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Reporting From the Front Lines:

Implementing Oregon's Alternative Payment Methodology in Federally Qualified Health Centers

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Abstract

Alternative payment models have been proposed as a way to facilitate patient-centered medical home model implementation, yet little is known about how payment reform translates into changes in care delivery. We conducted site visits, observed operations, and conducted interviews within 3 Federally Qualified Health Center organizations that were part of Oregon's Alternative Payment Methodology demonstration project. Data were analyzed using an immersion-crystallization approach. We identified several care delivery changes during the early stages of implementation, as well as challenges associated with this new model of payment. Future research is needed to further understand the implications of these changes.

Keywords

capitation; Federally Qualified Health Center; Medicaid; patient-centered medical home; payment methodology

The patient-centered medical home model of primary care strives to provide accessible, comprehensive, and coordinated team-based care that responds to the full range of individuals' health care needs (Jackson et al., 2013). Adoption is widespread and emerging evidence points to multiple benefits of this model, including increased provision of preventive services and improvements in the experience of care for both patients and staff (Carlin et al., 2016; Jackson et al., 2013).

However, under traditional fee-for-service payment methodologies that link payment to the volume of face-to-face visits, health care organizations are not reimbursed for the many patient-centered medical home activities that occur outside of the visit, such as phone consultations, medication management, patient education, or panel management (Olson,

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2012). Thus, there is a pressing need to test new models of payment that align reimbursement with the goals of the patient-centered medical home model of care (Edwards et al., 2014; Merrell & Berenson, 2010).

Recent changes in the health care landscape, including the implementation of the Patient Protection and Affordable Care Act (ACA), led some states to experiment with alternative payment methodologies as a way to achieve the triple aim of reducing utilization and costs while improving the quality and experience of care (Edwards et al., 2014; Kocot et al., 2013). At the forefront of this movement is Oregon's Alternative Payment Methodology (APM) demonstration project, which provides Federally Qualified Health Centers (FQHC) the option of shifting from a prospective payment system to receiving a capitated per-member-per-month rate for their Medicaid patients. FQHCs are nonprofit health centers committed to providing high quality comprehensive primary and preventive care to persons of all ages, regardless of their ability to pay or health insurance status. FQHCs primarily serve uninsured and Medicaid populations and are a critical component of the health care safety net. In 2015, more than 24 million patients were served by 1375 FQHCs, 68% of which were recognized as patient-centered medical homes (HRSA, 2015).

Three FQHC organizations (hereafter referred to as health center organizations) took part in the first phase of Oregon's APM demonstration project, beginning in March 2013. All three were leaders in implementing the patient-centered medical home model of care. This article describes the results of a qualitative study supported by the Robert Wood Johnson Foundation to assess practice-level changes during the first year of APM demonstration project. We focused specifically on understanding the impact of the new payment methodology on changes in workflow and care delivery within the patient-centered medical home model of care.

METHODS

We utilized a qualitative cross-case comparison study design, with a multiperspective approach, to understand changes made by practices involved in APM implementation. Between October 2013 and April 2015, we conducted full-day site visits to 10 individual practices within 3 health center organizations that span urban, suburban, and rural areas (Table 1). We observed practice workflows and operations and conducted a total of 26 semi-structured interviews, lasting between 25 and 90 minutes with a range of practice staff, providers, and leaders. We also observed 6 quarterly Learning Collaboratives—hosted by the Oregon Primary Care Association to provide technical assistance and share lessons learned—and attended other ad hoc meetings between the State of Oregon and the Oregon Primary Care Association during this period. This study was approved by the Oregon Health & Science University Institutional Review Board.

Data collection and analyses were conducted iteratively by a multidisciplinary team the using initial interviews as the basis for a series of follow-up interviews that targeted emerging themes. We conducted interviews in person and by phone as needed. Interviews were audio recorded and professionally transcribed. Transcripts were checked for accuracy, deidentified, and entered into an Atlas.ti (Version 7.0, Atlas.ti Scientific Software

Development GmbH, Berlin, Germany) database for qualitative data management and analysis. Field notes collected during site visits, and detailed notes from the Learning Collaboratives, were also entered into the database for analysis.

