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Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)

In many states, FQHCs provide care to a large number of Medicaid beneficiaries.¹ As state Medicaid programs increase their focus on value-based payment, it is important to consider how FQHCs may participate in payment reform strategies. This brief provides an overview of the following:

- ✓ FQHC Cost Reporting
- ✓ State Payment Reform Strategies that Include FQHCs
- ✓ Oregon's FQHC Payment Model
- ✓ Massachusetts Primary Care Payment Reform Initiative
- ✓ Considerations for States and FQHCs

By Beth Waldman and Mary Beth Dyer, Bailit Health Purchasing, LLC and James Waldinger, Public Consulting Group

Introduction

Federally Qualified Health Centers (FQHCs)² traditionally provide health care services primarily to low-income individuals who are covered by Medicaid or who are uninsured. Federal law requires that FQHCs be paid according to a prospective payment system (PPS) for both Medicare and Medicaid. Prior to 2001, Federal law required state Medicaid programs to reimburse FQHCs based on reasonable costs, using Medicare regulations and cost reports to identify the types of allowable costs that would be reimbursed. Beginning in 2001, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000³ required Medicaid programs to pay for FQHC services under a PPS in an amount calculated on a per-visit basis equal to the reasonable cost of such services documented for a baseline period, with certain adjustments, or to use an alternative payment methodology (APM). Under an APM, a state Medicaid program pays FQHCs in an alternative manner to PPS, but it guarantees that each FQHC is still paid at least the amount it would have received under PPS, sometime referred to as the “PPS floor.” Federal PPS requirements apply regardless of whether states are purchasing FQHC services directly or through a contract with a Medicaid managed care organization (MCO).

Brief Overview of the Prospective Payment System

Most Medicaid programs use the PPS rate to calculate FQHC payments. The PPS ensures that FQHCs are paid a minimum rate based on their individual costs to provide services to their particular populations. Under the PPS, FQHC rates are adjusted annually based on the Medicare Economic Index. As noted above, the PPS rate represents the floor at which an FQHC may be paid, but states can set rates at a higher level using an APM. Under federal law, an APM is simply an alternative to the PPS rate through which FQHCs can receive equal

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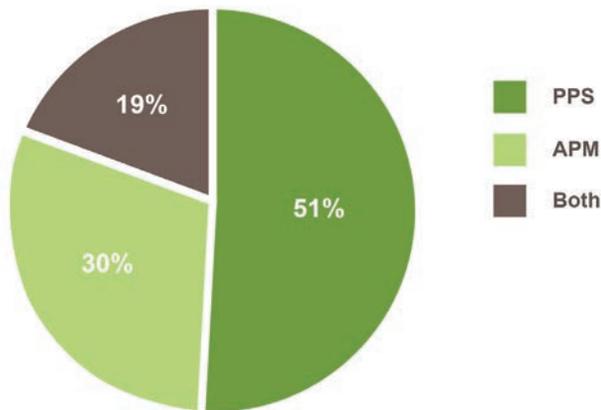
Beth Waldman joined Bailit Health in January 2007. Beth's broad expertise is in health care policy, program development and implementation. Prior to joining Bailit, Beth served as the Massachusetts Medicaid director.

Mary Beth Dyer has eight years experience with Bailit Health as well as prior state and federal government experience. She possesses specialty expertise in Medicaid managed care, performance incentive systems and value-based purchasing approaches.

James Waldinger focuses on Medicaid policy, analysis and implementation. Since joining PCG, he has served as a project manager and subject matter expert for various rate-setting, revenue enhancement, cost containment, program design, and auditing projects.

or higher rates than they would have received under the PPS. The following graph shows the number of states utilizing PPS, APM models, or both for Medicaid FQHC payments as of December 2014, according to a survey by the National Association of Community Health Centers.⁴

