NATIONAL ASSOCIATION OF Community Health Centers

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Spotlight on Health Center Payment Reform: Washington State's FQHC Alternative Payment Methodology

Introduction

In 2000, Congress created a specific payment methodology under Medicaid for FQHCs known as the FQHC Prospective Payment System (PPS). Rather than being paid fee-for-service, FQHCs receive a single, bundled rate for each qualifying patient visit with a "billable" provider.[i] This single rate pays for all covered services and supplies provided during the visit. It is inflated annually by the Medicare Economic Index (MEI). To provide increased flexibility, the law also allows states to design and implement an FQHC alternative payment methodology (FQHC APM) so long as:

- the total FQHC APM reimbursement is not less than the amount under the FQHC PPS methodology;
- each participating FQHC individually agrees to the FQHC APM; and
- the FQHC APM is documented in the state's approved Medicaid State Plan.[ii]

As health centers look to better align payment with practice, more and more are interested in utilizing the flexibility within federal Medicaid law to develop FQHC APMs in partnership with their state Primary Care Association (PCA) and Medicaid agency. These FQHC APMs delink payment from the face-to-face visit with the state's eligible list of providers and reimburse on a capitated per member, per month (PMPM) basis.

In 2017, health centers in Washington built upon the experiences of those in Oregon and worked with the Washington Association of Community and Migrant Health Centers (WACMHC) and Washington State Medicaid (Health Care Authority or HCA) to launch a capitated FQHC APM that incorporates quality metrics. This case study is intended to provide additional context and information for health centers and state PCAs as they explore models to address the unique circumstances in their states.[iii]

Washington State Context

- Washington expanded Medicaid (called Apple Health) in 2014 to nearly all non-elderly adults with incomes at or below 138% of the Federal Poverty Level (FPL).[iv]
- As of December 2017, 24% of Washingtonians are enrolled in Apple Health.[v]
- Health centers served 1,035,629 Medicaid beneficiaries and low-income Washingtonians in 2016.[vi] This included 33% of the total Medicaid enrollees in the state.
- 84% of Apple Health beneficiaries are enrolled in managed care served by five managed care organizations.[vii]
- Washington is engaged in a healthcare transformation effort called "Healthier Washington". A key goal of this transformation effort is that 90 percent of state-financed health care (including Medicaid) and 50 percent of the commercial market will be in value-based payment arrangements by 2021.[viii] In addition, Washington has obtained an 1115 Delivery System Reform Incentive Payment waiver to help facilitate this transition through regional Accountable Communities of Health (ACHs).[ix]
- Washington spends on average $5,296 per Medicaid beneficiary and is ranked 38th in the country for the average total per capita amount spent on Medicaid beneficiaries.[x]

Background

Washington State Payment Methodology for FQHCs

Washington State FQHCs have a long history of working under an FQHC APM. This paper describes the fourth iteration (APM4) implemented in July 2017, which is open to both FQHCs and Rural Health Clinics (RHCs). The previous version (referred to as APM3) used a Washington State-specific health care index (HCI) to annually inflate the rate between years 2000-2008. HCI exceeded MEI by approximately 2%. Beginning in 2009, the state adopted MEI for all future annual increases. APM3 also provided an opportunity for health centers to voluntarily rebase their encounter rates based on a cost report if that resulted in a higher rate than the annually inflated base rate.

State Medicaid agencies are responsible for paying the difference between the FQHC PPS rate and market Medicaid rates paid by managed care organizations (MCOs), unless designated to the MCOs.[xi] In Washington State, these "wrap around payments" are estimated by the state and flow from the state to the MCOs and then to the FQHCs on a prospective monthly basis. There is an annual reconciliation process to verify that the FQHC received the PPS revenue equivalency. This process is time intensive and requires FQHCs to pay an auditor to certify its accuracy. The state makes a supplemental payment to correct any underpayment, and FQHCs must refund any overpayment.

