

Washington State Health Care Authority

Report to the Legislature

OPTIONS FOR A NEW PAYMENT METHODOLOGY FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

As Required by Third Engrossed Substitute Senate Bill 5034
Chapter 4, Laws of 2013, Second Special Session (partial veto)

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List of Acronyms

ACO	Accountable Care Organization
APM	Alternative Payment Methodology
BIPA	Benefits Improvement and Protection Act of 2000
CCO	Coordinated Care Organization
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
ED	Emergency Department
FFS	Fee for Service
FQHC	Federally Qualified Health Centers
HCA	Health Care Authority
HCDS	Health Care Data Systems
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIT	Health Information Technology
MCO	Managed Care Organization
MEI	Medicare Economic Index
MIE	Medicaid Incentive Payment
OB	Obstetrics
PCCM	Primary Care Case Management System
PCMH	Patient Centered Medical Home
PCPCH	Patient Centered Primary Care Home
PEB	Public Employees Benefits Board
PMPM	Per Member Per Month
PPS	Prospective Payment System
PSHA	Puget Sound Health Alliance
QHP	Qualified Health Plan
RHC	Rural Health Clinic
RSN	Regional Support Network
SCHIP	State Children's Health Insurance Program
SHCIP	State Health Care Innovation Planning
SHIP	State Health Improvement Process (Maryland)
SIM	State Innovation Models
SPA	State Plan Amendment
SSA	Social Security ACT

SSI	Supplemental Security Income
TCC	Total Cost of Care
UDS	Uniform Data System
VBP	Value Based Purchasing

Executive Summary

Section 213(45) of 3ESSB 5034 includes the following directive:

By January 1, 2014, and after collaboration with federally qualified health centers, rural health clinics, managed care plans, and the centers for Medicare and Medicaid services, the authority will produce a report that provides options for a new payment methodology that rewards innovation and outcomes over volume of services delivered, and which maintains the integrity of the rural health clinic and federally qualified health center programs as outlined under federal law. The report will detail necessary federal authority for implementation and provide the benefits and drawbacks of each option.

Federally-designated clinics provide an essential primary care backbone for the Washington Apple Health Medicaid delivery system. Because of this vital safety net role, federal law stipulates a cost-based reimbursement methodology known as the Prospective Payment System (PPS). States are also permitted to develop, in conjunction with clinics, an Alternative Payment Methodology (APM) that must be approved by the Centers for Medicare and Medicaid Services (CMS) in the Medicaid state plan.

Washington State is on its third iteration of an APM in five years, a process which originally commenced in response to a federal audit. Following the 2006 audit, work ensued to develop an APM that dealt with the issues raised by CMS. This resulted in the ultimate establishment of the first alternative payment methodology in 2009 which increased encounter reimbursement rates annually by a Washington-specific healthcare index and established an annual reconciliation process. A 2011 budget proviso reinstated PPS with a five percent inflator, creating APM 2. This methodology lasted for three months, from April 7 to July 6, 2011.

Finally, in a 2011 special session, further changes were made through a budget proviso that led to the creation of APM3. This new approach adjusted payment rates approximately 10.6% lower than the original APM from 2009. The successive implementation of three methodologies and associated reconciliation requirements has created significant administrative and budgetary challenges for clinics and the state.

Considerable interest has been expressed by federally qualified health centers (FQHC) and rural health clinics (RHC) to move toward a new payment methodology that rewards innovation and outcomes over the volume of services delivered. Efforts were made over the last eighteen months to move in this direction, including the July 2012 submission of a concept paper to CMS titled, "Apple Health Innovations," requesting the necessary federal flexibility to move to a capitated model for clinic reimbursement without an onerous reconciliation requirement. At the time of submission, the concept paper was met with little interest from CMS and further progress was not made, although conversations have continued since that time between clinics, managed care organizations and the state.

Collaboration on this report has prompted a strong consensus on guiding principles which will serve as the underlying framework for future discussion. While no final agreement has been

reached between FQHCs, RHCs and the state on a specific single payment methodology, two APM options are discussed that reflect a continuum of potential future approaches. The next steps of this effort entail further discussion with FQHCs, RHCs, managed care organizations, CMS and other interested parties. New payment approaches require budgetary considerations, which are not modeled in this report.

1. State Health Care Innovation Planning

The discussion of new reimbursement approaches for federally designated clinics is occurring in the context of an extensive health innovation planning effort, funded through a \$1 million grant from the Center for Medicare and Medicaid Innovation (CMMI). A primary aim of the plan is to by 2019, shift 80% of state health care purchasing off of the fee-for-service platform to a value-based approach that pays for outcomes, not volume. An additional area of focus is the importance of serving the whole person, which requires new financing and reimbursement strategies that allow for bidirectional integration of physical and behavioral health care services, regardless of the practice setting.

The next steps on a new payment methodology for FQHCs and RHCs will be critical to achieving these aims, since a significant portion of primary care and behavioral health services to Medicaid enrollees are delivered in these settings. The existing constraints under federal law and their regulatory interpretation have stymied innovative reimbursement strategies. Other states like Oregon and Minnesota (refer to Appendix D) have seen some success in leveraging their health system transformation strategies to remove some of these barriers.