State FQHC Payment Approaches, 2014



Source: 2014 Annual PCA State Policy Survey, NACHC

To determine PPS or APM rates, FQHCs must provide detailed cost reports on an annual basis to state Medicaid programs; these cost reports are used to set the FQHC-specific rate. Federal PPS rules for Medicaid FQHC payments allow for some state flexibility in setting such rates. Some Medicaid programs, like that of Washington, D.C., pay the same PPS rate to FQHCs regardless of the service a patient receives.⁵ States such as Ohio, Connecticut and Illinois pay different rates to FQHCs, depending on whether the service provided is a medical, behavioral health, or dental service.⁶ Washington State allows FQHCs to choose whether they receive a blended rate or separate rate for each service.⁷ In many states, such as California, FQHC PPS rates are significantly higher than payments to Medicaid primary care providers under fee-for-service (FFS) payment methodologies;⁸ this is in part due to additional services that FQHCs provide that are not often available and/or reimbursed at private practices.

In states where FQHCs provide coverage to Medicaid beneficiaries through an MCO, the FQHC's payment must equal or exceed the state's PPS rate. For MCO members, states often agree to make an additional payment to the FQHC, supplementing the payment made by the MCO, to ensure that FQHCs receive payments that meet the PPS rate.⁹ For example, Oregon Medicaid, as applicable, provides an additional payment to an FQHC if needed to reconcile the FQHC's payments received through the MCO

with the established PPS rate.¹⁰ In other states, such as Washington and Illinois,¹¹ MCOs are required to pay FQHCs directly at established PPS rates.

FQHC Cost Reporting

Most FQHCs are required to submit a CMS 222-92 cost report to Medicare, or to file with their parent provider's cost report, in addition to meeting any reporting requirements mandated by their state Medicaid program. The cost reports provide financial information for each individual FQHC, to enable the state to align the PPS with the FQHC's cost of providing care. The reports should accurately reflect costs incurred to provide FQHC-covered services to Medicare and Medicaid beneficiaries. FQHC cost reports should provide the cost information necessary for a state Medicaid agency to determine a single PPS rate or, if desired, to calculate a PPS rate for each service type and for any supplemental payments, including payment reform strategies.

As states develop or review Medicaid cost reports for FQHCs, it is vital that any proposed report captures all relevant costs necessary to calculate an accurate PPS and/or supplemental rate(s), while limiting the burden of financial reporting.¹² States should work in tandem with FQHCs when developing and revising cost reports, to better understand provider reporting limitations and to ensure FQHC cost report submissions include correct and complete data. Proper training and guidance throughout the cost reporting process are paramount to ensure that the FQHC's costs are accurately recorded. States can provide FQHC cost report instruction through yearly trainings, manuals and guides, or phone-based support. Once the FQHC cost report is submitted, it is equally imperative that Medicaid agencies thoroughly review the reports to identify and flag any inconsistencies or potentially erroneous data.

State Payment Reform Strategies that Include FQHCs

Today, all state Medicaid programs pay FQHCs in accordance with the PPS requirements, paying either a straight PPS rate or using the APM option and reconciling their APM to the PPS. There are, however, a number of states that include FQHCs as part of a broader value-based payment strategy. These states have included FQHCs in payment reform efforts such as:

- Pay for Performance (P4P)
- Shared Savings
- Supplemental Care Management Payments
- Capitation

Under these payment reform efforts, providers, including FQHCs, continue to receive payment for services under existing arrangements with the state, and are eligible to receive additional funding based on the particular strategy as described below.

Pay for Performance

Under Medicaid P4P initiatives, participating FQHCs are eligible to receive P4P payments if they meet certain performance targets. In Colorado, for example, FQHCs that participate in the state's Accountable Care Collaborative as primary care medical providers are eligible to receive P4P based on quality performance in three measurement areas:

1. reducing ED visits,
2. increasing post-partum visits and
3. increasing well-child visits.¹³

In addition, some FQHCs participate in state-administered programs that provide P4P incentive payments for adoption of electronic health records. Consistent with other providers, FQHCs participating in APMs typically receive P4P payments several months after the designated performance period.

