focus on care for the whole person over time through innovative reimbursement based on payment per person, as opposed to a visit-based, volume driven approach. The APM's ultimate objective is to achieve higher-quality, patient-centered care that is delivered at lower total cost for Oregon's Medicaid and uninsured populations. To support the APM's ultimate objective, the project also aims to achieve improvements in cost, access,

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<sup>7</sup> Craig Hostetler, Laura Sisulak, Erika Cottrell, Jill Arkind, Sonja Likumahuwa. Origins in Oregon: The Alternative Payment Methodology Project. *Frontiers of Healthcare*. <http://frontiersofhealthcare.com/2014/04/17/origins-in-oregon-the-alternative-payment-methodology-project/> Accessed May 21, 2014

<sup>8</sup> Origins in Oregon: The Alternative Payment Methodology Project. *Frontiers of Healthcare*. Part 2: Building Trust and a Bridge to a New Way. <http://frontiersofhealthcare.com/2014/05/01/origins-in-oregon-the-alternative-payment-methodology-project-2/> Accessed May 21, 2014

<sup>9</sup> Oregon Health Authority. Coordinated care: the Oregon difference. <http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx> Accessed June 19, 2015

<sup>10</sup> How to work with a federally qualified health center. <http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/fqhcs-and-dsmt.pdf> Accessed June 19, 2015

and quality without disrupting cash flow or the financial viability of the clinics. Other supporting objectives include effectively addressing the social determinants of health, improving the documentation of services, and tailoring care to the specific needs of different population groups. On June 26, 2014 OPCA and State Medicaid met and reaffirmed that budget neutrality would be defined as maintenance or reduction of per capita primary care costs, defined as prior year base costs adjusted by an increase of 3.4 percent<sup>11</sup>. The APCM has adopted a “Quadruple Aim,” which operationalizes its ultimate objective across four domains:

- (1) Quality: (Data) Track 9 CCO focus measures, 5 UDS measures. Focus on two clinical measures, and sustain or improve patient satisfaction.
- (2) Access: (Achieve meaningful engagement) Document visits and/or engagement touches with 70% of established patients annually.
- (3) Financial: (Cost of care) Maintain or reduce adjusted per capita costs.
- (4) Segmentation: (Severity adjustment methods) Establish tool that allows supports tailoring care for various population segments (by June 2015)

### **Approach**

*Payment Model.* At its core, the APM is a global primary care PMPM payment that is intended to be budget neutral. However, it is not primary care capitation because the participating clinics do not bear downside risk. At this point the APM per member per month payment (PMPM) includes only physical health; the following services are carved out of the PMPM: dental services, mental health/addiction services, prenatal/OB services, and maternity case management services. The PMPM is for primary care only, and excludes laboratory, radiology, specialty, urgent care, and emergency department (ED) care.

The APM is calculated as follows<sup>12</sup>:

- (1) By examining the prior year’s PPS payments and historical average patient health services utilization (pre-implementation of the APM), the state converts the average per capita spending across all Medicaid MCOs (now transitioned to CCOs) per health center into a PMPM rate for each CHC; this PMPM rate is applied for all subsequent years (the “individual clinic rate”). The PMPM is calculated for all those “active” patients: those who have had contact at least once with that CHC in the past year. For Medicaid patients enrolled in an MCO (approximately 90 percent of Oregon’s Medicaid recipients), the MCO will pay to the CHC a primary care capitation or continued FFS that is equivalent (the “basic rate”) to the MCO’s payment rate to any other provider.
- (2) The difference between that basic rate received from the MCO and the individual clinic rate calculated by the state is then converted into a “wraparound” PMPM payment to the CHC, to

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<sup>11</sup> Oregon APCM Pilot Metrics and Accountability Plan (reviewed June 19, 2015)

<sup>12</sup> Transforming Payment for Oregon’s Community Health Centers through an Alternative Payment Methodology. Full Proposal Narrative to Robert Wood Johnson Foundation. Proposal ID 9377.