FQHCs and RHCs will play a vital role in the delivery system transformation activities envisioned under the innovation plan. Dealing with fundamental challenges related to reimbursement, with simplification and innovation as equally significant goals, is a foremost concern to all parties as the innovation plan moves toward the implementation phase. Progress in this area will be iterative and the need to phase-in reimbursement changes with as much flexibility as possible has been a well-documented concern of both FQHCs and RHCs. The next steps on APM4 will be greatly aided by the clear vision and strategies laid out in the 5-year innovation plan.

2. Background and Context

2.1 FQHC Characteristics

FQHCs, also known as Community Health Centers (CHCs), serve low income and underserved populations, including but not limited to: migrant, homeless, and school based populations, and public housing residents. FQHCs provide a scope of services including: primary medical, dental, and behavioral health, case management and enabling services, such as transportation and interpretation. Services are provided on a discount fee schedule and no one is refused services based on inability to pay. FQHCs receive federal base grants to provide partial support for care to the uninsured, as well as limited capital grants to support infrastructure, access to 340B drugs, malpractice coverage under the Federal Tort Claims Act and cost based reimbursement for their Medicaid patients. FQHCs must maintain a 51% consumer majority board to ensure responsiveness to community needs.

FQHCs emerged from the Neighborhood Health Center program, part of President Johnson's War on Poverty program in 1965. After multiple primary health care programs were authorized separately to fulfill similar missions, they were consolidated in 1996 through the Health Centers Consolidation Act (Section 330 of the Public Health Service Act).

In Washington, there are currently 26 FQHC organizations operating over 180 delivery sites (both rural and urban) providing services to nearly 800,000 clients in 2012 or 1 in 10 Washingtonians. Eighty-five percent of the patients served are at 150% or below the poverty level resulting in the FQHCs providing services to a large, disproportionate share of Medicaid and Medicare enrollees and the uninsured. With an additional 325,000 Medicaid enrollees anticipated to enroll under the Affordable Care Act, it is anticipated the FQHCs will be the health care home for about 170,000 of this population who are currently served as uninsured patients in the FQHCs. Additionally, it is expected the newly eligible population, i.e. those who have not had a provider or coverage in the past, will also seek access in the community health center setting. By 2018, the FQHCs are projected to serve over 1 million patients.

FQHCs are currently transforming themselves into Patient Centered Medical Homes (PCMHs). The PCMH model is progress toward achievement of the Institute of Healthcare Improvement (IHI) Triple Aim: 1) Reducing the per capita cost of health care, 2) Improving the health of populations, and 3) Improving the patient experience. By the end of 2013, almost all of the FQHCs will have received some level of certification as PCMHs. This represents a step in the practice transformation process involving a shift from the traditional definition of clinical provider (physician, doctor of osteopathy, nurse practitioner, physician assistant) to a care team model. All professionals in the care team (dental and behavioral health included) work to the top of their license delivering services through multiple connections often known as “touches” (see pages 16 and 17, numbers 1 and 6, under Model 1) by members of the PCMH team. Consequently, the traditional FQHC reimbursement methodology, paying for billable visits delivered by billable providers, does not reflect this new model.

2.2 RHC Characteristics

The Rural Health Clinic (RHC) program was created in 1977 by Congress to preserve access to primary care in rural areas. One hundred percent of RHCs are located in rural areas, are often the sole medical providers in a given geographic area, see a disproportionate share of Medicaid and Medicare beneficiaries, and are required to use nurse practitioners and physician assistants, as well as physicians, to deliver care.

There are 109 RHCs in Washington State. In 2009, 14 RHCs closed due to bankruptcy or decertification. About half of RHCs in the state are owned and operated by Critical Access Hospitals, the remaining are small businesses or non-profit organizations. Most RHCs are very small, with fewer than five providers, and focus primarily on direct care delivery with limited administrative staffing.

2.3 Current Managed Care Delivery System

The Health Care Authority (HCA) is Washington State's single state agency responsible for administration and supervision of the Medicaid program. The HCA is also responsible for purchasing state employee benefits.

In July 2012, the HCA concluded a competitive joint procurement process with contracts awarded to five managed care organizations (MCOs). These MCOs cover more than 800,000 enrollees in the Medicaid, CHIP and current Basic Health programs, with more than 90% of Medicaid expansion enrollees expected to be served by the plans starting in January 2014. Details of the entire competitive procurement process are available at: <http://www.hca.wa.gov/procurement.html>.

Through this process, the Medicaid program has advanced its path toward comprehensive coverage delivered by managed care. The full phase-in of Supplemental Security Income recipients will culminate in more than 80% of current Medicaid, CHIP and Basic Health enrollees being enrolled in managed care, before several hundred thousand more enrollees are added through the Medicaid expansion beginning in 2014.