Washington State FQHC APM Goals

There were several concerns with Washington State's FQHC APM3 methodology that stakeholders wanted to address in creating FQHC APM4 (see "Washington's FQHC APM4" figure[xii]):

1. **Simplifying the Reconciliation Process:** All parties wanted to simplify the reconciliation process. In some cases, the retrospective reconciliation process was resulting in substantial and unexpected overpayments which could challenge the financial viability of the FQHC when discovered and due years later.
2. **Moving to Value-Based/Alternative Payment Models**: HCA was an active participant in the Health Care Payment Learning Action Network (HCP-LAN), which promotes national adoption of advanced alternative payment models.[xiii] A core principle of the HCP-LAN is that there should be a quality component to any alternative payment model. HCA has adopted a statewide common set of metrics and is using attainment of these metrics to improve delivery system performance across the state.
3. **Flexibility to Support the Use of Care Teams**: FQHCs in Washington operate as Patient Centered Medical Homes, which emphasizes team-based care, but APM3 did not result in payment unless certain care team members (physicians, advanced practice nurses, physician assistants, certain behavioral health clinicians) engaged the patient face-to-face. As a result, care team members could not always practice at the top of their license, and those "billable" clinicians were managing smaller panels of patients than was possible with the team

Figure 1. Washington's FQHC APM4

Source: Washington Health Care Authority

approach. It was in the best interest of all stakeholders, Medicaid enrollees included, that the payment methodology not inhibit optimum use of the full care team.

4. **Flexibility to Support Alternatives to Emergency Rooms:** Several Washington State FQHCs were already operating under value-based arrangements with payers, including shared savings arrangements, that they did not want disrupted by APM4. The per-visit methodology under APM3 did not afford them the maximum flexibility they sometimes needed to provide patients with alternative access to emergency room care. For example, if an FQHC adds nurse triage, patients may be inclined to contact them before heading to an emergency room for a non-emergent condition. They also may be inclined to use nurse triage for issues that they would otherwise travel to the FQHC for a billable visit. Since nurse triage visits are not "billable" under APM3, the FQHC will incur its added expense without receiving a payment to financially sustain that service.
5. **Aligning Payment Approaches Across Borders:** One large Washington State FQHC that also operated several health center sites in Oregon recognized the value that Oregon's capitated FQHC APM offered and wanted an aligned payment methodology to implement a single model of care across all sites.

Enabling Legislation

In 2013, the Washington State Legislature passed Senate Bill 5034, which directed HCA to collaborate with key stakeholders (including FQHCs, RHCs, and MCOs) and produce a recommendation for a new payment methodology that "rewards innovation and outcomes over volume of services delivered".[xiv] The stakeholders developed the following agreed upon set of principles:

1. "The APM will move away from reliance on face to face visits and volume based purchasing toward a model which rewards for outcomes, encourages the usage of alternative patient/provider connections and a broader workforce.
2. The APM will encourage innovative payment practices and provide an opportunity for shared risk and shared savings, while not compromising ability to manage contracts.
3. The APM will strive to be simple, fair, transparent, trustworthy and inexpensive to administer.
4. The APM will support increased uniformity of payment for similar services across clinics and will be actuarially sound. Payments will be predictable and comply with federal standards.
5. The APM will be supported by a statewide measure set with improved data capacity, and strive towards improved, more robust risk adjustment.
6. The APM will include support for practice transformation such as quality improvement, HIT/HIE support and workforce training.
7. Developing an APM is an evolutionary process, aligned with health innovation planning and movement toward more integrated delivery of care.
8. Throughout this process and into the future, all relevant parties will maintain open and honest lines of communication, especially when changes in statute, state plan and/or waiver are under consideration to build a culture of collaboration.
9. The APM model will incentivize participation; however, participation of FQHCs or RHCs will be optional". [xv]

Although not stated in that framework, it was also important to the state that APM4 be, at most, cost neutral to the state relative to APM3 on a per Medicaid enrollee, per year basis. FQHCs, on the other hand, were looking to enhance practice revenue in order to implement innovative, member-centric models of care. Short of a new revenue stream, this could only be accomplished by an FQHC APM that allowed expansion of primary care provider panel size and use of the most cost efficient yet clinically appropriate member of the full care team.