maintain budget neutrality for the individual clinic. Pay for performance (P4P) incentives for quality or shared savings can also be negotiated between the CHC and its MCO(s) in addition to the budget-neutral individual clinic PMPM. There are quality bonuses available through the CCOs: two percent of the ultimate CCO capitated budget and scheduled to rise ultimately to five percent. Actual payments under the APM will be reconciled periodically with FFS-equivalent revenues that would have been paid under PPS, given actual health services utilization during the current payment period. In the event the individual clinic PMPM does not equal or exceed the FFS-equivalent payment, the state would pay the difference. This reconciliation mechanism mitigates downside utilization risk under APM for the individual clinic, while still allowing the clinic to capture cost savings and quality benefits from a value-based approach to care delivery. If the Medicaid recipient is an “open card” or FFS patient (not under an MCO contract with the clinic), the state would pay the full APM amount up front based on prior FFS equivalents. Open card capitation is still reconciled to actual FFS payments and the state pays additional if the capitation revenue is below FFS revenue.

To avoid duplicate payments to clinics due to patients in APM-participating clinics receiving services from other primary care providers (“leakage”), the OHA and OPCA initially developed a means of attributing patients uniquely to a given clinic based on claims data for the prior 18 months. On December 30, 2014, the OPCA and OHA amended this attribution process. Claims for all APM enrolled patients are now monitored monthly and APM enrollment is changed for purposes of APM payment when leakage occurs, subject to a three-month grace period for new pilot clinics. Payment to the FQHC is pro-rated so that enrollment net of leakage is reflected in monthly PMPM payments. For every two visits to another FQHC by a clinic’s attributed member, the original clinic has its attributed (paid) enrollment decreased by one member; for every single visit to a non-FQHC clinic, the original FQHC also has its paid enrollment reduced by one member. Starting February 1, 2015, the attribution timeline was moved to a six-month look-back period to enhance interactions with patients changing clinics and to facilitate more timely payment reconciliations.

*Delivery system reform.* The advanced care model (ACM) is a crucial complement to the APM payment reform strategy; and as of July 2014 the APM and ACM strategies have been jointly named the Alternative Payment and Care Model (APCM) -- to reflect their integration within the Phase II clinics. Several of the participating clinics have been engaged in primary care transformation for the past decade, further inspired by the Patient-Centered Primary Care Home Program (PCPCH) established by the Oregon legislature in 2009<sup>13</sup>. The advanced care model of the CHCs involves changes in workflow, new templates for care, a revised division of labor within a team-based care model, group visits, and use of a “touches tool” to document and track enabling services that support patient-centered care.

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<sup>13</sup> Patient-Centered Primary Care Home Program. [http://www.oregon.gov/oha/pcpch/Pages/about\\_us.aspx](http://www.oregon.gov/oha/pcpch/Pages/about_us.aspx)  
Accessed May 30, 2014.

Those enabling services (touches), many of which were non-reimbursable under FFS-based payment, are fundamental to delivering patient-centered care. By supporting the whole person, these “touches” allow care providers to address the social and behavioral determinants of their patients’ health, rather than solely concentrating on the patient’s immediate medical needs. The following enabling services are currently being tracked<sup>14</sup> :

- Accessing community resources and services
- Case management
- Education in a group setting
- Exercise class participation
- MyChart encounter via secure web portal
- Support group participation
- Telephone visit
- Home visits (non-billable under PPS, of two types)
- Warm hand-off (non-billable)
- Coordinating care: clinical follow-up and transitions in care setting
- Coordinating dental care
- Coordinating care: information management
- Flowsheet documentation of health screening
- Transportation assistance
- Health education supportive counseling (one-on-one)
- Support group participation
- Telemedicine encounter