HCA makes monthly managed care enhancements to FQHCs and RHCs for each client enrolled in an MCO and served through the clinic system. FQHCs and RHCs receive payment from the state in addition to the payments they receive from the MCOs for services provided to enrollees. Some of these contracts have risk, both upside and downside, and some payment arrangements are tied to quality measures. Federal law, established in Section 1902(bb) of the Social Security Act,¹ requires managed care visits to be reimbursed at amounts equal to that of fee-for-service (FFS) encounter visits. To achieve this, the aggregate of state enhancement payments and MCO payments ensures that FQHC/RHCs receive total managed care reimbursement equal to their FFS encounter rate for each billable visit.

HCA will begin a new managed care reimbursement approach in April 2014 consistent with the budget proviso in 3ESSB 5034. Under the new approach, HCA will no longer directly pay monthly enhancements to the FQHCs and RHCs for their managed care enrollees. Instead, managed care plans will pay the enhancement to FQHCs and RHCs, either on a per member per month (PMPM) basis, or by incorporating the enhancement into the encounter rate as required by Section 1902(bb). HCA will ensure the FQHCs and RHCs are being reimbursed in accordance with Section 1902(bb).

FQHCs and RHCs maintain reservations with the new approach.

¹ (A) In general.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section [1932\(a\)\(1\)\(B\)](#)), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract. See Appendix B for more information.

2.4 Evolution of Payment Methodologies

Applicable Federal Statute (See Appendix B)

Payment for FQHCs and RHCs is guided by Section 1902(bb) of the Social Security Act, which defines parameters for a prospective payment system (PPS), and includes the option of an alternative payment methodology. The original purpose of the PPS system was to prepare a forward-looking payment model that would cap the rate of growth in costs per encounter to certain inflation factors and to accommodate changes in the scope of services. It was also designed for FQHCs and RHCs to have certainty of payment that would enable them to develop the infrastructure necessary to better manage patient care. In the case of the FQHCs, the methodology was also developed between CMS and the Health Resources and Services Administration to assure the costs of providing services to Medicaid clients was not supplemented by the federal base grants provided to serve the uninsured.

Federally Required Prospective Payment System

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPPA)² replaced the traditional cost-based reimbursement system for FQHCs and RHCs with a new prospective payment system (PPS),¹ which reestablishes the Federal requirement that FQHCs and RHCs be reimbursed at a minimum rate for services provided to Medicaid patients. This payment baseline is not nationwide; it is based on the average of each FQHC's and RHC's fiscal years 1999 and 2000 reasonable cost per visit rates. Therefore, it is a unique payment rate for each FQHC and RHC. For existing FQHCs and RHCs, a baseline per visit rate was established for services provided between January 1, 2001, and September 30, 2001, and then adjusted to take into account any change in the scope of services during that year. For fiscal year 2002 and the years thereafter, the per visit rate equals the previous year's per visit rate, adjusted by the Medicare Economic Index (MEI) for primary care and any change in the FQHC's or RHC's scope of services.² While the PPS establishes a Medicaid per visit payment rate floor, it does not require states to reimburse FQHCs and RHCs using the PPS methodology. States may choose to implement an alternative payment methodology (APM), including continuation of reasonable cost reimbursement, as long as it does not pay less than what FQHCs and RHCs would have received under PPS, and the affected FQHCs and RHCs agree to the APM.

In 2003, a cost-ratio analysis was developed to calculate enhancement rates in collaboration with Washington Medicaid, FQHCs and RHCs. Using surveys and cost reports, a cost ratio was established for each FQHC and RHC to approximate additional funding requirements. The cost ratio was expressed as the additional percentage of dollars required to meet full FQHC and RHC costs. These additional dollars were then distributed among the total number of Medicaid managed care enrollees and paid on a PMPM basis.

Alternative Payment Methodology 1 (APM1)

In 2006, a CMS audit found insufficient evidence that Washington's PPS methodology for making enhancement payments met the federal requirements of Section 1902(bb), included for reference in Appendix B. Specifically, HCA was unable to demonstrate that enhanced payments

² Public Law No. 106-554.

were sufficient to make each FQHC's and RHC's total reimbursement for each managed care visit equivalent to its encounter rate.

In collaboration with representatives from the Governor's office, FQHCs, RHCs, and their association representatives, Washington Medicaid developed an Alternative Payment Methodology (APM), as allowed under federal Section 1902(bb)(6)³ of the Social Security Act. During the negotiation, FQHC and RHC representatives advised that the new reconciliation methodology would create an incentive to increase billable visits.

Rebasing and reconciliation were included in the new methodology, which became effective January 1, 2009. Under that APM, encounter reimbursement rates were increased annually by a Washington-specific healthcare index. An annual reconciliation was also introduced; the first to take place for calendar year 2009.

Later, during the 2010 legislative session, changes were attempted to meet biennial budget reductions of approximately \$20.3 million. The budget proviso, which was not implemented, was as follows:

Effective January 2011, the department will reduce cost-based encounter payments to federally qualified and rural health centers (FQHCs and RHCs) by reinstating the federal prospective payment system that was replaced by an alternate payment methodology in 2009.

Alternative Payment Methodology 2 (APM2)

During the 2011 legislative session, further changes were made to implement a second version of APM based on the following budget proviso:

The first 2011 supplemental operating budget, HB 3225, directed the Department to reduce cost-based encounter payments to federally-qualified and rural health centers (FQHCs and RHCs) by reinstating the federal prospective payment system that was replaced by an alternate payment methodology in 2009. Funds are provided to implement a new alternate payment methodology that the department will develop within available funds and in consultation with the Office of Financial Management and the legislative fiscal committees.