A multidisciplinary team analyzed interview and field note data using immersion-crystallization cycles (Crabtree & Miller, 1999). In the first step, we read interview transcripts or field notes as a group to develop a collective understanding and to tag and name segments of text that were important to developing this understanding. After reaching consensus and developing a stable code list, we analyzed the remaining data using a constant comparative method (Crabtree & Miller, 1999). In the second phase of analysis, we reviewed the coded text to develop a comprehensive understanding of practice operations and identified practice changes, experiences, and challenges during the early stages of implementation.

RESULTS

Study practices differed in size, urban/rural status, and percentage of visits covered by Medicaid (see Table 1). During site visits, observations and interviews we observed and heard about numerous practice changes, experiences, and challenges during the early stages of APM implementation. We describe next the 3 buckets of care delivery changes that we identified—innovations in scheduling, diversifying patient encounters, and human resource transformation. In addition, we describe the primary challenges encountered during this early stage of implementation—defining patient populations and documenting the delivery of care under a new payment method (see Table 2).

Changing the organization and delivery of care

Innovations scheduling—An immediate change made by practices was redesign of daily schedules. Specific changes included longer patient visits and dedicated time during the workday for care coordination and communication among team members.

Longer patient visits—Practices increased visit time from 15 to 20 minutes. Longer visits provided more time for care teams to address patients' needs beyond the primary reason for the visit, and to focus on prevention and health maintenance activities. The extra visit time was also utilized for warm hand-offs to care team members, providing other services within the practice such as behavioral health, health education and coaching, pharmacy counseling, and social services. On the other hand, longer visits translated into fewer patient appointment slots each day. To continue meeting patients' needs for access, practices experimented with other ways of providing care beyond the face-to-face practice visit. These changes are described in more detail in the "Diversifying visit types" section.

Dedicated time for care coordination—In addition to longer visits, more time was built into the daily schedule for care coordination and administrative duties including charting, billing, care planning among team members, and review of patient e-mail messages. Administrators and providers reported a greater emphasis on conducting outreach, providing preventive care, and using health information technology tools to view their panel as a whole. Many providers were enthusiastic about these changes.

Some practices set aside time for weekly care team meetings to discuss workflow changes or complex patients. Topic-specific workgroups were formed by one practice to address relevant issues such as visit no-shows and drug and alcohol abuse screening. Implementing these changes came with challenges. Many providers questioned why they were spending time in meetings instead of seeing more patients. In addition, some teams struggled with how to effectively utilize their meetings.

Diversifying patient encounters

Removing the link between the volume of face-to-face visits and reimbursement enabled practices to experiment with more flexible ways of communicating, educating, and providing care to patients.

Group visits—Practices designed group visits for patients with shared diagnoses, or to provide educational sessions on specific topics such as chronic pain, diabetes nutrition, pregnancy care, or parenting. One location began offering group exercise classes at their practice. For some practices, space availability was a challenge for this approach.

Telephone visits—The shift to APM spurred one practice to begin utilizing telephone visits while other practices hoped to begin doing so in the future. Phone visits were scheduled just like in-person visits and were described as appropriate for a range of patient care needs such as medication management and review of laboratory or imaging results. Typically 10-minutes long, 2 phone visits could replace 1 in-person visit. Strategically planning them as the first appointments of the day or after lunch alleviated provider concerns about running late and missing their scheduled face-to-face visits.

Online patient portal—Staff and administration described a greater focus on use of the online patient portal to communicate asynchronously with patients, to answer questions, and to determine the need for in-person visits. Practices reported that APM provided increased incentive to engage patients using alternative modes of communication, and efforts were underway to further encourage utilization.

Human resource transformation

Across all 3 participating health center organizations, we observed changes in the way human resources were utilized to provide comprehensive team-based care, including hiring new staff and modifying existent roles. This enabled care team members to work at the tops of their licenses.

Engaging new team members—Practices hired new care team members such as clinical pharmacists and behavioral health specialists to provide additional services to patients. One started an entirely new department to focus on establishing care for new patients, whereas another created a population health specialist position to better understand and meet the needs of the entire patient panel.

