

Spotlight on Health Center Payment Reform: Oregon Alternative Payment and Advanced Care Model

Introduction

Primary care associations throughout the country are grappling with how to help lead health centers in their state into the exciting, yet challenging frontier of care and payment transformation. Oregon stakeholders – the Oregon Primary Care Association (OPCA), health centers and the State – quickly embraced health system reform following passage of the Affordable Care Act, and have been willing to lead their organizations through significant transformation. Oregon’s initiative, the Alternative Payment and Advanced Care Model (APCM), is inclusive of both care and payment transformation in this frontier. It’s goal is to lead the development of and align payment with an efficient, effective and emerging care model that achieves the quadruple aim of improving patient and employee experiences and population health (quality, access, and health equity) while reducing system costs. To that end, Oregon’s APCM Accountability Plan includes quality, cost, access, and patient engagement measures.

Oregon’s APCM is a formal Alternative Payment Methodology (FQHC APM), approved by CMS through a State Plan Amendment in 2012. The payment methodology and associated policies have been developed through a collaborative effort of OPCA, participating health centers and the Oregon Health Authority (OHA), which is the state’s Medicaid agency. Over three years into implementation, the model continues to evolve.

Oregon Context

- Oregon expanded Medicaid in 2014, and with the Affordable Care Act (ACA) increased coverage to nearly all non-elderly adults with incomes at or below 138% of the Federal Poverty Level (FPL).¹
- 25% (1.02 million) of Oregonians are covered by Medicaid and CHIP as of July 2016, a net increase of 63% since 2013.²
- Approximately 91% of Oregon Medicaid enrollees are in a collaborative care organization (CCO), while another 5% are enrolled in “other managed care programs.”³
- 411,462 Oregonians (60% of whom are enrolled in Medicaid) are cared for by health centers.⁴
- There is a proposed mandate for CCO’s to pay some percentage in alternative payment methodologies in the state’s pending 1115 waiver. Currently, adoption of APMs are encouraged.

¹ Medicaid.gov website (accessed October 24, 2016); available from <https://www.medicaid.gov/>.

² *Medicaid and CHIP in Oregon* (access October 24, 2016); available from <https://www.medicaid.gov/medicaid/by-state/stateprofile.html?state=oregon>.

³ *Oregon Health Plan: Coordinated Care, Managed Care and Fee for Service Enrollment for January 15, 2016*. Oregon Health Authority, Office of Health Analytics.

⁴ Oregon health center 2015 UDS reports

Background

Oregon Prospective Payment System

Since the Prospective Payment System (PPS) was established for federally qualified health centers (FQHCs) under the Benefits Improvement and Protection Act of 2000, PPS policy in Oregon has evolved. Most notably:

- Flexible rules and regulations allowing health centers to make “Changes in Scope” at the state level. For example, many clinics were able to integrate costs for IT expansion and medical home investments into their PPS rate.
- Rules for new health centers establishing PPS rates are flexible.
- Medicaid managed care is a significant presence under Oregon health reform, but PPS payments are maintained at the state level through wrap around payments. Quality bonus payments or other pay for performance payments are made outside of PPS payment, coming directly from one of the state’s regionally defined accountable care organizations known as a coordinated care organizations (CCOs).

Oregon health centers were early and aggressive adopters of the medical home, called Patient Centered Primary Care Home in Oregon, pursuing both state certification and practice change vigorously. These health centers were focused and united in their enthusiasm for the model, but soon the resources, intensity, and effort required felt like a burden to providers still laboring under visit-based reimbursement. OPCA, several health centers, and the OHA began to explore alternative payment structures that would remove the barrier of visit based payment, allow for more transformative use of the medical home, and address provider burnout issues.