Individual clinics are pursuing several care delivery initiatives to achieve their objectives. One clinic has identified its high-utilizers by using health data and then collaborating with their major MCO, which has embedded the MCO’s employed outreach workers directly in the clinic. That same clinic has four care delivery teams working to integrate behavioral health with medical care, incorporating a behavioral health consultant within each team. Proactive patient engagement is another aspect in the clinic’s redesign of care delivery – encouraging patients to develop self-care plans and formally measuring patient activation as part of the process. This clinic also is slowly progressing on classifying patients into similar groups – not for purposes of risk stratification, but to develop clinical pathways for persons with similar needs. Another clinic highlighted that the transformation to team-based care also is necessitating new information flows, training, different capabilities in hiring, and performance standards. As one interviewee stated, “[We are] developing clear standing orders and protocols, so the rest of the team will be empowered to take certain tasks off the shoulders of the RN or doctor, and everyone works at the top of their license.” The clinic also is expanding the number of medical assistants (MAs),

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<sup>14</sup> Oregon Health Authority. APM Touches Report: Engagement Touches. May 31, 2015.

administrative support staff, and mental health expertise. This care team reconfiguration supports the practice's work on the social determinants of health: transportation, education, poverty, and employment opportunities. A patient representative from a third clinic reported that the inclusion of a pharmacist on the care team, and the presence of a common patient record across different care settings, substantially improved the care of the patient's asthma.

In May 2015 one clinic reported that its participation in the REACH project for high-utilizing Medicaid patients coincided with zero readmissions for participants during the prior month. This care management program joins a physician, care coordinator, pharmacists and social workers as a team to care for those patients. While behavioral health is carved out of the APM payment, the clinic has a full time social worker embedded in the care team pods, serving not only patients with behavioral health problems, but also the practice's patients as a whole. This clinic is using the Patient Activation Measure<sup>15</sup> and collaborative care planning as mechanisms for enhancing patient engagement.

*Tracking measures.* In addition to tracking the extensive set of enabling services ("touches"), the clinics are systematically measuring aspects of performance that will help to achieve the Quadruple Aim of the APCM:

#### CCO Focus Measures

- Alcohol and drug misuse (SBIRT)
- Depression screening and follow-up plan
- Follow-up for children prescribed ADHD medication
- Timeliness of prenatal care
- Developmental screenings
- Adolescent well care visits
- Colorectal cancer screening
- Diabetes: poor control of HbA1c (blood glucose level)
- Hypertension (blood pressure ) control

#### Uniform Data System (UDS) measures (required by HRSA)

- Tobacco screening
- Childhood immunizations

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<sup>15</sup> Hibbard JH et al. Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers. Health Services Research 2004 Aug. 39(4) (Pt. 1): 1005-1026.



- Weight control: children and adults
- Cervical cancer screening

*Patient engagement.* The APM-participating health centers have adopted a broad portfolio of activities to engage patients in their own care. In addition to the engagement touches, the clinics' patient and family advisory councils also promote active patient engagement. One provider organization's key informants discussed how the director of programs meets monthly with patient advisers from each of the organization's clinics to discuss new ways of engaging patients in their own health, and how patients might best be integrated within the team caring for their own health. One example of the patient advisory council's function was to approve the strategic decision to place secure, private information on the MyChart portal for viewing by the individual patient.

*Logic model.* The underlying logic model can be summarized as follows: Patient-centered, PMPM-based primary care payment reform supports innovation in health services delivery toward whole-person, team-based care. The reasoning is that, by restructuring payment to PMPM rather than per face-to-face visit or per encounter, providers will be freed from the "production treadmill" of face-to-face visits to allow providers to effectively manage population health for their patients. This patient-centered payment will allow providers to give better care, defined as care focused more upon the needs of the patient. This will also allow providers to better manage total patient costs, as they now have an incentive to optimize (not maximize) face-to-face visits and the use of enabling services ("touches" including contact via phone, email, and Skype), while increasing post-visit follow-up and improving management outside the walls of the clinic. The consistent flow of money into the clinic each month helps support this goal by reducing the unpredictability and delays of incoming payments; as one interviewee noted, the APM is offering predictable payment and financial stability.