Revising role descriptions—By removing the link between payment and a face-to-face visit with a primary care provider, practices could delegate patient care responsibilities to

other members of the care team, and engage staff members in the crafting of new job descriptions and the redesigning of existing roles. Primary care providers were encouraged to take on leadership roles and to think holistically about how to structure and utilize the unique skills of different team members, who were encouraged to “work at the top of their license.” For example, one practice redesigned its care work-flow such that medical assistants conducted diabetic foot examinations and front desk staff disseminated patient education materials (including healthy recipes and lay language information on diabetes). In another, medical assistants were responsible for chart reviews to ensure patients were up to date with prevention, screening, and health maintenance services. In many practices the registered nurse role shifted from patient triage to seeing patients for issues that did not require a primary care provider.

Although the ability to change team members’ functions was a welcome change for many, the transitions were not always smooth. Revised roles sometimes meant expanded responsibilities, additional burdens, and workflow adjustments that not everyone felt comfortable with.

Defining patient populations and documenting care delivery

A condition of the demonstration project required participating practices to undergo a monthly patient attribution process. Practices were also required to document the visit and non-visit-based care they provided to patients.

Patient attribution—To receive payment, practices were required to prove that patients were engaged in care with their health center organization, and no other, for the previous 12 months. Practices hired new staff to manage patient identification, attribution lists, and the reconciliation process. Patients of practices located within isolated geographic regions were more easily attributed, as there were often no other practices at which to receive care. In many cases, it was difficult for health centers in cities with multiple practices to know whether their patients had received care elsewhere. Thus, verifying attribution often involved coordination with other health centers as well as with the state Medicaid office. This was cited as an ongoing challenge, adding to a list of documentation requirements that resulted in increased administrative burden.

Documenting delivery of care—Billing staff were required by federal law to submit “shadow claims,” wherein practices submitted claims for services provided to Medicaid patients, even though they were not reimbursed for those services on a prospective payment system basis. The purpose was to ensure “budget neutrality”—that the practice received at least as much money as they would have under the traditional payment system. If the practice came up short, the state paid the difference. This process required additional effort by health center billing departments.

In addition, the Oregon Primary Care Association and the state agreed on 18 specific visit and non-visit-based care activities named, “Care Services That Engage Patients” (Care STEPs) that all practices were required to document in their electronic health record and report to the state. Care STEPs included direct interactions between the health care team and the patient, the patient’s family or authorized representative(s), or with other health care

providers who themselves interacted with the patient (through in-person, digital, group, or telephone visits). Reporting Care STEPs ensured a robust understanding of the care delivered under the new model, providing insights into how it might change over time.

Documenting Care STEPs reliably and consistently required additional time, initiative, and workflow changes. Many practices described feeling “measurement fatigue” and expressed frustration with multiple documentation and reporting requirements. Some providers worried that the additional time spent documenting would take away from their ability to provide care. As a result, the Oregon Primary Care Association and the state have continued to refine the number of Care STEPs that practices are required to document to make the process less onerous and more reliable.

DISCUSSION

Traditional fee-for-service payment systems are thought to impede the adoption of the patient-centered medical home model of care by incentivizing visit volume rather than the provision of accessible, patient-centered, coordinated, comprehensive, and team-based care (Olson, 2012). At the heart of Oregon’s APM was the hope that it would provide a way off the treadmill of churning out visit upon visit and to experiment with alternative ways of providing holistic care for a population of patients.

We found that Oregon’s APM enabled practices to experiment with different ways of organizing and providing care, including innovations in scheduling, diversifying patient encounters, and transforming human resources. The changes described here created the infrastructure and scaffolding necessary for future innovations in care delivery within the patient-centered medical home model. With these pieces in place, practices have continued to evolve their scope of care to focus on social determinants of health and other upstream factors that impact their patients.

Key challenges of APM implementation included attributing patient populations to health center organizations and documenting the diverse care types provided under the new payment method. In addition, the dramatic increases in health center patient volume that came with ACA Medicaid expansion in January 2014 likely exacerbated the challenges associated with payment reform.

Innovations in payment models for primary care are becoming increasingly widespread across the United States (AAFP, 2016). An example of a program similar to Oregon’s APM demonstration project is the California Department of Healthcare Services FQHC APM Pilot, which is planned to begin in late 2017 (CDHCS, 2016). Health center organizations and practices participating in programs such as this may benefit from the findings presented here.