The APM2 approach with the PPS rate inflated by 5 percent was implemented for only a short period of time, from April 7, 2011 to July 6, 2011.

³ (6) Alternative payment methodologies.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section [1905\(a\)\(2\)\(C\)](#) or to a rural health clinic for services described in section [1905\(a\)\(2\)\(B\)](#) in an amount which is determined under an alternative payment methodology that—
(A) is agreed to by the State and the center or clinic; and
(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

Alternative Payment Methodology 3 (APM3)

APM3 was then developed as an effort to achieve budget savings for the state compared to APM1. During the 2011 special legislative session, further changes were made to meet biennial budget reductions of approximately \$42.0 million in state funds. The budget proviso, currently in effect, is as follows:

Federal law requires that federally-qualified health centers (FQHCs) and rural health clinics (RHCs) are paid a cost-related per visit rate for services to persons covered by the Medicaid and State Children's Health Insurance programs. In 2009 the Department of Social and Health Services replaced the federal Prospective Payment System (PPS) that was based on 2001 costs adjusted by a national measure of medical inflation with an alternative payment methodology (APM) using a higher Washington specific inflation measure. The Health Care Authority will adopt a new payment methodology effective July 1, 2011, that will revert to the lower national measure of medical inflation. As a result, payment rates will be an average of approximately 10.6 percent lower than projected under the 2009 APM.

Ongoing Issues

As Washington's history shows, three alternative payment methodologies have been used in the past five years in response to the 2006 federal audit findings and state budget balancing directives. These methodology changes have presented significant implementation challenges to HCA, FQHCs, and RHCs. The parties recognize these challenges and are working collaboratively to resolve them alongside the development of this report. Included in this discussion is the priority for HCA, RHCs, and FQHCs to collaboratively develop a comprehensive Change in Scope process.

3. Foundational Principles and Proposed Payment Models

In the earliest discussions related to this report, all parties felt it necessary to develop a principles framework that would guide further development of options. Much was garnered from key principles contained within the previous Apple Health Innovations flexibility request, with further updates and changes brought about by conversations since that earlier work.

The following principles reflect the shared values of the HCA, FQHCs and RHCs, as they relate to exploration of any future alternative payment methodology that must reward innovation and outcomes over volume of services delivered, and maintain the integrity of the RHC and FQHC programs as outlined under federal law:

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.

Model 1 – An approach proposed by FQHCs

The FQHCs APM 4 model is built on three principles: (1) the payment system aligns with primary care practice transformation; (2) the model begins the development of a robust data set definition and collection; and (3) it creates the infrastructure as a bridge to a true population based pay for performance system. The APM 4 is a three year contract (2015-2018). It is a capitated PMPM enhancement system that supports a team approach of managing and delivering quality care. The reconciliation process is not based on the number of billable visits, but assures the FQHCs are being paid at least equal to what would have been paid under federal statute.

Model 2 – An approach proposed by RHCs

The recommended model for the future RHC payment methodology moves RHCs from the existing fee-for-service model to a care coordination model. The recommended model creates incentives for quality care outcomes, replacing the current model which drives volume of care. Like other managed care payment models, this recommended model pays RHCs in a per member per month model via an enhanced capitation rate. This rate is in addition to the payment made upon claims submitted to managed care organizations.

Additional Payment Model Details

Following is a more detailed discussion of how components from each model align with the shared principles. While there are many areas of similarity between the proposals, there are some critical differences. These models reflect proposals brought forward by the FQHCs and RHCs and are indicative of the further work necessary to reach consensus on an implementable approach that will achieve the shared principles and aims of the HCA and its delivery system partners.

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.	
MODEL 1	MODEL 2
A per-member, per-month enhancement payment system not based on visits or “touches.” FQHCs transform to Patient Centered Medical Home (PCMH) model. Broadens the workforce of providers to the care team utilizing appropriate connection modalities (telephone, email, etc.). Alternative patient connections are tracked as “touches” but not for purposes of payment.	An enhanced capitation model promotes medically appropriate, alternative methods of staffing and care delivery. A further extension of this method is when insurance companies also pay RHCs a PMPM for primary care (or more than primary care, depending on RHC size).
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.	
MODEL 1	MODEL 2
Current contracts between FQHCs and managed care organizations may include shared savings, which are excluded from this model. Additional shared savings incentives would be based on quality performance.	Enhanced capitation puts primary care providers at partial risk for RHC services provided in the clinic. It also allows RHCs partial shared savings if they can deliver the services in medically appropriate, but more cost effective ways, than face to face visits with a provider (i.e. email, group, or nurse visits).
3. The new APM will strive to be simple, fair, transparent, trustworthy and inexpensive to administer.	
MODEL 1	MODEL 2
Builds on existing payment and administrative systems, allowing for smooth transition to APM4. Initial voluntary rebasing permitted at commencement of system. Eliminates focus on fee-for-service billing, collections, denial processing, etc.	The enhanced capitation model is simple to administer for both the state and RHCs. It gives RHCs financial stability through predictable payments, as well as helps maintain even cash flow through diversity in payment sources (partially from insurance companies, partially through the state).
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.	
MODEL 1	MODEL 2
APM4 will be adjusted yearly by MEI and payment will be at least equal to federally required PPS. Where there are actuarially significant differences in patient populations (e.g. blind and disabled), rates will be adjusted.	The enhanced capitation model provides predictable payments, without the instability of recoupment. A streamlined, timely reconciliation process will ensure compliance with federal requirements that RHCs are paid at least the federally required minimum. Voluntary rebasing would be available at transition to APM4.