On February 1, 2016, Washington State received a federal State Innovation Model (SIM) Testing grant with the aim to move 80 percent of state-financed health care and 50 percent of the commercial market from volume to value by 2019.[xvi xvii] They planned to test four payment redesign models, one of which is FQHC APM4.[xviii]

Simultaneously, HCA was negotiating an 1115 federal waiver agreement with CMS for The Healthier Washington Medicaid Transformation.[xix] It provides up to $1.5 billion in federal investment for regional health system transformation projects that benefit Apple Health (Medicaid) clients. It allows the state to test new and innovative approaches to providing health coverage and care. Its goals are:

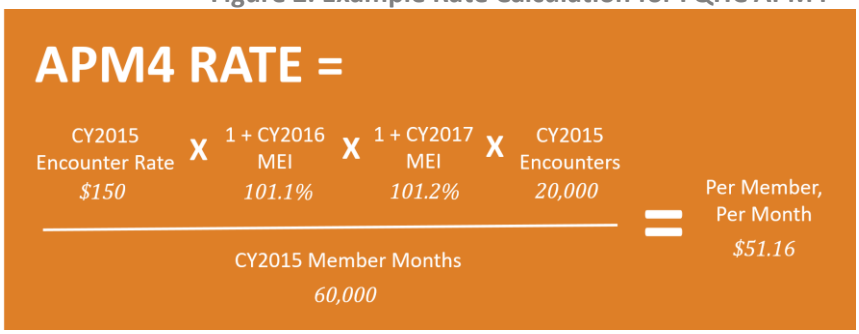
- Building healthier communities through a collaborative regional approach
- Integrating how we meet physical and behavioral health needs so that health care focuses on the whole person
- Improving how we pay for services by rewarding quality over quantity

Overview of Washington State's Capitated FQHC APM (APM4)

Payment Definition and Flow

Rate calculation:

Figure 2. Example Rate Calculation for FQHC APM4



The basic construct of the Washington State FQHC APM4 is to calculate an individual per member, per year (PMPY) budget neutral amount for each FQHC and pay that amount in a per member, per month (PMPM) amount. That PMPM is calculated by multiplying the FQHC's encounter rate under APM3 times the total number of billable encounters to enrollees in Medicaid managed care and dividing that by total Medicaid managed care months, all in calendar year 2015. MCO assignment rosters are the source for determining managed care months. CY2015 will be used to calculate the APM4 rate even for FQHCs that choose to defer participation in the first year and opt in at a future date. That 2015 baseline APM4 PMPM is trended forward to future years inflated by MEI to calculate the initial and subsequent APM4 rates.

Covered Medicaid population populations and services:

An overwhelming majority of Medicaid beneficiaries in the state are enrolled in managed care. When APM4 was implemented in 2017, dental services, specialty mental health services, and services aimed at treating substance use disorder were not part of managed care contracts. These services are therefore carved out of APM4 reimbursement. When HCA implements its plan to integrate those behavioral health services into managed care, they will likely continue to carve out those services from APM4 until they have established proof of concept for the current model structure and scope of services. All other FQHC primary care services including maternity and lower-level mental health services are included in APM4. Services not included in the cost report to calculate PPS are not included.

Member attribution:

Member assignment is based on MCO assignment, so each FQHC will receive an APM4 payment for each of those individuals on a monthly basis

Compensation for care provided to unassigned Medicaid managed care enrollees:

Although Medicaid managed care members are expected to seek all of their primary care services from their assigned primary care provider (PCP), FQHCs have and continue to provide services to some unassigned individuals. This baseline out-of-network leakage is built into the base PMPM calculation of APM4. When these unassigned individuals present to the FQHC for care, they are encouraged to either work with the individual to get them reassigned to the FQHC as PCP or redirect that individual to the proper clinic. Leakage should improve over time as populations are better managed. There are established mechanisms in place for the FQHC if the MCO is not responsive to re-assignment requests.

Flow of dollars:

As with APM3, APM4 dollars are paid to FQHCs by their contracted MCOs, but HCA is the ultimate source of those funds.

Quality component of APM4:

Managed care payers commonly used primary care capitation in the 1980's and 90's. In some cases, it resulted in reduced access to primary care. Stakeholders involved in APM4 planning sessions all agreed that mechanisms needed to be put in place to monitor and discourage this unintended consequence. While the Oregon FQHC APM does so by measuring alternative access to care via traditionally non-billable encounters, the Washington State APM4 does so by monitoring outcomes on quality metrics for which PCPs are solely or predominantly the accountable provider. Although the model does not hold FQHCs directly accountable for addressing social determinants of health, it does so indirectly through the APM4 quality metrics which necessitate reducing barriers to patients' participation in their care plans.