Shared Savings

Under shared savings programs, providers are eligible to receive a portion of savings that accrue to a state based on a provider-attributed population. Providers are sometimes required to perform at a threshold level relative to certain quality measures to qualify for savings distributions. There are a number of examples of FQHCs participating in Medicaid shared savings programs.

In Minnesota, 10 urban FQHCs in the Minnesota-St. Paul area have come together to join the FQHC Urban Health Network (FUHN), which participates as a virtual integrated health partnership under the state's ACO initiative. FUHN provides services to Medicaid beneficiaries through managed care plans that contract with the state. Based on its agreement with the state, and managed care plan requirements to participate in the initiative, FUHN is eligible to share in any savings attributed to it. FUHN then distributes the savings among its FQHC members. Any shared savings are paid to participating FQHCs separate and apart from the PPS.¹⁴

Care Management Supplemental Payment Programs

In Connecticut and Missouri, FQHCs are eligible to receive supplemental payments for provision of care management

services to Medicaid members. Often these payments are made as part of a patient-centered medical home initiative or through a health home program. Many FQHCs in Oregon participate in that state's Patient Centered Primary Care Home (PCPCH) program. These states provide care management supplemental payments apart from the PPS.¹⁵

In states where supplemental payments are developed for all Medicaid primary care providers and not specifically for FQHCs, such as through medical home programs, states have not developed cost reports to determine the care management payment. Similarly, managed care plans have not utilized cost reports when developing capitation rates.

Capitation

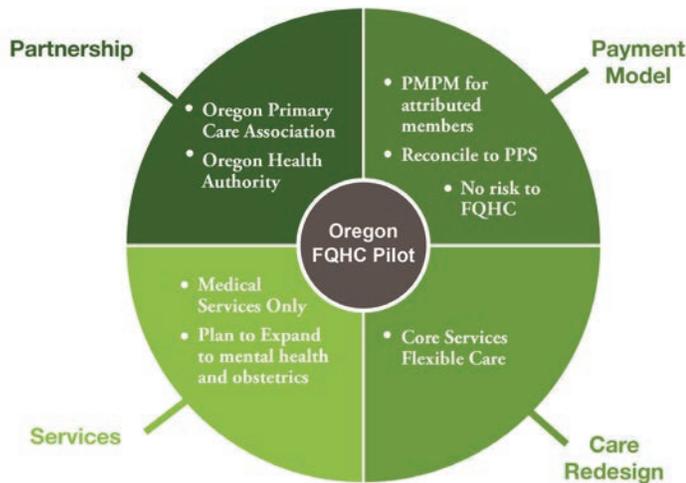
Many states are considering primary care capitation as part of their value-based payment strategies. Both the Oregon and Massachusetts models described below include primary care capitation as the foundation of their APM. Having a capitation rate, instead of a per-visit rate, enables FQHCs to provide beneficial but traditionally non-reimbursable services to Medicaid patients served through the capitation model. The capitation model provides both flexibility and a predictable flow of funds to providers.¹⁶

Oregon's FQHC Payment Model¹⁷

In partnership with the Oregon Primary Care Association, Oregon developed and implemented an APM pilot that began with three FQHCs – all certified PCPCHs – and expanded to include eight more.¹⁸ FQHCs that are not participating in this payment model continue to be paid based on the PPS. The state's Coordinated Care Organizations (CCOs) provide contracted FQHCs payment that is then reconciled by the state on a quarterly basis. The state pays the FQHC the difference between the CCO payment and the FQHC's PPS rate.

The Oregon pilot program was developed by the Oregon Primary Care Association in response to difficulties FQHCs experience in recruiting and retaining physicians. The APM pilot helps to remove some of the pressure that physicians feel by removing the need for a specific volume of office visits, instead paying the FQHCs a per-member per-month (PMPM) payment for attributed members. Attribution is based on a primary care visit to the FQHC within the last 18 months.¹⁹ While the FQHCs are paid on a PMPM basis, the state is still required to reconcile those payments to ensure that they are at least equal to the PPS rate.