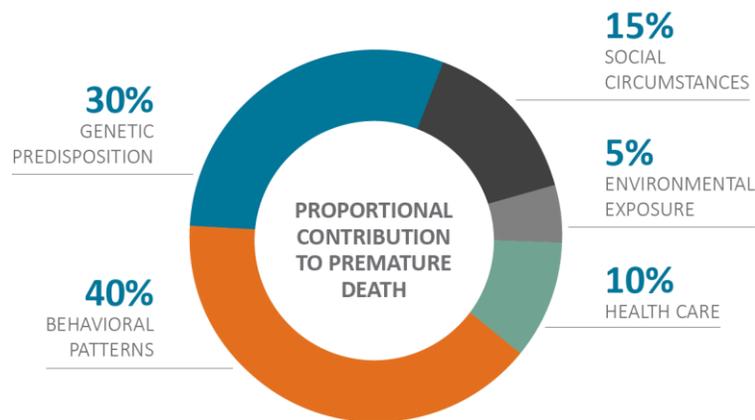
APM vs. APM

The acronym APM is used in literature to refer to both the FQHC-specific methodology available to states under the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), and to a variety of other payment methodologies. In this paper we use FQHC APM to refer to health center specific Alternative Payment Methodologies as defined in BIPA.

Oregon APCM Goals

The goal of Oregon’s APCM is to lead the development of and align payment with an efficient, effective, and emerging care model that achieves the quadruple aim in Oregon health centers. As early and aggressive adopters of the medical home, the health centers were already learning that improving health for their increasingly complex patient populations would require the flexibility to transform the care model beyond the traditional medical model. Understanding and addressing the social, environmental and behavioral health challenges facing patients (as demonstrated in Figure 1) would be critical to long term success of the model.

FIGURE 1: Proportional Contribution to Premature Death⁵



For the payment methodology in particular, stakeholders identified visit based payment as a key impediment to desired outcomes, including provider engagement, medical home implementation and ability to advance the quadruple aim. At the time that OPCA initiated the effort, all Oregon health centers were paid under the federally defined PPS methodology, with a well-defined Change in Scope process, annual adjustment by the Medicare Economic Index (MEI), and no other targets or limits to visits beyond state constraints related to same day visits.

The political climate in Oregon in 2011-12 was ripe for change. Oregon was facing unsustainable budget growth for Medicaid spending, and had already sustained substantial cuts to both Medicaid populations and services covered in recent years (for example, reduced adult dental to emergency only and created a budget-limited lottery for non-mandated adults). Providers and policymakers alike recognized that Oregon could not continue business as usual and expected to see any progress towards the quadruple aim outcomes. Stakeholders in Oregon began to explore opportunities to advance health care transformation through the expansion of health homes (ACA section 2703 funding) and eventually through its pursuit of an 1115 waiver approach centered on the coordinated care organization (CCO) structure.⁶

The state (though the OHA) agreed to consider innovative approaches to payment with the promise of moving health centers incrementally towards value based payment. OPCA began negotiating an FQHC APM (authorized under BIPA). Even though the state had yet to define its 1115 waiver/CCO transformation effort, OHA was receptive and already thinking creatively about incentivizing greater adoption of the medical home and accountability for improved outcomes.

Aspects of the financial foundation for health centers piloting the FQHC APM effort included:

- A high proportion of Medicaid and uninsured patients in their payer mix.
- High enrollment in Medicaid managed care.
- A PPS rate that was largely inclusive of added costs due to medical home and meaningful use implementation.

⁵ McGinnis J.M., Williams-Russo P., Knickman J.R. "The Case for More Active Attention to Health Promotion," Health Affairs 2002;21(2):78-93.

⁶ Oregon's 1115 Medicaid Demonstration Waiver (accessed October 24, 2016); available from <http://www.oregon.gov/oha/OHPR/Pages/1115-Demonstration-Waiver.aspx>

- Relatively stable patient visit utilization over time.
- Beginning participation in quality bonus or medical home incentive payments through Medicaid managed care.

As details of Oregon’s CCO “experiment” emerged, the health centers’ approach to FQHC APM was in clear alignment with the goals and approach to providing better, coordinated care under a global budget. Some of the defining features of that experiment that are well aligned with the FQHC APM include:

- CCOs (Oregon version of an ACO) accept full risk for their Medicaid population under a global budget.
- There is a defined list of CCO quality metrics that the CCOs are incentivized to meet/exceed. Largely, these have become the metrics for the FQHC APM and advanced care model.
- CCOs are encouraged to pursue alternative payment arrangements with their providers to incentivize greater quality, customer satisfaction and lower costs.
- The agency’s Medicaid budget is held to 2% below Medicaid inflation, encouraging cost reduction strategies.
- Primary care homes are emphasized.
- Over time, the model seeks to integrate medical, dental and mental health payment.