FQHC performance is measured against a subset of the Washington State Common Metrics whereby non-performance would result in reduced payment through prospective adjustment in the PMPM APM4 rate while still complying with Federal PPS rules. This is possible because an FQHC's per visit revenue would never be less than it would have been under per visit APM3, but as average billable encounters PMPY decrease through alternative access to their primary care services, that per visit revenue equates to a per visit increase. It is that incremental increase in per visit revenue that is put at-risk for performance on the quality metrics. Each FQHC is judged against its own historical performance on those metrics until finally attaining target performance. The payment tied to quality will not proportionately exceed what is reflected in the quality withhold component of HCA's MCO contracts.

Incremental improvement toward target performance on metrics will be recognized as will attainment of an ultimate target. When an FQHC is further from the target score, the calculation weighs improvement more than the actual score. As the FQHC approaches the target for an individual metric, the calculation weighs the score attained more than performance improvement. If there is loss of some or all of the benefit of APM4 due to inadequate performance, there will be a path back to earning the full benefit by demonstrating adequate improvement in subsequent year(s).

Measures tracked:

The following principles were followed in developing the quality component of APM4:

- Access to primary care is fundamental to APM4 and needs to be prioritized.
- Metrics need to align with those FQHCs have negotiated with health plans, which means choosing metrics that were part of the Washington Common Measures Set and included in the Apple Health managed care contract.
- PCPs should be solely or predominantly the accountable provider.
- Metrics should reflect those that have addressable variation in performance.
- There should be significant opportunity for improvement in that performance for the Washington State Medicaid population lagged national Medicaid performance.

The most challenging aspect to designing the quality component of APM4 was trying to avoid the impact of statistical variation on FQHCs with fewer assigned patients for whom the metrics applied. Strategies were gleaned from an April 2016 white paper prepared by Mathematica, including:[xx]

- Select measures that are broadly applicable to large numbers of Medicaid patients (e.g., screening measures).
- Aggregate data from multiple health plans.
- Create a composite score.
- When a particular measure applies to a small number of members, remove it from the composite and give other subcomponents more weight.

The performance measures chosen for Year 1 of APM4 are:

1. Comprehensive Diabetes Care - Poor HbA1c Control (>9%)
2. Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
3. Controlling High Blood Pressure (<140/90)
4. Antidepressant Medication Management
    - Effective Acute Phase Treatment
    - Effective Continuation Phase Treatment (6 Months)
5. Childhood Immunization Status - Combo 10
6. Well-child visits in the 3rd, 4th, 5th and 6th years of life
7. Medication Management for people with Asthma: Medication Compliance 50%
    - (Ages 5-11)
    - (Ages 12-18)

The applicable cohort of members for each metric will be determined by continuous enrollment and assignment. The weighting of each metric within the composite score and the target improvement and attainment goals are set annually in consultation between HCA and the FQHCs.

HCA will calculate claims-based quality measures. Each participating FQHC will self-report quality measures based on data abstracted from its electronic health record, attesting in writing to its validity. HCA retains the right to audit those results at its own expense.

Medicaid change in scope:

Under federal Medicaid law, a health center's payment rate (whether FQHC PPS or APM) should be adjusted to take into account any increase or decrease of the type, intensity, duration and/or amount of services furnished by the health center. This process is called a "change in scope." Change in scope rules in place for APM3 are applicable for APM4. New FQHCs without a utilization history will be given an interim APM4 rate until the first audited Medicaid FQHC cost report is available. Stakeholders agreed that HCA's change in scope policy will continue to be a subject for ongoing discussion.

Impact on other value-based agreements:

APM4 will not interfere with value-based opportunities that are individually negotiated by FQHCs and MCOs. In fact, the APM4 metrics were chosen to mirror metrics that MCOs must improve in order to earn a one percent withhold on their premium.

Risk born by MCOs, health centers, and state Medicaid agency:

Every stakeholder involved in the APM4 planning carefully evaluated the model for any potential risk as well as benefit.