Oregon FQHC Pilot Structure



Currently, only medical services are included within the pilot model, but the state is planning to include mental health and obstetric services soon. In developing the PMPM payment, Oregon looks at the FQHC’s PPS utilization and revenue for the prior year. Two rates are developed for each participating FQHC – a full PMPM rate for those attributed patients that are not enrolled in managed care, and a partial PMPM for those attributed patients that are enrolled in a CCO. There is no risk to the FQHCs in this model, as their PMPM rates are compared quarterly with payments the FQHC would have received under the PPS. If the FQHC’s PMPM rate falls below the PPS level, then Oregon will make up the difference.

To understand how the FQHCs are redesigning care under this payment model, Oregon requires the FQHCs to document the types of care they provide – core services, flexible care, or otherwise non-reimbursable, non-billable services. Core services are services typically provided by a PCPCH. Flexible care services are those that are allowable through a Coordinated Care Organization. This categorization helps Oregon to understand how many “touches” a particular member has (e.g., telephone visits, email messages, visits with non-professional staff) and how many of these touches are services that are non-billable under traditional FQHC payment rules.

While there is no additional payment tied to quality measurement or performance, each participating FQHC in Oregon is required to submit quarterly reports on the following measures:

- Oregon’s FQHC Quality Measures
- Tobacco Screenings
- Cervical Cancer Screenings

- Depression Screenings
- Weight Control (Adults; Kids)
- Diabetes Control
- Hypertension Control
- Patient Experience
- Childhood Immunizations

For the Patient Experience quality measure, Oregon specifically looked at:

- % of patients who would recommend their care team to family/friends
- % of patients visits with an assigned clinical care team
- % of patients assigned by CCO who had a visit during the quarterly reporting period

Oregon has not publicly reported data regarding the model. However, state officials reported that they are pleased with its success to date. A formal evaluation of the program is in progress.

Massachusetts Primary Care Payment Reform Initiative

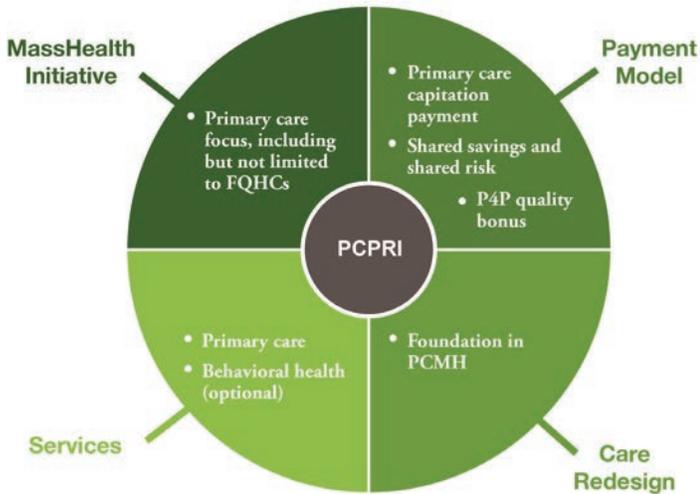
In March 2014, Massachusetts implemented its Primary Care Payment Reform Initiative²⁰ (PCPRI) for Medicaid members participating in the state’s Primary Care Clinician Plan. PCPRI seeks to improve access to primary care, and enhance patient experience, quality, and efficiency through care management and coordination. In PCPRI, provider practices commit to redesigning and delivering primary care consistent with a patient-centered medical home (PCMH) approach and a focus on behavioral health integration. MassHealth contracted with 28 primary care centers, including FQHCs. Under PCPRI, FQHCs receive a primary care capitation payment and take responsibility for a comprehensive set of primary care services for an attributed patient. Through the PCPRI, providers are eligible to share savings generated for an attributed panel as a result of non-primary care spending. Any savings the FQHCs may earn through the PCPRI are paid outside of the PPS. The PCPRI model also includes a P4P component related to quality performance.

Participating FQHCs choose one of three clinical models that vary the amount of behavioral health services included in the capitation payment. In the first year, most chose the least integrated option; however, the state is looking towards increased integration over time.