The Advanced Care Model and its five strategies constitute an operational statement of the logic model. That statement begins with the APCM goal: "Align payment with an efficient, effective, and adaptable payment model that achieves the Quadruple Aim in Oregon CHCs." Next, five strategies are articulated, with the first strategy being the foundation for all others: (1) Teams use actionable, real-time information/data (focus on 2 quality measures and one social determinants of health metric).

The other four strategies are parallel pillars that support the APCM goal:

- (2) Teams expand access through new visit types (e.g., group and e-visits)
- (3) Teams engage each patient annually (e.g., by adding new roles for the care team)
- (4) Team-based care improves patient engagement and/or self-management support (e.g., co-design care, tap motivational interviewing)

(5) Teams enhance appropriate care and reduce unnecessary utilization (e.g., support through community and public health partnerships, utilize social determinant of health information to design care interventions)

### **Project Progress**

Overall, in terms of implementation through Year 1 of the project (March 2013 – February 2014), the clinics were receiving payment on schedule and at expected levels. Initially, this required significant effort but the payment processing has now been refined. Based on first year results no reconciliation payments have been required from the state. It is too early to isolate changes in utilization or cost, and the “touches tool” is highly variable in its documentation of enabling services. The general impression is that quality measures are improving or staying constant during Year 1, ED utilization has decreased, and the clinics’ response to APM has been positive.

Building on primary care redesign initiated under the PCPCH program, team member roles are evolving toward whole person care, e.g., greater integration of preventive and non-clinical care, such as cooking classes. Patients no longer are required to make visits on separate days for behavioral health and physical health (medical care) because of constraints on billing for those distinct services on the same day. That said, much of Year 1 focused on data collection from the health plans, the state, and member attribution. The patient-centered payment model has freed more time for teams to “huddle” (formerly viewed as lost revenue under PPS) and work on panel management and quality improvement<sup>16</sup>.

Another APM participating clinic reported a greater sense of urgency in defining new team roles – community health care workers (CHWs), RN care managers, and “behaviorists” (specializing in behavioral health). Former hierarchies are flattening, and the focus on team care (enabled by APM) is helping to build trust. The clinic is exploring how to collaborate more effectively with the medical neighborhood and community as part of their participation in CCOs. This clinic noted the limits of APM in spurring care delivery innovation, given that the PMPM does not include subspecialty care. The clinic interviewees also noted the enhanced financial stability and steady cash flow provided by the APM, which also has allowed greater predictability in the hiring of new staff<sup>17</sup>.

A third clinic interviewee observed that—due to ACA-supported Medicaid expansion, which has resulted in more than 200,000 new Medicaid recipients, and the APM incentives—this clinic is seeing significantly more Medicaid patients and is very actively establishing them as clinic patients. Care teams are engaging in more outreach (via phone, e-mail, and MyChart), as well as providing more preventive services. The clinic’s parent provider organization is deploying resources from a Center for Medicare and Medicaid Innovation (CMMI) grant to “hot-spot” by linking frequently hospitalized patients back to primary care. This clinic is advancing a new care model – emphasizing pre-, during, and post-clinic visit phases and

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<sup>16</sup> OPCA’s Population Health Design Summit. January 2014. <http://www.orpca.org/files/SummitNotesJan2014.pdf>  
Accessed May 15, 2014 Also, see: Interview# 042814 GM1100

<sup>17</sup> OPCA’s Population Health Design Summit. January 2014. <http://www.orpca.org/files/SummitNotesJan2014.pdf>  
Accessed May 15, 2014

quality improvement. It is also looking at pharmacy integration and using the patient activation measure to support the development of self-care plans. The clinic seeks to spread this care model to all patients, not just those under APM, which account for roughly half the clinic's population<sup>18</sup>.