Risk born by MCOs – From a health plan perspective, the APM4:

- Expands PCP capacity in medically underserved areas by allowing clinicians to work at the top of their license within care teams.
- Eliminates the threat that the current APM3 reconciliation process presents to FQHC financial stability.
- Allows FQHCs to offer more member-centric access to primary care aside from a face-to-face encounter with a billable provider.
- Has the potential to reduce potentially avoidable emergency room visits though enhanced access to primary care services at the FQHCs.
- Focuses FQHCs on improving their performance on selected quality metrics from the Washington Common Measures Set, some of which have financial implications for health plans.

The only concern from health plans was that the APM4 would not create any increased administrative burden for them and that it would be financially neutral for them in terms of primary care expense. Health plans were supportive of the evolving the APM4 model during the planning sessions.

Risk born by health centers – APM4 was built on the general capitated framework that FQHCs in Washington had been supporting since 2013. Practice transformation facilitated by this payment model would likely require upfront investment in staff and other infrastructure. Without additional start-up dollars, the FQHCs may need to focus initially on reallocating responsibilities of current staff. In order to participate in APM4, an FQHC is required to have their payments under APM3 reconciled up through 2015. Unreconciled years varied by FQHC but in some cases were multiple. Although that reconciliation would eventually happen even under APM3, the process was sped up for those wanting to participate in APM4 in its first year. The outcomes of such reconciliations came with a degree of uncertainty.

Risk born by state Medicaid agency – Finally, there was also a degree of risk for the state. Since HCA had accepted federal SIM testing dollars, they were accountable for bringing the FQHCs to a consensus on APM4 and enrolling them to participate. Although APM4 was expense neutral to HCA on a PMPY basis, it may allow FQHCs to attract more enrollees by their member-centric care than they would have otherwise.

In as much as HCA pays more for primary care for individuals assigned to a FQHC than to a non-FQHC, there is additional budget expense. In as much as APM4 results in improvement in patient quality and hospital utilization outcomes, HCA total cost of care is reduced. HCA was already making its bet on the latter as the basis for its payment reform efforts.

FQHC Participation Criteria and Implementation

APM4 was designed to be inclusive, so participation criteria were deliberately minimal:

- Signing a Memorandum of Understanding with HCA
- CY2015 APM3 reconciliation delivered to HCA by July 1, 2017 and completed by October 15, 2017
- Completing the Value-Based Purchasing Survey by July 1, 2017 which asks about current value-based payment (VBP) activity as well as plans and barriers to expanding participation in VBP[xxi]

Of Washington State's 27 FQHCs, 16 agreed to participate in the first year commencing July 1, 2017. The MOU that they signed covers participation July 1, 2017 through December 31, 2022. The health centers were required to include all of their sites. Others FQHCs and RHCs in the state have the option to participate in future years and can opt into APM4 on a calendar year basis. All of the original 16 health centers submitted the relevant performance year baseline data. FQHCs retain the right to opt out of APM4 and return to APM3 on a calendar year basis with 90 days' notice.

Strategies to ensure the FQHC APM is equal to what PPS would have been:

Retrospective FQHC reconciliation of the wrap-around payment occurs only to the extent necessary to demonstrate Federal PPS equivalency is met. There is no reconciliation payment by the FQHC if average billable encounters PMPY fall. HCA and the FQHCs continue to consider how the reconciliation process could be simplified.

Timing of reconciliation process and wrap payments:

To participate in APM4, the following timeline must be followed:

- The FQHC must provide any non-claims-based quality data by July 31 following the calendar year performance period.
- The quality improvement score validation process is completed by August 31.
- HCA delivers the composite quality score to each FQHC by September 30.
- Reconciliation to assure equivalency to APM3 using AUP must be completed on or before September 30. Failure to do so could jeopardize FQHC's participation in APM4 and require them to return to APM3 methodology.
- The APM4 rate for the following year is set by December 31. Results from a particular performance period prospectively sets the APM4 rate for two years hence.