Under PCPRI, the FQHCs can choose one of three risk tracks for non-primary care payments that vary the amount of risk (from 0 to 6%)²¹ and the amount of savings (up to 6%). While all participants started in a shared-savings-only

model, in the second and third years of PCPRI, some participants will be required to take on some downside risk based on the size of their patient panel.

MA Primary Care Payment Reform Initiative



Considerations for States and FQHCs

FQHCs can participate in payment reform initiatives: The PPS requirement, including the option to use an APM that reconciles to the PPS, provides states and FQHCs considerable opportunity to experiment with payment models without putting FQHC stability at risk. As described above, FQHCs can actively participate in state payment reform initiatives that make payments above the PPS for pay for performance, shared savings, or care management supplemental payments. In addition, states and FQHCs can experiment with primary care capitation rates and reconcile those payments against the PPS to ensure that they do not drop below the PPS floor. Where states are using total cost of care payment models, only the primary care piece is reconciled against the PPS rate.

Attribution may be easier in states that already require PCP selection or assignment: Many state Medicaid programs require beneficiaries, whether through a Medicaid managed care plan or through a Primary Care Case Management program, to select a primary care provider. States that already require a PCP selection or assignment, can develop a straightforward attribution model for the majority of their beneficiaries. Where there is no requirement for a designated PCP, the development of a PCP attribution model is often one of the biggest challenges a state faces. If a state does need to develop an attribution model, it is important to devote sufficient time and resources as these models are often difficult to develop, implement and reconcile.

System changes are likely needed: States implementing primary care capitation models directly are likely to have to make system changes to accommodate implementation of this new payment model. This also requires sufficient time and resources to implement. Where states implement these models through managed care plans, fewer system changes may be necessary to implement the model.

Evaluation strategy should be developed upfront: To determine whether the payment initiative is working, it's important for states to develop an evaluation strategy early on. The evaluation strategy should measure effectiveness of the payment reform, including impact on both cost and quality, and ensure collection of appropriate information from FQHCs to understand their performance.

Reconciling PMPM payments to the PPS rate requires a large effort: Significant work is required to reconcile PMPM payments against the PPS rate. Oregon was not able to convince CMS that reconciliation was not needed. California has developed a similar model to Oregon's and hopes to avoid full PPS reconciliation of the PMPM approach by attesting to compliance.²¹ It is not clear if CMS will be willing to agree to California's proposal for attestation in lieu of a full PPS reconciliation.

FQHCs should be able to take on risk: While FQHCs to date have not readily taken on risk for services outside of the PPS rates, there is nothing within the PPS rate requirements that would preclude them from doing so. Massachusetts FQHCs are eligible to take on risk through the PCPRI program. Only one FQHC has transitioned into the risk arrangement thus far, but that is partly because of the significant panel size that is required to enter into a risk arrangement. Since FQHCs typically depend on Medicaid for much of their revenue, many have few reserves. However, state payment reform efforts would benefit if those FQHCs that are financially stable enough to take on risk for a Medicaid population are given the opportunity to do so without jeopardizing their long-term viability. FQHCs are key providers of Medicaid services in many states, and they are in strong positions to provide coordinated and integrated care that results in improved outcomes and reduction of avoidable costs.

Conclusion

While FQHC payments must be made in accordance with PPS requirements, there is ample opportunity for states to include FQHCs in payment reform models that do not require the FQHCs to take on downside risk for the services they deliver. For those FQHCs that are financially stable,

they can also venture, once they've gained experience in shared savings program, towards arrangements where they share in risk for total cost of care.

APMs can offer FQHCs an opportunity to improve patient care by investing in team-based care and alternative delivery models that provide more appropriate care without being limited to PPS-defined patient encounters.

Alternative payment arrangements can benefit FQHCs, the state, and most importantly Medicaid beneficiaries. At the core of these payment reforms are the desire to improve health outcomes, patient satisfaction, and access to appropriate primary and preventive care for Medicaid patients, including those treated at FQHCs.