While not confirming a causal relationship, there are early indications that the APM is starting to affect the market. For example, the clinics and MCOs are increasingly incentivized to craft PMPM contracts. In addition, the OHA runs monthly "leakage" reports for the clinic, which (among other things) track how often an "established patient" at one APM-participating clinic receives primary care services in another clinic or care setting. This leakage of prepaid (APM) patients to other clinics receiving FFS for the same patient potentially would increase total Medicaid spending. The monthly reports provide APM clinics with information on their established patients' use of institutional care (including ER), pharmacy, lab, radiology, and specialty care. Early findings from a preliminary study of the pilot FQHCs indicate that ER utilization is declining significantly, hospital utilization is down, patient feedback remains positive, quality levels are maintaining at pre-APM levels, and engagement touches are increasing in parallel with improved documentation and changes in team work<sup>19</sup>.

The Year 1 assessment by the state confirmed budget neutrality; as of our May 2015 site visit, budget reconciliations had not been completed. The first year's results showed touches lower than anticipated. In two of the Phase I clinics, visits were below the baseline (pre-APM) year's. An independent study of the Phase I pilot clinics confirmed a modest decline in (face-to-face) visits (in year 1), and also that primary care physicians were spending more time per visit and that ED utilization had declined from baseline (pre-APM) levels and that quality had improved on some measures. While final results are not in yet, early indications suggest that total cost of care results are positive.

One clinic interviewee noted that quality had improved and the rate of hospitalization and ED use had decreased. The same clinical leader remarked that the APCM was supporting an expanded care team (e.g. behavioralist, social worker, and pharmacist) that previously would not have been possible. As one clinic administrator mentioned, the move away from "the tyranny of the urgent" – allowing more time per patient – is also supporting more panel management and outreach to patients. Several commentators noted that the Phase II clinics have been able to benefit from the learning in Phase I

The mindset of clinicians seems to have been impacted as well – expressed as a feeling that "... it's okay to get off the treadmill." Under APCM there is a commensurate broadening of the involvement of the care team in outreach, and this expands the revenue-generating capacity of the practice. Another clinic interviewee estimated that the APM had resulted in an additional \$600,000 in revenue over the life of

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<sup>18</sup> OPCA's Population Health Design Summit. January 2014. <http://www.orpca.org/files/SummitNotesJan2014.pdf> Accessed May 15, 2014 Also, see: Interview # 050514 ET1500

<sup>19</sup> Laurie Francis and Laura Sisulak. Designing care to meet patient needs and improve outcomes (Slide 14). Presentation at RWJF-sponsored conference: Payment Reform: Honing the Models and Pushing the Boundaries. Chicago: October 23-24, 2014.

the pilot. Another benefit of the APM has been stabilizing and acceleration of clinic cash flow by the provision of upfront payment.

### **Facilitators and Barriers**

Facilitators and barriers are presented in no particular order.

#### *Facilitators.*

- The commitment of the APM clinic participants has been critical. The participating clinics have displayed a mission-oriented vision and a readiness to change that has enhanced progress.
- Strong clinic leadership has been key.
- Collaboration among the APM participants has been excellent.
- The decision to make APM participation voluntary assisted in garnering the upfront support for infrastructure investment and maintenance by the clinics. The phased rollout enabled different successive clinic cohorts to learn from one another's experience.
- The infusion of new revenue has motivated clinic staff and helped them to stay engaged.
- All Phase I and II clinics have benefitted from the high-quality data system of OCHIN, which has allowed for more sophisticated data analysis, especially in quality improvement.
- Support from key legislators and political forces were instrumental. An abundance of forward-looking political leaders aware of the perverse incentives of fee-for-service, coupled with a Governor with strong interests in health care reform, have provided further impetus for value-based payment. The state's willingness to experiment and the strong relationship between OHA and OPCA has helped "kick-start" the APM (now renamed the APCM) project, as well as sustain momentum.
- The intensity of health reform in the state and the subsequent major grant from CMMI to fund the CCOs have reinforced the motivation to adopt the APM.
- The Meaningful Use standards for application of EHRs and information technology have spurred further innovation in the clinics, with strong facilitation by OCHIN.
- The expansion of Medicaid through the ACA has also augmented the patient population for the CHCs and supplied new revenue, which reinforces the case for advancing the innovative care model across a now larger patient panel.
- The OPCA has played a major sponsoring and managing role in the APM project. The idea to undertake the APM was spawned at OPCA. OPCA was able to obtain state and federal approval of a State Plan Amendment (SPA), and this established the foundation for APM. OPCA has been successful in moving the project forward: "herding the cats," challenging the clinics, and encouraging the long term view. OPCA leadership has enabled a very open, transparent and collaborative process for the participating clinics and other stakeholders.
- CareOregon, the largest Medicaid managed care organization, has been a strong supporter. The major grant to the state of Oregon of \$17 million for support of the CCOs has been an important complementary facilitator for APM. As a risk-accepting entity within its CCO, CareOregon has