Outlier policy:

If the FQHC experiences an increase in the PMPY average rate of visits, it will receive the reconciliation payment but also has the opportunity to request that the APM4 rate be reset upward. The range of average PMPY PCP visit rates vary among Washington FQHCs with some rates at more than twice the rates of others. For example, an FQHC located in a more remote area of the state may face added challenges to recruiting and retaining primary

care providers. As a result, access to care is limited, and the population may be more dependent on the emergency room for acute but non-emergent needs. If that FQHC becomes more successful in recruiting primary care providers, its visit rate may increase toward the state average. Performance on the APM4 quality metrics would likely also improve. HCA views that as desirable. The FQHC can appeal for an increase in their APM4 rate by filing a justification statement and demonstrating significant improvement on its composite quality score.

Results and Future Plans

It is too early to gauge the success of APM4 short of the fact that a majority of Washington's FQHC chose to participate. HCA and the health centers in Washington are committed to working together to address unanticipated challenges. A small working group meets regularly to focus on:

1. Quality performance measure reporting process and data validation sustainability
2. The approach to reconciliation
3. The change in scope process
4. The health plan credentialing process

The Washington State APM4 model represents an important example of the transition to outcomes-based payment and population health management. It offers a path for participating FQHCs to make fuller use of their care teams as patient centered medical homes. Finally, it aligns well with efforts earn additional dollars in complementary value-based arrangements with health plans.

Endnotes

[i] Unlike other providers, health centers cannot and do not restrict how many Medicaid patients they care for if payment is too low. Congress created the FQHC PPS/APM methodology in recognition of this federal program requirement and to ensure federal 330 grant dollars are used as Congress intended—to care for patients without health insurance rather than subsidizing care for Medicaid patients.

[ii] 1902(bb)(6) of the Social Security Act

[iii] Healthier Washington, "Clinics transition to new, value-based payment model". https://www.hca.wa.gov/assets/program/APM4-fact-sheet.pdf

[iv] Medicaid.gov website. Available at https://www.medicaid.gov/

[v] Ibid.

[vi] HRSA Health Center Data. Available at https://bphc.hrsa.gov/uds/datacenter.aspx?q=t4&year=2016&state=WA

[vii] Washington State Health Care Authority website. Available at https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/apple-health-managed-care

[viii] "HCA Value-based Roadmap 2017-2021," (accessed March 5, 2018) available at https://www.hca.wa.gov/assets/program/vbp-roadmap-2017.pdf

[ix] "Medicaid Transformation: Initiative 1: Transformation through Accountable Communities of Health" (accessed March 5, 2018) available at https://www.hca.wa.gov/assets/program/medicaid-demonstration-i1-factsheet.pdf

[x] Kaiser State Health Facts. Medicaid Spending per Enrollee – FY2014

[xi] SHO # 16-006 (2016). https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf

[xii] Healthier Washington, "Clinics transition to new, value-based payment model" (accessed March 9, 2018) available at https://www.hca.wa.gov/assets/program/APM4-fact-sheet.pdf

[xiii] "HCA APM4 Fact Sheet"available at https://www.hca.wa.gov/assets/program/APM4-fact-sheet.pdf

[xiv] Senate Bill 5034. 2013. (Washington State). http://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Senate%20Bills/5034-S.E3.pdf#page=1

[xv] Washington State Health Care Authority Report to the legislature "Options for a New Payment Methodology for Federally Qualified Health Centers and Rural Health Clinics" January 1, 2014.

[xvi] For more information on State Innovation Model grants, visit: https://innovation.cms.gov/initiatives/state-innovations/

[xvii] Washington State Health Care Authority. "HCA Value-based Roadmap 2017-2021". January 2018. https://www.hca.wa.gov/assets/program/vbp-roadmap-2017.pdf

[xviii] Washington State Health Care Authority. "Paying for value". https://www.hca.wa.gov/about-hca/healthier-washington/paying-value

[xix] For more information on The Healthier Washington Medicaid Transformation, visit: https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation

[xx] McCall, N. and Peikes, D. Tricky Problems with Small Numbers: Methodological Challenges and Possible Solutions for Measuring PCMH and ACO Performance. April 2016.

[xxi] Washington State Health Care Authority Provider Survey on Value-Based Payment (VBP) - CY 2016. https://www.hca.wa.gov/assets/program/provider-vbp-survey-template.xlsx

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