Endnotes

¹ In 2010, 38.5% of patients seen by FQHCs were covered by Medicaid. Uniform Data System Report, Health Resources and Services Administration, U.S. Health and Human Services Agency (2010). This number is likely to have grown with the expansion of Medicaid under the Affordable Care Act.

² See FQHC description, accessed December 2015 at <http://www.brsa.gov/healthit/toolbox/RuralHealthITToolbox/Introduction/qualified.html>.

³ See section 1902(bb) of the Social Security Act.

⁴ McKinney, D., Ertle, L., and Wong, W., "2014 Update on Implementation of the FQHC Prospective Payment System (PPS) in the States," National Association of Community Health Centers, State Policy Report #52, December 2014, accessed December 2015 at <https://www.nachc.com/client/2014%20pps%20report%20LE%20Edits%20%2020%2015.pdf>.

⁵ See DC FQHC Regulations; 29-4500.

⁶ See for Illinois: Illinois Department of Healthcare and Family Services, Handbook for Providers of Encounter Clinic Services; Chapter D-200 Policy and Procedures for Encounter Clinic Services; for Ohio: Chapter 5160-28 of the Ohio Administrative Code; and for Connecticut: see calculated rates for medical, dental and mental health/substance abuse services, accessed December 2015 at www.ct.gov/dss/lib/dss/pdfs/ratesetting/fqhs/fqhc_1415-8_rates.pdf.

⁷ See Federally Qualified Health Centers Provider Guide, Washington Apple Health, July 1, 2014.

⁸ "The California Alternative Payment Methodology Pilot: Real and Smart Reform," the California Primary Care Association, December 2014. Accessed December 2015 at <http://www.cpa.org/cpca2013/assets/File/Policy-and-Advocacy/Active-Policy-Issues/Payment-Reform/2014-12-10-CPCA-CA-APM-RealSmartReform.pdf>.

⁹ See for example, Chapter 5160-28-07 of the Ohio Administrative Code.

¹⁰ Oregon State Officials, telephone interview with Issue Brief author, February 20, 2015.

¹¹ See for Illinois: Illinois Department of Healthcare and Family Services, Handbook for Providers of Encounter Clinic Services; Chapter D-200 Policy and Procedures for Encounter Clinic Services; see also Federally Qualified Health Centers Provider Guide, Washington Apple Health, July 1, 2014.

¹² States should reference all relevant documentation including State Plan Amendments covering FQHCs, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards codified at 2 CFR 200, and costing guidelines outlined in 42 CFR 413, to determine all allowable direct and indirect costs to be captured within the cost report.

¹³ For information on Colorado's Key Performance Indicators (KPIs), accessed December 2015 at www.colorado.gov/pacific/hcpf/accountable-care-collaborative-acc-incentive-payments.

¹⁴ FUHN Officials, site visit with author, December 2014.

¹⁵ To develop a supplemental payment for FQHC care management, states may collect and utilize information from FQHCs' cost reports of care management. With care management utilization included in the cost reports, states will be able to establish an appropriate rate based on costs associated with the assessment, coordination, monitoring, or evaluation of a patient's service needs.

¹⁶ "Update on payment Reform Trends, Implications for California Community Health Centers," John Snow, Inc. (JSI); Prepared for the California Family Health Council and Regional Associations of California; January 2013.

¹⁷ Oregon State Officials, telephone interview with author, February 20, 2015.

¹⁸ One of the additional sites is a rural health center, and not an FQHC.

¹⁹ Individuals can only be attributed to one FQHC so there is need to reconcile to ensure the most appropriate FQHC if an individual would otherwise be attributed to more than one FQHC.

²⁰ Burns, M., and Bailit, M.; Alternative Payment Models and the Case of Safety-Net Providers in Massachusetts; Blue Cross Blue Shield of Massachusetts Foundation, March 2015.

²¹ There is currently one FQHC participating in the PCPRI with downside risk. Author email communication with Massachusetts official on July 25, 2015.

²² "The California Alternative Payment Methodology Pilot: Real and Smart Reform," the California Primary Care Association, December 2014.