provided valuable technical assistance to clinics and was instrumental in securing the REACH grant through CMMI.

- Patients have been excited about this work; through their role on FHQC boards and advisory councils, they understand the APM incentives and appreciate the potential to improve access to care.
- The Robert Wood Johnson Foundation – both in providing the grant resources and in conducting quarterly verbal check-in between the RWJF project officer and the APM project stakeholders – is perceived as offering significant value-added to implementation of the APM.

#### *Barriers.*

- The APM project is competing with a series of other top-priority challenges for the attention of clinics, the OHA, the CCOs, and other major stakeholders. These include implementation requirements of the ACA, the transition of MCOs to CCOs and the fixed budget facing those CCOs, and the development of meaningful and timely data analytics.
- The Oregon health insurance exchange (Cover Oregon) ran into major problems with its web portal, which led to delays in fully implementing APM and establishing APCM in the first two quarters of 2014.
- The 25 percent increase post-ACA in the Medicaid population significantly taxed primary care provider and clinic capacity
- While not barriers per se, the intellectual capital, software development, and building of reporting structure require significant investment and represent a major challenge.
- The transition from PPS to APM has imposed significant cash flow challenges to the OHA in processing payments. Specifically, APM payments due upfront to participating community health centers are a current cash liability for the state. Yet, at the same time, lags between services incurred under the pre-APM PPS (per visit) system and ultimate claims reported (the incurred but not reported, or IBNR, lag) require the OHA to process per visit claims over time with uncertainty around the State's ultimate payment liability. Thus, OHA ends up advancing prospective payment for APM as well as PPS payment for past services of the same clinic. Until reconciliation of the two payment streams is completed, the OHA is exposed to increased cash outflows, and that represents a revenue cycle management challenge.
- While the PCPCH and advanced care models are well aligned with the value-based payment concept, engaging in primary care practice transformation while introducing a new payment model clearly strains the clinics' organizational capacity.
- Inertia itself is a big challenge: changing how providers see and care for patients, how clinical care teams interact, and changing systems for employees and patients are all forms of disruptive innovation, and it takes time to adjust to those changes.
- The clinics must manage additional emerging demands: further refining meaningful and reliable measures of enabling services (the "touches tool"), tracking the social determinants of health

and managing care “upstream,” and moving from ICD-9 to ICD-10. Even with explicit definitions (as in the APM Engagement Touches Report), the touches can be difficult to define and track. Documenting those services also places additional administrative burden on clinic staff.