Oregon FQHC APM overview

Payment Definition and Flow

Oregon’s FQHC APM was implemented March 2013 after approval of the State Plan Amendment was granted in the summer of 2012. The basic framework of the payment model was determined at that time, though some details of implementation continue to evolve.

Rate calculation:

- The model is a capitated per member, per month payment based on each health center’s historical PPS payments.
- A participating health center uses payment and patient data for applicable (included) services from its most recent reconciliation period that has been finalized by the state. Typically this time frame for the rate calculation is within the prior year.
- FQHC APM rates are adjusted annually by the Medicare Economic Index (MEI). The process for applying a Change in Scope rate adjustment is still under determination.
- Each health center establishes a “Wrap Cap” rate paid for managed care patients, which approximates the health center’s wrap around payments. In addition, a full FQHC APM rate is calculated and paid for the very few remaining fee for service clients each clinic may serve.
- CCOs continue to pay the health center as they would any other provider for contracted services. This may be through a primary care capitation rate or fee for service.

FIGURE 2. Rate Calculation for Oregon’s FQHC APM

$$\text{APM RATE} = \frac{\text{Applicable wraparound} + \text{Reconciliation revenue}}{\text{Health center member months}}$$

Attribution process:

- Health centers generate their own “day one list” of active patients, including all Medicaid patients who have had a visit in the 18 months prior to the first day of implementation.
- The State of Oregon reviews each health center’s day one list and adjusts it for patients who are served elsewhere and for patients no longer eligible for Medicaid.
- Once established, these patients stay on the health center’s attribution list unless they see another provider, move out of area or become ineligible for Medicaid.
- New patients may be added to a health center’s list if they have a billable visit with the health center, gain coverage eligibility and have had a visit in the prior 12 months as an uninsured patient, or who have a defined intake visit with a licensed provider (defined in Oregon statute).
- The state monitors health centers for patient reassignment. If a patient sees another FQHC, Rural Health Clinic or Indian Health Services provider, s/he is end dated on the day prior to that visit. If the patient sees another community provider, s/he is end dated after two visits within a 6 month period.
- Health center sites participating in the FQHC APM may add patients back to their list after evidence of a new billable visit at the health center.
- Patient claims data from the rate setting period is secured to develop each health center’s member month calculation, and these rules of patient assignment are mimicked in the calculation of the rate denominator (member months). Because of patient movement and loss of eligibility, all health center rates have a denominator less than 12 member months that reflects their own patients’ utilization patterns.

Services and populations:

- Oregon’s FQHC APM currently includes primary care medical services only. Mental health services, dental and obstetrical services are excluded and paid at the health center’s PPS rate.
- All Medicaid populations are included in the model, with the exception of patients who qualify for emergency and prenatal care only due to immigration status.
- Managed care, Open Card (fee for service), and Medicare/Medicaid patients are all included in the model.

Non-traditional patient encounters:

One area that has demanded significant attention during model development and implementation is the topic of tracking non-traditional patient encounters. These encounters are referred to as engagement “touches” and are intended to capture patient interactions and support accomplished outside of a traditional billable visit. Key aspects of tracking these encounters include:

- Working with the primary electronic medical record vendor, OCHIN, OPCA developed a tracking tool to capture 18 encounters (provided in Figure 3) that are not otherwise captured in the record.
- These touches are added to other encounters recorded in the record such as phone encounters and billable visits to populate a quarterly report tracking all encounters by patient.
- A handful of these touches can be implemented and adopted by care team members doing direct patient care and health promotion activities outside of the traditional medical setting.
- Implementing efficient workflows to capture these patient encounters has been a challenge. OPCA is preparing to launch a redesign of the tool to be more intuitive and care team-centered, to improve the experience and capture of alternative patient engagement.

FIGURE 3. Non-Traditional Patient Encounters Being Tracked



Social care and social determinants of health:

Recognizing the important role of social factors in influencing the health of most health center patients, Oregon’s Advanced Care Model is heavily invested in expanding the understanding of patient complexity and building programs and partnerships to better address the needs of our patients. OPCA and the participating health centers approach the work in the following ways:

- They are building on the work of the national Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)⁷ project to automate and expand the use of their patient assessment tool that queries about several domains of social determinants. Currently, most of the health centers

⁷ Information on PRAPARE is available at: <http://nachc.org/research-and-data/prapare/>

participating in OPCA's Advanced Care Model learning collaborative are piloting the use of this tool with a subpopulation of their patients.