5. The APM will be supported by a statewide measure set, with improved data capacity and strive towards improved, more robust risk adjustment.	
MODEL 1	MODEL 2
Tracking of quality measures and payment for achievement of certain quality levels so that APM4 can be an effective bridge to pay for performance. Utilize a few standard quality measures from federal Uniform Data System (UDS), with future measures of the Triple Aim.	Future statewide rollout of PSHA data, with requirements for PSHA to include (and appropriately statistically adjust for) small and rural practices. Measures of preventive care should be from the US Preventive Task Force.
6. The APM will include support for practice transformation such as quality improvement, HIT/HIE support and workforce training.	
MODEL 1	MODEL 2
Provides upfront investment for PCMH Transformation. Allows FQHCs to replace billable visits with most appropriate modality of care (patient “touches” such as telephone visits, group visits, secure email, encounters with non-billable providers, etc.). Encourages workforce development. Applies to a broader range of providers working at top of license and provision of services (i.e. clinical pharmacy and behavioral health services).	Additional support for practice transformation would be welcomed, but out of scope with this model.
7. Developing an APM is an evolutionary process, aligned with health innovation planning and movement toward more integrated delivery of care.	
MODEL 1	MODEL 2
Payment systems align with transformation and will integrate behavioral health and clinical pharmacy services. The system will support development of a robust data set definition and collection. The infrastructure developed in APM4 is a bridge to pay for performance.	The enhanced capitation model moves RHCs an additional step forward, with more development needed in the broader context of the Washington State Health Care Innovation Plan.
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.	
MODEL 1	MODEL 2
FQHCs will actively participate in regular meetings and periodic updates at both the State and Federal levels (i.e., review changes in statute; participate in the development and review of state plan amendments).	This model is fully supportive of inclusion of open and honest lines of communication, especially when changes in statute, state plan and/or waiver are under consideration.

9. The APM model will incentivize participation, however participation will be optional.	
MODEL 1	MODEL 2
Participation in APM4 would be optional for FQHCs. Choice between federally required PPS or APM4 with 3-year agreement.	The ability to deliver care without the constraints of face to face provider visits provides a strong incentive for RHCs to participate.

In addition to foundational principles, there are key details relevant to any payment model. Below you will find each model’s approach to these details:

1. The process to establish the APM will be highlighted (SPA, waiver, other).	
MODEL 1	MODEL 2
State Plan Amendment (SPA)	The current SPA supports this method. Changes to the Washington Administrative Code (including WAC 142-549-1400, Rural health clinics – reimbursement and limitations) will be needed.
2. The APM will describe the reconciliation process to be employed.	
MODEL 1	MODEL 2
Robust Change in Scope to recognize significant changes in patient population, clinical practice and/or cost, and to satisfy APM4 requirements around minimum payments. FQHCs will annually complete an attestation and submit to the state to assure the FQHC is being paid at least equal to what would have been paid under federally required PPS.	Reconciliation is required to ensure RHCs are paid at least equal to the amount they would be paid under PPS. Two reconciliation options would be available: 1) the annual “audited” method currently being developed with the FQHCs, and 2) the process currently being developed with the RHCs, but: <ul style="list-style-type: none"> • Completed quarterly (along with payment of any underpayments), • Without FFS equivalency (since the concept of FFS equivalency is moot if there is no recoupment), • With RHC submission of encounters only, instead of all claims (since all claims aren’t needed if there is no FFS equivalency).
3. The APM will recognize what services are included and how to capture additional services in the future.	
MODEL 1	MODEL 2
Medical services only. Services outside the Medicaid Managed Care, Dental, Maternity support services, pregnancy, and RSN mental health will not be included. Additional services may be added at the time of a new Medicaid managed care procurement.	RHC services, with all OB payments and OB enhanced delivery carved out and paid directly by the HCA.

4. The APM will detail the timeline and scale of implementation of the model.	
MODEL 1	MODEL 2
January 1, 2015	July 1, 2014 implementation Scale: Could philosophically be scaled to broader than RHCs

4. Next Steps

4.1 HCA/FQHC/RHC Committee Continuation

One of our foundational principles speaks to the culture of collaboration and open communication needed to move this process forward. To satisfy this principle and provide necessary channels for further deliberation on a future payment methodology, we propose to continue the joint HCA/FQHC/RHC Committee established for purposes of this report. We propose these meetings happen once a month until an APM 4 is established.