Limitations

The practices that participated in the first phase of Oregon’s APM demonstration project were leaders in patient-centered medical home implementation and Oregon’s ongoing health transformation efforts. Some were already providing, or planning to implement, care

delivery changes before the beginning of the pilot. It is therefore possible that the practices involved in this first phase of APM implementation are unique, thus making their experiences less generalizable. Furthermore, we did not explicitly explore how practices within the same health center organization varied.

In addition, the demonstration project occurred in the midst of several simultaneous health care transformation efforts, such as the ACA and development of Oregon's Medicaid Accountable Care Organization (ACO) system (Kline & Walthall, 2010; McConnell, 2016). It was therefore difficult to parse out which practice-level changes were direct results of the new payment model. Yet, interviews revealed that the implementation of APM removed major roadblocks and enabled practices to align their infrastructure with the patient-centered medical home model of care. Within this context, the findings we present are those that were most clearly associated with the shift in payment methodology.

Future research

Practices considering or in the midst of implementing payment reform may benefit from our findings. Since the time of this study, 10 additional health center organizations have joined Oregon's APM demonstration project with still more planning to join. The practices described here have continued to evolve, specifically with regard to innovations for engaging medically complex patients and addressing social determinants of health, that continue to push the boundaries of the patient-centered medical home concept.

Future research is needed to describe the further spread and evolution of payment reform in Oregon and other states. In addition, future research is needed to understand the impact of payment reform on health care quality, access, and expenditures as well as variation in these outcomes both within and between health centers. Our team is currently analyzing pre-/post changes, and comparing practices that did and did not implement APM, to isolate its impact on practice- and patient-level clinical outcomes, and patient-level econometric outcomes (Angier et al., 2016).

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References

- AAFP. Advanced primary care: A foundational alternative payment model (APM) for delivering patient-centered, longitudinal, and coordinated care. 2016. Retrieved from <http://www.aafp.org/dam/AAFP/documents/advocacy/payment/apms/ES-AdvancedPrimaryCare-121316.pdf>
- Angier H, O'Malley JP, Marino M, McConnell KJ, Cottrell E, Jacob RL, ... DeVoe JE. Evaluating community health centers' adoption of a new global capitation payment (eCHANGE) study protocol. *Contemporary Clinical Trials*. 2016; 52:35–38. DOI: 10.1016/j.cct.2016.11.001 [PubMed: 27836506]
- Carlin CS, Flottemesch TJ, Solberg LI, Werner AM. System transformation in patient-centered medical home (PCMH): Variable impact on chronically ill patients' utilization. *Journal of the*

- American Board of Family Medicine. 2016; 29(4):482–495. DOI: 10.3122/jabfm.2016.04.150360 [PubMed: 27390380]
- CDHCS. Federally qualified health centers alternative payment methodology pilot. 2016. Retrieved from <http://www.cpga.org/cpga2013/assets/File/FINALFQHC-APM-Concept-Paper20161019.pdf>
- Crabtree, BF., Miller, WL. Doing qualitative research. 2. Thousand Oaks, CA: Sage Publications; 1999.
- Edwards ST, Abrams MK, Baron RJ, Berenson RA, Rich EC, Rosenthal GE, ... Landon BE. Structuring payment to medical homes after the Affordable Care Act. *Journal of General Internal Medicine*. 2014; 29(10):1410–1413. DOI: 10.1007/s11606-014-2848-3 [PubMed: 24687292]
- HRSA. Health center data. 2015. Retrieved from <https://bphc.hrsa.gov/uds/datacenter.aspx?year=2015>
- Jackson GL, Powers BJ, Chatterjee R, Bettger JP, Kemper AR, Hasselblad V, ... Williams JW. Improving patient care. The patient centered medical home. A systematic review. *Annals of Internal Medicine*. 2013; 158(3):169–178. DOI: 10.7326/0003-4819-158-3-201302050-00579 [PubMed: 24779044]
- Kline JA, Walthall JD. Patient Protection and Affordable Care Act of 2010: summary, analysis, and opportunities for advocacy for the academic emergency physician. *Academic Emergency Medicine*. 2010; 17(7):e69–e74. DOI: 10.1111/j.1553-2712.2010.00802.x [PubMed: 20653573]
- Kocot SL, Dang-Vu C, White R, McClellan M. Early experiences with accountable care in Medicaid: special challenges, big opportunities. *Population Health Management*. 2013; 16(Suppl 1):S4–S11. DOI: 10.1089/pop.2013.0058 [PubMed: 24070249]
- McConnell KJ. Oregon's Medicaid Coordinated Care Organizations. *The Journal of the American Medical Association*. 2016; 315(9):869–870. DOI: 10.1001/jama.2016.0206 [PubMed: 26847402]
- Merrell K, Berenson RA. Structuring payment for medical homes. *Health Affairs (Mill-wood)*. 2010; 29(5):852–858. DOI: 10.1377/hlthaff.2009.0995
- Olson A. Primary-care physician compensation. *Mount Sinai Journal of Medicine*. 2012; 79(4):490–496. DOI: 10.1002/msj.21322 [PubMed: 22786738]