- A key component of the care model work is the effort to identify a patient population at high risk for poor outcomes, prototype care team responses, and ultimately assess, pilot and spread interventions to meet complex needs. This strategy, called segmentation, is a required component of health center accountability and participation in the care model learning community.
- Currently, the payment model does not adjust financially for patient complexity.

Financial risk under the model:

Oregon's FQHC APM does include some increased risk to health centers (as described below), though the Change in Scope process that is in development will address increases and decreases in complexity and scope of services. Additionally, the federal protection of PPS law mitigates catastrophic consequences. Risk to OHA and the CCOs is also largely unchanged.

- Health centers receive a fixed payment, per member, per month, based on historical patients and their utilization patterns. As such, health centers are at risk for any increases in primary care utilization or proportion of high utilizing patients.
- Because the payment is fixed, health centers are essentially at risk for costs associated with implementing the model, including a significant investment in data capacity and care team growth.
- To counter these risks, health centers are protected by the PPS reconciliation requirement each year which would compensate health centers up to PPS equivalency if the FQHC APM payments dip below. It is important to note, however, that billable visits on average are likely to decline over time, making it increasingly unlikely that health centers will trigger added payment from OHA. The Change in Scope process that is in development will allow health centers to adjust their rates to address changes in complexity and scope of services provided.
- The federal requirement that an FQHC APM be voluntary always provides the health center with an option to exit the model if their participation is threatening viability.
- The State experiences the typical risk as the payer of a capitated rate, that a health center could restrict access to primary care despite prepayment. Therefore, tracking non-billable encounters and quality metrics, data that has never been available to OHA, is a crucial check and balance.
- The payment model leaves the payment relationship and risk assumptions with CCO's largely unchanged. To the degree that the health center is successful in transforming to improve care, the CCO benefits from any financial and quality improvements.

FQHC participation criteria:

Health centers participating in the FQHC APM model are required to sign a participation agreement with OHA, committing to execute the program and its requirements in good faith, provide data quarterly as outlined in the accountability plan and submit quarterly reconciliations to PPS. Because participation in an FQHC APM is required to be voluntary, OPCA works from the perspective that it can advise health centers about whether they are good candidates for the model, but that it can neither compel nor prevent a health center from participating. Instead, OPCA emphasizes the qualities below of a good candidate for participation. The health center should:

- Have a clear, articulated vision for primary care transformation, and current reimbursement provides a barrier to realizing that vision.

- Be in good financial standing and have adequate reserves. It is a red flag for a health center to pursue the model with the sole intent or need to improve cash flow.
- Have at least 1,000 Medicaid patients annually.
- Have up to date reconciliations with OHA, not more than 6 months in arrears.
- The health center is encouraged to complete a self-assessment for operational readiness, and among other topics is asked to consider competing priorities, stable leadership and data reporting and analysis capacity.

As of October 2016, a total of 13 of the state’s 32 health centers are participating in the APM, which serve 157,561 Medicaid patients out of 240,542 served through Oregon health centers (66%). (See Figure 4 for more details).

FIGURE 4. Health Centers Participation in Oregon’s APM

Phase	Date Launched	Cohort Participants	Medicaid Patients Served
I	March 2013	3 health centers	45,030
II	July 2014	4 health centers and 1 rural clinic	77,933
III	July 2015	3 health centers	17,987
IV	July 2016	3 health centers	16,611