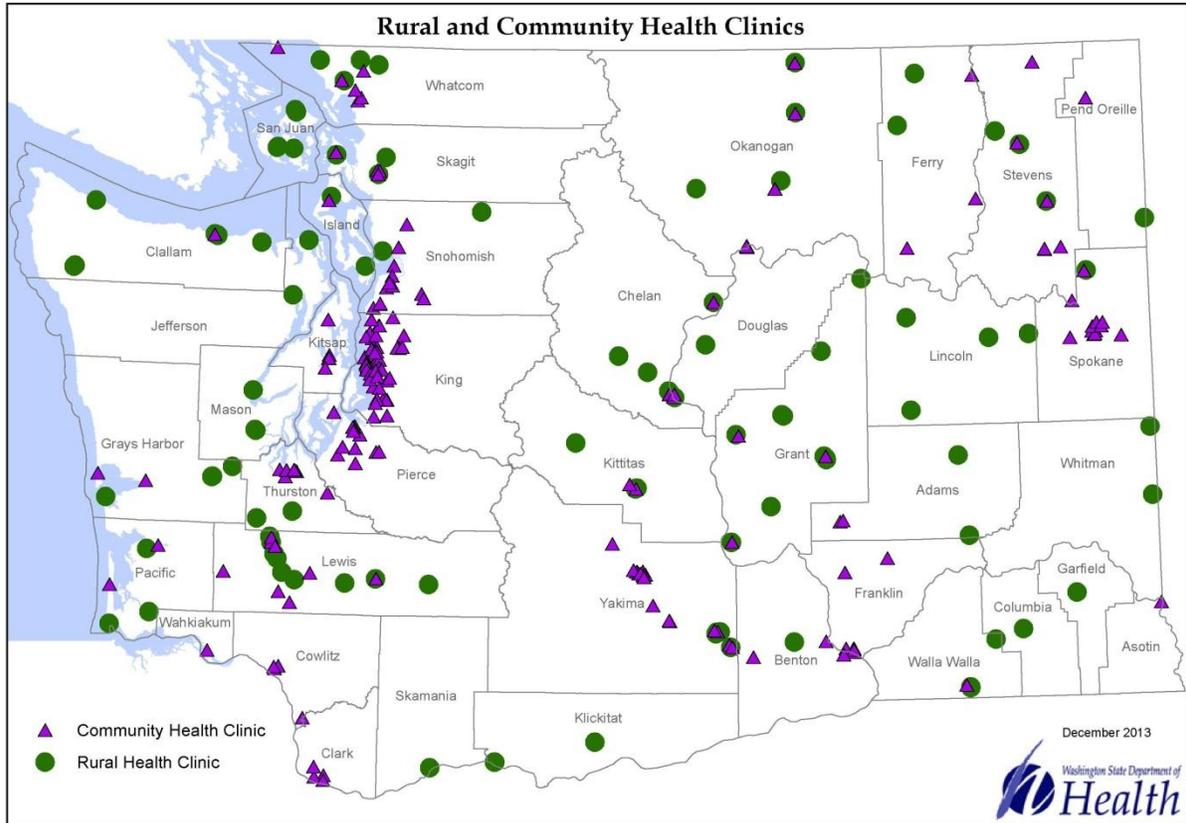
4.2 Additional Actions

In addition to the continuation of the HCA/FQHC/RHC Committee, further details regarding the model will have to be developed. Specifically, as a more detailed payment model is developed, financial modeling and analysis will be necessary to project administrative and budget implications for the state, managed care plans and clinics.

Due to the need for further development of the underpinning details of the models and further evaluation, the parties involved felt it premature to present benefits and drawbacks to each model. It is the intention of the HCA/FQHC/RHC committee to strive toward creation of one model that captures the principles stated above with the appropriate details that enable informed decisions to be made.

As this work progresses toward a greater level of detail, we will need to engage our federal partners at CMS. We will also continue to work with managed care organizations to recognize their role in this process. In addition, we will consult with other agencies and the legislature as necessary.

Appendix A. Map of FQHC and RHC Sites



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Appendix B. Applicable Federal Statute

Section 1902(a)(15):

Sec.1902.[42 U.S.C. 1396a](a) A State plan for medical assistance must—

(15) provide for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (bb);

Section 1902(bb)

(bb) Payment for Services Provided by Federally-Qualified Health Centers and Rural Health Clinics.—

(1) In general.—Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) Fiscal year 2001.—Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) Fiscal year 2002 and succeeding fiscal years.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) Establishment of initial year payment amount for new centers or clinics.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the

entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) Administration in the case of managed care.

(A) In general.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(B) Payment schedule.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) Alternative payment methodologies.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

Appendix C. Washington State Plan Amendment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

JAN 11 2012

Douglas Porter, Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-015B

Dear Mr. Porter:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 11-015B. This amendment modifies the alternative payment methodology for Federally Qualified Health Centers (FQHCs) and updates the reimbursement methodology for new FQHCs and FQHCs that have merged.

This SPA is approved effective July 7, 2011.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Joe Fico at (206) 615-2380 or Joseph.Fico@cms.hhs.gov

Sincerely,

A handwritten signature in black ink that reads "Carol J.C. Peverly".