- Not all participating clinics had access to the same reporting tools used for tracking patient metrics and attribution. This increased administrative time for clinic managers, who are already dealing with a full plate of job responsibilities.
- Patient attribution under the PMPM form of reimbursement has proven a challenge. Patients are free to switch managed Medicaid plans or providers at any time; if an attributed patient is seen twice at another location or once at another FQHC they are reattributed to that organization. To address this issue, one participating clinic diverted the time of an individual who was previously responsible for revenue cycle management (now much less of an issue due to the consistent, upfront PMPM rate each month) to managing the attributed patient lists.
- The complexity of change is highlighted by the five percent of total budget that the state is looking for the CCOs to save by focusing on high-utilizers.
- Some decisions are harder than originally anticipated. For example, determining which services are in versus outside of the APM requires study of historical claims and negotiations between the state and individual clinics, while realizing that individual clinics differ somewhat in their scope of services.
- Individual clinics’ capacity to take on one more innovation—“change fatigue” – is a barrier to moving as smoothly and expeditiously to APM as originally envisioned. For example, behavioral health care, which is not a covered service at this time in the APM, raises some payment and billing issues. Specifically, behavioral health is carved out of APM payment, but paid under PPS for the participating clinics. While behavioral health is an important element of primary care, it is paid through a separate volume-driven mechanism, which complicates integration of physical and behavioral health and adds administrative cost to clinic billing.
- It is still difficult to retrieve timely and actionable data on quality of care from the EHR. Some clinics have greater data analytic capacity than others. Clinics experience delays in receipt of data from the CCOs, and notification from the ER to the clinic that an established clinic patient was seen or admitted the prior evening is often lacking. The EPIC data system is not particularly user-friendly, and often the APCM-participating clinics need to call on OCHIN expertise to generate useful reports. As one interviewee expressed, the population health management capacity is not there. For example, a consistent data system for managing a population subgroup (“segment”) of diabetics who are homeless and African American – that is, use of real-time data to manage care in light of social determinants of health – is not yet available for most of the clinics.
- Changing internal systems to benefit one segment of the patient population (Medicaid enrollees) without replicating those changes for other population segments is hard to justify clinically, administratively, and economically. Clinics confront the reality of living under two

different payment regimens: FFS and value-based, person-centered payment. Even after adopting the APM approach, one clinic noted that its method for compensating individual providers still has a major variable pay component based on relative value units. Two other clinics highlighted the misalignment between their predominantly production-based provider compensation methods and the intent of the APM, person-centered payment incentives. One clinic response has been to build in a compensation incentive for panel size. Leadership turnover at the administrative and clinical level can also be a barrier in implementing APM.

## **Evaluation and Sustainability**

*Evaluation.* OCHIN has received a separate RWJF grant to evaluate the APM in Oregon’s Community Health Centers<sup>20</sup>. The purpose of the evaluation, in collaboration with a team from Oregon Health Sciences University, is to develop and share insights regarding processes for implementing global capitated payments in CHCs and other alternative payment arrangements that could enhance quality and equity by migrating from FFS payment models. This mixed methods evaluation is meant to provide a baseline for a larger five-year evaluation of the impact of APM as a “natural experiment.” The tasks include completion of a baseline survey of eight CHCs (including the March 2013 Phase 1 APM clinics and the planned July 2014 Phase 2 APM clinics). In parallel, an interactive blog is hosted by OCHIN to share best practices and distribute key learning from the APM implementation. The blog is aimed at a wide range of stakeholders, and representatives of these diverse stakeholder groups will be asked to contribute to the blog, assist in interpreting preliminary findings, and offer input on dissemination of information and products from the APM project. Bi-weekly, online practice diaries, site visit interviews, and ongoing quantitative analyses of practice surveys will also be conducted.

The OCHIN study team will conduct a longer term retrospective evaluation of APM’s impact, based on pre-APM and post-APM comparisons. The OCHIN evaluation, led by Dr. Erika Cottrell, is addressing the extent to which APM has induced the APM Phase I clinics have redesigned their work flows to address patient and population health needs, and is examining whether the APM clinics have experienced lower total costs of care, changes in patterns of health services use, and better quality of care. The study is scheduled for completion by June 30, 2015<sup>21</sup>. The OHA has commissioned a second set of analyses, likely to be completed in July-August of 2015, which will examine total cost of care and other parameters (including budget neutrality) related to the APM and its Phase II successor, the APCM. The clinics and OPCA have also created dashboards to support internal evaluations of performance on the tracking measures discussed in an earlier section of this report.