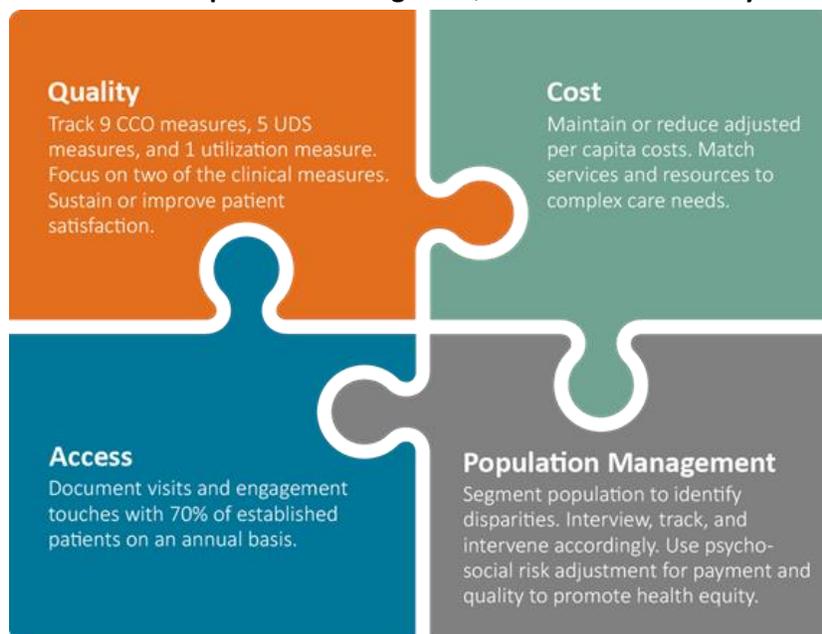
Measures Tracked

From the beginning of the conversations with the OHA (the state Medicaid agency), advancing quadruple aim goals was a shared vision between all parties. Prior to even submitting the state plan amendment for the proposed FQHC APM, the state sought agreement about what metrics health centers would track and report. As measurement strategies have progressed in the environment, most notably the development of the list of metrics tied to incentives under Oregon’s CCO reform, OPCA and the health centers have adjusted accordingly. As of this date, OPCA is currently in the process of reviewing the accountability plan for updates with participating health centers and OHA. Figure 5 is a schematic outlining the current accountability plan components.

Some of OPCA’s key lessons learned regarding accountability planning include:

- Begin by creating big-picture/conceptual agreement between the PCA, health centers, and State regarding accountability (“North Star goals”).
- Keep coming back to your North Star goals as you develop an accountability approach.
- Be clear about what you are trying to move towards in the care model so that your metrics incentivize the right things.
- Think carefully about measurement design and what behaviors your metrics will drive.
- If the point is to get off the visit, make sure you are not replacing it with another production model.

FIGURE 5. Components of Oregon FQHC APM Accountability Plan



Timing of Reconciliation Process and Wrap Payments

Reconciliation is a requirement of Oregon’s State Plan Amendment. Each participating health center completes a form that shows their PPS reconciliation for medical visits (tied to submitted shadow claims)⁸ next to reported revenue under the FQHC APM. OPCA’s agreement with OHA is for health centers to submit reconciliations quarterly, though settlement will occur only annually if needed, so as to smooth out quarterly fluctuations. If a health center is below the PPS threshold in a given quarter such that they have a financial hardship, they may negotiate an interim payment with OHA directly.

OHA collates the quarterly reconciliations and provides a final accounting of the annual reconciliation. Once all claims are closed, patient attribution is settled for the annual period. To date, no health center has required a settlement to PPS over a full year.

FQHC APM Implementation

As described earlier, Oregon has implemented four phases of its financial model, and a fifth is currently scheduled to go live in July of 2017. From the state perspective, a key issue related to rolling out a new phase of health centers is the budgetary impact. Because health centers participating in the new payment model will begin receiving prospective payments when they join, but still have wrap around payments from prior periods, for a period of time it appears that the state is making double payments. This is problematic when onboarding a new health center and their lagging wrap around payments span a state budget year. OPCA has addressed this challenge by planning for the inclusion of new health centers sooner in the state budget process, and requiring health centers to have a shorter lag time for their reconciliation payments.

⁸ Claims are still submitted but zero paid due to capitation.

After the initial pilot phase, OPCA began to develop increasingly structured processes to onboard new health centers. They have developed a detailed plan that includes: support for health centers making the decision to participate in the FQHC APM pilot, work to develop health center rates, training regarding model policies and procedures, and integration into the Advanced Care Model learning collaborative. This full process takes about a year from beginning to go-live, and includes the following components:

1. Decision Support for Opting Into Oregon APM:

- Approximately 4-5 month process. All Oregon health centers not already participating are invited to join the opt-in process.
- 2 detailed meetings about the financial and care model.
- Individual consultation with each health center from OPCA's financial and care model leads.
- Readiness assessment, financial tools and follow up from OPCA's APCM team.
- Health centers are given a hard deadline to opt into the FQHC APM before the end of the year (driven by the state's needs for clear budget impact data).

