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

Executive Summary: August 2015 Report

Introduction and Context

The Oregon Primary Care Association (OPCA) serves as the initial applicant organization and facilitator for the value-based reform project. The Oregon Health Authority (OHA) works directly with OPCA and CHCs on billing arrangements, rules, and regulations. The Alternative Payment Methodology (APM) intends to replace encounter-based Prospective Payment System (PPS) for Medicaid patients in Community Health Centers (CHCs) with per-member-per-month (PMPM) payment. Care redesign processes known as the advanced care model (ACM) were later added to this model to form the Alternative Payment and Care Model (APCM). The momentum for the APM and later APCM grew out of Oregon's participation in the earlier Safety Net Medical Home Initiative. Three CHCs participated in the first year, with four additional clinics joining the following year.

Project Objective

The intent of the APCM is to encourage focus on patient-centered care by restructuring payment to PMPM to free providers from a visit based, volume driven approach. The APCM's ultimate objective is to achieve higher-quality, patient-centered care that is delivered at lower cost for Oregon's Medicaid and uninsured populations.

Approach

The APCM is a global primary care PMPM payment free of downside risk for the clinics. The APCM includes only physical health; future inclusion of mental health, OB/GYN, and dental care is being considered. The APCM is calculated by the state through examination of the prior year's PPS rate and historical average patient health services utilization pre-implementation of the APCM for "active" patients: those who have established contact with that CHC in the past year. For Medicaid patients enrolled in an MCO, the difference between that base rate received from the MCO and the individual clinic rate calculated by the state is converted into a "wraparound" PMPM payment to the CHC.

Delivery system reform. The advanced care model of the CHCs involves changes in workflow, new templates for care, and use of a "touches tool" to document and track enabling services that support patient-centered care. Individual clinics are pursuing several care delivery initiatives including employing outreach workers, integrating behavioral health, and developing protocols to empower the care team to take work off the shoulders of the RN or doctor. Several clinics have focused on identifying high-utilizers through collaboration with their supporting MCOs. Proactive patient engagement has been critical; one clinic noted the impact of the Affordable Care Act (ACA)-supported Medicaid expansion led to more than 200,000 new recipients in Oregon which they have pursued through outreach and additional preventive services.

Tracking measures. The clinics are measuring aspects of performance related to quality, access, and cost. These measures are derived from the Uniform Data System measures required by the Health Resources and Services Administration, or are measures being currently tracked by the CCOs.

Project Progress

All Year One clinics began receiving payment under the new methodology on schedule and at expected levels starting March 2013. All phase two clinics began on July 2014 with the exception of the Multnomah County Health Department, which did not begin until September 2014. The Year One assessment by the state confirmed budget neutrality, with patient touches lower than anticipated and a modest decline in face-to-face visits. Primary care providers spent more time per visit, and emergency department utilization declined from baseline levels. Quality improved on some measures, and no decreases were noted.

Facilitators and Barriers

Facilitators.

- The OPCA as a major sponsor and strong leader of the APM project.
- The decision to make APCM participation voluntary.
- Clinic linkage with the OCHIN system.
- The intensity of Oregon health reform and major CMMI grant; forward-looking political leaders.
- The expansion of Medicaid through the ACA.
- The Robert Wood Johnson Foundation's grant resources and quarterly verbal check-ins.

Barriers.

- Competition for the attention with a series of other top-priority challenges.
- The Oregon health insurance exchange's (Cover Oregon) major web portal issues.
- The 25 percent increase in the Medicaid population post-ACA significantly taxed primary care capacity.
- Justification for changing internal systems to benefit just one segment of the patient population.
- The transition from PPS to APCM imposed significant cash flow challenges for the OHA.
- Patient attribution is challenging and requires additional staff resources to manage.
- Leadership turnover; the recent departure of the governor who was a supporter of the project.

Evaluation and Sustainability

Evaluation. OCHIN and a team from Oregon Health Sciences University have received a separate RWJF grant to evaluate the APCM. This mixed methods evaluation will provide a baseline for a larger 5-year evaluation of the impact of APCM as a natural experiment. In parallel, a web blog is hosted by OCHIN to share best practices and key learnings from implementation. The OCHIN study team also will conduct a longer term retrospective evaluation of APCM's impact, based on pre and post-APCM comparisons.
Sustainability. The project is expected to be self-sustaining and the stakeholders anticipate will result in cost-savings after implementation. Spread to additional phase three clinics is expected. One project leader implied that the project has roughly three more years of projected local and national grant support before it must become self-sustaining.

Lessons Learned

Several clinics remarked that having agreed-upon performance metrics prior to implementation would have been desirable, along with an accountability plan in place at inception. The payment model is seen as a bridge to value-based payment but not necessarily the "best" form of payment; one interviewee favored payment including both upside potential and downside risk. Having the delivery and payment model aligned at the start would have accelerated progress; a lesson learned that the OPCA was able to implement for the second phase of clinics with the learning collaboratives.