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health
Operations

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11-15B (P&I)	2. STATE Washington
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 7, 2011 July 7, 2011 (P&I)	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT	
		a. FFY 2011 (\$4,225,000) (\$2,877,000) (P&I)	
		b. FFY 2012 (\$18,064,000) (\$15,939,000) (P&I)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
Attachment 4.19-B pgs 33, 34, 35 (P&I)		Attachment 4.19-B pgs 33, 34, 35 (P&I)	
10. SUBJECT OF AMENDMENT:			
Federally Qualified Health Center (FQHC) Rates			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Exempt			
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
		Ann Myers	
13. TYPED NAME:		Department of Social and Health Services	
Susan N. Dreyfus		Medicaid Purchasing Administration	
14. TITLE:		626 8th Ave SE MS: 45504	
Secretary		POB 5504	
15. DATE SUBMITTED:		Olympia, WA 98504-5504	
6/8/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: June 8, 2011		18. DATE APPROVED: JAN 11 2012	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVAL: JUL 07 2011		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
Carol J.C. Revery		Associate Regional Administrator	
23. REMARKS:		Division of Medicaid & Children's Health	

8/18/2011 - Pen & Ink Changes Authorized by the State.
10/13/2011 - Pen & Ink Changes Authorized by the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XVI. Federally Qualified Health Centers

Effective January 1, 2001, through December 31, 2008, the payment methodology for Federally Qualified Health Centers (FQHCs) conforms to Section 1902(bb) of the Social Security Act (SSA). As set forth in Section 1902(bb)(2) and (3), all FQHCs that provide services on January 1, 2001, and through December 31, 2008, are reimbursed on a prospective payment system (PPS). The reconciliation for calendar year 2009 will be done starting in calendar year 2010 and every year thereafter.

Effective January 1, 2009, fee-for-service (FFS) and managed care organization (MCO) payments to FQHCs will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. Those FQHCs that do not choose the APM will continue to be paid under the PPS.

For the period beginning January 1, 2009, the PPS and APM will utilize the centers' base encounter rates, using the PPS methodology in place at the time. Because the FQHC cost reports reflected the centers' fiscal year, the base rates were adjusted to a calendar year, as illustrated by the following formula (the example reflects a center with a fiscal year ending March 31):

$$\frac{(((FY99 R * FY99 E) / 12) * 3) + (FY00 R * FY00 E) + (((FY01 R * FY01 E) / 12) * 9)}{((FY99 E / 12) * 3) + (FY00 E) + ((FY01 E / 12) * 9)}$$

R = Rate
E = Encounters

For FQHCs receiving their initial designation after January 1, 2001, their base rates were established using an average encounter rate of other FQHCs located in the same or adjacent area with similar caseloads, on an interim basis until their permanent rates were determined.

Effective January 1, 2009, and each January 1 thereafter, PPS rates will be increased by the percentage change in the Medicare Economic Index (MEI) for that period.

Effective January 1, 2009, and each January 1 thereafter, APM rates will be increased by a Washington-specific health care index developed by IHS Global Insight. To ensure that the APM pays an amount at least equal to the PPS, the greater of the Washington-specific index or the MEI will be used. The greater of the Washington-specific index or the MEI will also be applied retroactively to the centers' base encounter rates.

For services provided on and after July 7, 2011, each center will have the choice of receiving either (1) its PPS rate, as determined under the method described above or (2) a rate determined under a revised APM. The revised APM will be as follows: for centers that rebased their rate effective January 1, 2010, their 2008 allowed cost per visit inflated by the cumulative percentage increase in the MEI between 2009 and 2011. For centers that did not rebase in 2010, their rate is based on their PPS base rate from 2002 (or subsequent year to the extent the 2002 rate was updated to account for the addition of a new site or type of service) inflated by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and the cumulative increase in the MEI from 2009 through 2011. The rates will be inflated by MEI effective January 1, 2012 and each January 1 thereafter. The State will compare each year's APM rate to the rate that would have been paid under PPS to ensure the APM payments are at least equal to the payments that would have been made under PPS.

TN# 11-15B
Supersedes
TN# 08-010

Approval Date

JAN 11 2012

Effective Date 7/7/11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XVI. Federally Qualified Health Centers (continued)

The State will periodically rebase the FQHC encounter rates using the FQHC cost reports and other relevant data. Rebasing will be done only for centers that choose the APM.

FQHCs receiving their initial designation after January 1, 2001, will be paid an average encounter rate of other FQHCs located in the same or adjacent area with similar caseloads, on an interim basis. Within two years of receiving its initial designation, the FQHC must demonstrate its true costs using standard cost reporting methods, to establish its base encounter rate. The State will audit the new center's cost report to ensure the costs are reasonable and necessary.

The new FQHC will receive this rate for the remainder of the calendar year in which it is established and will receive annual increases thereafter consistent with the payment methodology (PPS or APM) chosen by the center.

If two or more FQHCs merge, a weighted average of the centers' encounter rates is used as the encounter rate for the new center.

An adjustment will be made to a center's encounter rate if the center can show that they have experienced a valid change in scope of service.

A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of service will occur if: (1) the center adds or drops any service that meets the definition of FQHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as defined in the State Plan Amendment.