2. Criteria for Participation:

- The state requires that each participant has at least one year of finalized wrap around reconciliations, and that reconciliations are timely (within a year).
- Considering that participation is voluntary in Oregon's FQHC APM, OPCA is in a position of recommending favorable criteria for participation, rather than approving or denying participants. That said, health centers look to OPCA's expertise to guide them in reaching a decision.
- To date, OPCA has not had to limit onboarding health centers due to their capacity, though it would be challenging to onboard more than 4 or 5 health centers in each phase. To date, they have had 3-5 health centers interested in each phase.

OPCA's lessons learned about favorable conditions for participation include:

- Clear vision for care transformation that is supported by the removal of visit based payment.
- Strong finances and cash flow.
- Minimum of 1,000 Medicaid patients and ideally, a majority of patients should be in non-visit based payment after transitioning to the model.
- Stable leadership team who is on board with financial and care transformation.
- Solid level of data capacity for reporting and data management which to build upon.
- Capacity and history of positive change management, and evaluate their environment for competing priorities.

3. Once opting in, OPCA leads a six month rate development and on-boarding process that includes:

- Collecting data and running rates.
- Training participants in program policies and requirements (reporting)
- Supporting systems changes at the state and health center level to allow capitation payments.
- Integrating pilot health centers into the Advance Care Model learning community.
- Facilitating additional peer training and support with current participants.

Results and Future Plans

OPCA, the health centers, and the State (through OHA) have embarked upon a long journey to develop, implement and refine the FQHC APM. It is a journey they are still navigating, and one that has presented many lessons that can be shared:

- The health care system is very stable and does not change quickly or easily.
- Payment can be a barrier to delivering care that improves outcomes and retains staff.
- Changing payment does not change the front lines of care delivery.
- To change care, you must have a clear vision that reflects the evidence regarding the causes of health and wellbeing in patients and staff.
- Keep payment and care aligned and evolving to support a human-centric model.
- Establish and document clear agreement about the vision and goals of your transformation effort between the State, health centers and PCA; steadily align your accountability plan with those goals.
- Care model transformation and payment change are a lengthy and iterative process. All parties should agree that project goals will not be met in a matter of months or even a year, and flexibility in model development will be essential.
- Anticipate the considerable resources and capacity required to develop the financial model at the PCA, the health centers and the State.

As noted throughout this case study, OPCA continues to adjust the model in partnership with health centers and OHA. Major areas of emphasis in the coming year include:

- Revisions to the Accountability Plan to better align with CCO metrics, enhance accountability and align metrics with care model development.
- A significant review and revision of the methodology to track and capture patient engagement (“touches”).
- Continued work on financial model components (Change in Scope; pursuing a pilot to add mental health payment).
- Further development of the Advanced Care Model, particularly expansion of the strategies to segment patient populations for social and medical needs.

OPCA continues to gather evidence of program success relative to the North Star goal. The movement of quadruple aim outcomes takes years to demonstrate. However, OPCA is pleased to note some key areas of success:

- They have created a financial model that appears to be budget neutral for each health center on a per patient, per year basis when compared with rate development.
- No health center has triggered a required state payment under reconciliation to be whole with PPS.
- Each health center has a designated transformation team and is actively participating in the Advanced Care Model learning community.
- With few exceptions, reported quality outcomes are improving or holding for participating health centers.

- The State benefits from predictable monthly payments to APM health centers and has been encouraged by the innovation around addressing social determinants of health barriers. The State participates in the APCM learning communities and sees the work first-hand which deepens their commitment to the model.
- The state has independently commissioned a review of utilization and cost outcomes, to be released. They have shared that cost and utilization trends are positive for pilot health centers, though understandably there are challenges in proving causation to the FQHC APM.
- Most health centers in the model have significantly expanded data capacity, including reporting and analytics, and the ability to track and manage their patient population as a whole. In OPCA's view, this is a critical capacity to prepare health centers in the state for the future of value based payment.



Prepared by:
Oregon Primary Care Association
4th Ave., Suite 200
Portland, Oregon 97204

For more information about this publication, please contact:

Kersten Burns Lausch
Deputy Director, State Affairs
klausch@nachc.org
202.331.4606



National Association of Community Health Centers
1400 I Street, NW, Suite 910
Washington, DC 20005
www.nachc.org/states

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS16089, Technical Assistance to Community and Migrant Health Centers and Homeless for \$6,375,000.00 with 0% of the total NCA project financed with non-federal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.