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Medicaid alternative payment model leads to strong reduction in imaging

A shift from visit-based to capitated payment spurs new modes of patient care at Oregon community health centers

In 2013, a group of Oregon community health centers (CHCs) teamed up with Oregon's state health authority to introduce a novel payment model known as the **Alternative Payment and Advanced Care Model (APCM).** Rather than generating revenue for individual services performed in the clinic on the basis of visits, clinics were paid a capitated rate based on their overall active patient panel size. This approach was intended to enhance transformation and allow clinics to meet patients' primary care needs within the quality accountability framework of the Oregon Medicaid program. A total of 15 CHCs providing care to 150,000 Medicaid members adopted the model between 2013 and 2018.

A key question is the extent to which payment models drive desired clinical changes in primary care. One goal of the APCM was to better align with the primary-care medical home (PCMH) model, which aims to provide comprehensive, coordinated and high-quality care centered on the needs of individual patients. Although evidence on the effectiveness of the PCMH model has been mixed, it is unclear if the underlying payment model – which has traditionally been fee-for-service – has inhibited the potential for greater improvements in quality or reductions in health care spending.

This study assessed changes in clinics that took part in the APCM together with those in a comparison group that did not participate. Using Medicaid claims, the study team analyzed five service areas: (1) traditional primary care services (including imaging, tests, and procedures); (2) other services provided by CHCs that were excluded from the APCM (dental, behavioral health, and obstetrics services); (3) emergency department visits; (4) inpatient services; and (5) other services of non-CHC providers (i.e. specialty care).

Lindner S, Kaufman M, Marino M, et al. A Medicaid alternative payment model program in Oregon led to reduced volume of imaging services. *Health Affairs*. 2020;39(7):1194-1201.

Access to abstract

KEY FINDINGS

- A per-member per-month payment model **led to fewer traditional primary-care services** for Medicaid members at community health centers in Oregon
- This difference was driven entirely by **reductions in imaging services** (radiographs, ultrasound)
- A companion study showed **higher use of e-visits and telephone visits** — services not billable under traditional Medicaid rules

OHSU

42%

Reduction in traditional face-to-face clinical services following implementation of the APCM model

Traditional clinic visits drop dramatically, driven by reductions in imaging

After the APCM was introduced, clinics' volume of traditional primary-care services declined by 42%. This reduction was attributable to a decrease in imaging visits, including radiography and ultrasound, two services often implicated in low-value care. The analysis further showed that patients did not subsequently obtain these services in alternative settings.

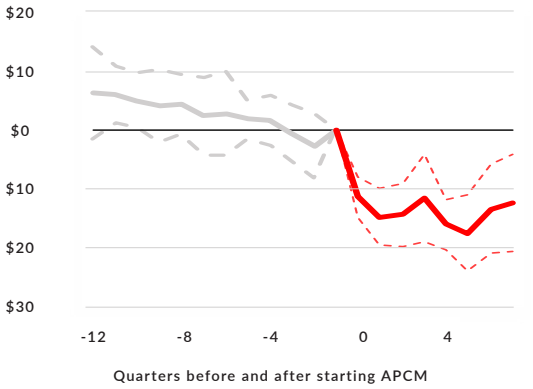
Use of other types of services was unaffected. Inpatient care, emergency department visits, specialty care, and non-primary care services — all services excluded from the APCM — remained unchanged across this period.

Quality assurance came from Oregon Medicaid. A switch to global or capitation-based payment reforms generally incorporates quality metrics to ensure that access to care is maintained. In this case, the APCM was embedded within Oregon's overall Medicaid transformation, which ensured that participants were accountable for maintaining care quality comparable to peers in Oregon.

New care modes emerge

While traditional in-person visits decreased with implementation of the APCM, a companion study showed that **clinics made greater use of traditionally non-billable patient interactions** such as e-visits and telephone consultations. The shift to these modes had the added benefit of reducing clinic crowding and improving access times for patients who did need to be seen in-clinic.

Figure 1. After clinics joined the APCM, volume of primary-care services decreased, as measured in per-member monthly cost equivalent.



Implications

The primary-care home model seeks to improve quality and value of care in primary-care settings. Traditional volume-based payments may, however, perpetuate incentives for clinicians to continue providing lower-value care.

Our evaluation of Oregon's APCM suggests that switching from a visit-based to a capitated model allowed clinics flexibility to reduce revenue-driven low-value services and explore new forms of patient-centered care. This flexibility may be particularly important when caring for patients with chronic conditions and complex needs.

Please see full publication for references.

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

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