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<sup>20</sup> DeVoe J. A Mixed Methods Evaluation of Payment Reform in Oregon’s Community Health Centers. Application ID: 23077

<sup>21</sup> Erika Cottrell. OCHIN Research Summary. APM Evaluation: Evaluating a Capitated Alternative Payment Methodology in Oregon Community Health Centers – 7/1/2013 – 6/30/2015.

*Sustainability.* The project is expected to be self-sustaining and the stakeholders anticipate that it will result in cost-savings for those clinics involved. Spread to the Phase Two clinics occurred in July 2014. Most of those clinics wanted to see at least one year's worth of financial data from the Phase One clinic experience before adopting the new model. They intend to continue the project despite the end of RWJF funding. Meanwhile the OPCA is also recruiting a new set of Phase III clinics. Despite funding challenges, a lot of the work is underway at OPCA. Two OPCA senior managers are dedicating a majority of their work to this project. Their continued support of the APM project is necessary, and the OPCA is exploring additional funding to support continued oversight and management of the project. After the next few years, the APM implementation will need to shift to a self-sustaining model based on the internal funds of payer and provider organizations. . The project has received a follow-up grant to compensate an external consultant working on payment rates and support for the model of care learning community. OCHIN is committed to continuing support of OPCA and the clinics, as they continue on this APM implementation.

As recognized by the stakeholders, a sustained, robust implementation of the APM and other value-based payment models in Oregon will require financial buy-in by other payers beyond OHA and Medicaid. Other payers and the CCOs seem to understand this, but – according to one clinic interviewee – “it will take them a while to get there.” Broad-gauged payer adoption of value-based payment is crucial to addressing the free-rider problem alluded to earlier. The same key informant argued that business and industry are reaching the limits of their tolerance for the current system, and will only accept a payment model that incepts value.

### **Lessons Learned**

The stakeholders in the APM project generally confirm the importance of changing the payment system to one based on value, and correspondingly moving away from volume-driven, fee-for-service (or per visit) payment. Several remarked that having agreed-upon performance metrics prior to APM implementation would have been desirable; at the same time, interviewees recognized that development of the alternative payment model and the accompanying advanced care model (originally, the ACM) was an organic process, and none suggested explicitly that delaying APM implementation -- until the ultimate performance measures and accountability matrix were developed -- would have produced better results. One project leader did remark that the APM project would have benefited from having an accountability plan in place at the inception.

The APM payment model is seen as a bridge to value-based payment, not necessarily the ultimate “best” form of payment. One interviewee would favor a payment that included upside potential, and –if necessary – downside risk. That said, several interviewees pointed to the value of aligning payment method with a population-based, whole person-centered service delivery model. While one leader remarked, “You get what you pay for,” none of the interviewees directly recommended changing payment model first to drive subsequent changes in care delivery. Thus, the notion of changing and



aligning service delivery and payment models in parallel with each other seems to capture stakeholder views most faithfully. One interviewee remarked that having service delivery model and payment aligned at the “get-go” would have accelerated progress. Several commentators observed that individual provider compensation methods must move away from predominantly production-based incentives (e.g., RVUs, number of visits) toward compensation focused on population health, quality, and access, in order for APM and other value-centric payment models to thrive. Another project champion reflected on the need for care teams to embrace an activated role for non-licensed and non-physician providers in developing treatment plans, economizing on physician and nurse time, and enhancing population health management and outreach.

As one project leader put it, “relationships matter.” In that vein, the careful orchestration of implementation, support, and ongoing collaboration and communication among the OPCA, OHA, OCHIN, the individual clinics, and other major stakeholders has been a major bonding mechanism to sustain the APM and APCM initiatives over time. Keeping the patient in mind first, and integrating social determinants of health with care delivery, has helped integrate the efforts across diverse stakeholders.