Table 1

Descriptions of Participating Practices

Health Center Organization	Practice	Urban/Rural	Total Visits	Medicaid Visits, %
1	1	Urban	51 839	43.2
2	2	Suburban	14 229	47.6
2	3	Suburban	27 404	44.5
2	4	Suburban	26 795	60.7
2	5	Suburban	493	17.4
3	6	Rural	11 075	34.7
3	7	Rural	8 377	40.5
3	8	Suburban	33 284	45.1
3	9	Rural	2 786	37.9
3	10	Suburban	1 639	25.9

Table 2

Selected Practice Member Quotations

Practice Member Quotations		
<i>Care delivery changes</i>		
Innovations in scheduling		
Longer patient visits	•	So basically, all of our appointments are twenty minutes. And we used to be fifteen minutes. We changed it when we knew we were going to go into the APM model (Health center organization 2).
Dedicated time for care coordination	•	We have weekly quality huddles with each of our teams. And during those quality huddles we have all of the providers, the MAs, we have the clinic leadership . . . our clinical pharmacist [. . .] our clinical application specialist and then a data analytics person there [. . .] And we just talk about quality, safety issues and look at data (Health center organization 3).
Diversifying visit types		
Group visits	•	Yeah, group visits have already been going on . . . and its centering pregnancy and those type of group visits. And [. . .] parenting [. . .] But we want to spread that [. . .] And hopefully APM does allow us a little leeway and flexibility to do that (Health center organization 2, Practice 4).
Telephone visits	•	So I'm thinking about the amount of money that potentially was saved just in that phone call for forty-five minutes. We kept her from going to the ER and possibly kept her from coming in three or four more times [. . .] (Health center organization 1, Practice 1).
Human resource transformation		
Online patient portal	•	And we're at thirty-seven percent at [our clinic] that are active on MyChart, so pretty good numbers. So there are all kinds of little projects going on all the time. And definitely, that flexibility to do that comes from APM (Health center organization 1).
Engaging new team members	•	[. . .] we have our clinical pharmacist, which is also a new position that we added because of APM (Health center organization 3).
Revising role descriptions	•	The medical assistants have changed. They've had increased skill building, chart scrubbing to prepare not just for the next day but looking ahead for the week, looking at their provider's template for the week, being trained up in skills such as the diabetic foot exam (Health center organization 3, Practice 9).
<i>Participating requirements</i>		
Defining patient populations and documenting care delivery		
Patient attribution	•	So we're having to do this attribution. We're having [to] do this dance. [. . .] This constant shuffle of managing the patient population list. And that's on top of all the stuff we used to do (Health center organization 1, Practice 1).
	•	So we are trying to educate our patients, and [say], "please don't go over there. You need to come to us. If you have an issue, give us a call." And that's what, that's the area where we need to improve our systems, right? [. . .] Because, see, that issue of our patients going to a different site, well, we jeopardize our revenue if our patients are not able to get to us and have to go someplace else (Health center organization 2).
Documenting delivery of care	•	In the first year it has been a lot about the data, dealing with attribution, rosters, basic things about changing a billing system from fee-for-service to capitation. Data analysis consumes so much of our time. We are hoping to get . . . the 'nuts and bolts' infrastructure in place so that we can begin to work on the model of care (Health center organization 2).
	•	You still have to bill. And then we have touches. And so we're billing normal billing, even though you get paid on a PMPM. And then we account for our touches too. And that design is still being developed with the state from an APM accountability perspective (Health center organization 3).