The center is responsible for notifying the FQHC Program Manager in writing of any changes during the calendar year, no later than 60 days after the effective date of the change. Within 60 days of notification, the State will verify the change meets the definition of change in scope of service.

If the change represents a decrease in scope of service, the State will recalculate the base encounter rate by decreasing it by the average cost-per-encounter detailed in the center's most recent rebasing. If the change represents an increase in scope of service, the State will recalculate the base encounter rate on an interim basis by increasing it by the average statewide cost-per-encounter as detailed in the most recent rebasing of other centers that provide the service. Once the center can demonstrate its true costs of providing the service, it must submit adequate documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary, and adjust the interim rate by the accepted cost-per-encounter to establish a final encounter rate. The new encounter rate(s) will be effective on the date the new service was fully implemented and available.

TN# 11-15B
Supersedes
TN# 08-010

Approval Date

JAN 1 1 2012

Effective Date 7/7/11



JAN 11 2012

Douglas Porter, Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-016B

Dear Mr. Porter:

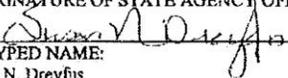
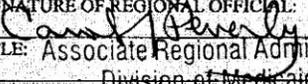
The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 11-016B. This amendment modifies the alternative payment methodology for Rural Health Clinics (RHCs) and updates the reimbursement methodology for new RHCs and RHCs that have merged.

This SPA is approved effective July 7, 2011.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Joe Fico at (206) 615-2380 or Joseph.Fico@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health
Operations

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11-16 B	2. STATE Washington
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 7, 2011 July 7, 2011 (P&I)	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT: a. FFY 2011 (\$648,000) (\$475,000) (P&I) b. FFY 2012 (\$2,753,000) (\$2,608,000) (P&I)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B pgs 3, 4, 5 (P&I)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B pgs 3, 4, 5 (P&I)	
10. SUBJECT OF AMENDMENT: Rural Health Center (RHC) Rates			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Exempt <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Ann Myers Department of Social and Health Services Medicaid Purchasing Administration 626 8 th Ave SE MS: 45504 POB 5504 Olympia, WA 98504-5504	
13. TYPED NAME: Susan N. Dreyfus			
14. TITLE: Secretary			
15. DATE SUBMITTED: 6-13-11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: June 13, 2011		18. DATE APPROVED: JAN 11 2012	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED: JUL 07 2011		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Carol J.C. Beverly		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS: 8/18/2011 - Pen & Ink changes authorized by the State. 10/13/2011 - Pen & Ink changes authorized by the State.			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

II. Clinic services (cont.)

Effective January 1, 2001, through December 31, 2008, the payment methodology for Rural Health Clinics (RHCs) conforms to Section 1902(bb) of the Social Security Act (SSA). As set forth in Section 1902(bb)(2) and (3), all RHCs that provide services on January 1, 2001 and through December 31, 2008 are reimbursed on a prospective payment system (PPS). The first reconciliation was for payments made in calendar year 2009 and was done starting in calendar year 2010. Thereafter, a reconciliation will be done for each calendar year in the following calendar year.

Effective January 1, 2009, fee-for-service (FFS) and managed care organization (MCO) payments to RHCs will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. Those RHCs that do not choose the APM will continue to be paid under the PPS.

For the period beginning January 1, 2009, the PPS and APM will utilize the clinics' base encounter rates, using the PPS methodology in place at the time. The base rates were calculated as illustrated by the following formula:

$$\frac{(1999 \text{ Rate} * 1999 \text{ Encounters}) + (2000 \text{ Rate} * 2000 \text{ Encounters})}{(1999 \text{ Encounters} + 2000 \text{ Encounters})}$$

For clinics receiving their initial RHC designation after 2001, their base rates were established using the first available Medicare-audited cost report.

Effective January 1, 2009, and each January 1 thereafter, PPS rates will be increased by the percentage change in the Medicare Economic Index (MEI) for that period.

Effective January 1, 2009, and each January 1 thereafter, APM rates will be increased by a Washington-specific health care index developed by IHS Global Insight. To ensure that the APM pays an amount at least equal to the PPS, the greater of the Washington-specific index or the MEI will be used. The greater of the Washington-specific index or the MEI will also be applied retroactively to the clinics' base encounter rates.

For services provided on and after July 7, 2011, each center will have the choice of receiving either (1) its PPS rate, as determined under the method described above or (2) a rate determined under a revised APM. The revised APM will be as follows: for centers that rebased their rate effective January 1, 2010, their 2008 allowed cost per visit inflated by the cumulative percentage increase in the MEI between 2009 and 2011. For centers that did not rebase in 2010, their rate is based on their PPS base rate from 2002 (or subsequent year to the extent the 2002 rate was updated to account for the addition of a new site or type of service) inflated by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and the cumulative increase in the MEI from 2009 through 2011. The rates will be inflated by MEI effective January 1, 2012 and each January 1 thereafter. The State will compare each year's APM rate to the rate that would have been paid under PPS to ensure the APM payments are at least equal to the payments that would have been made under PPS.

The State will periodically rebase the RHC encounter rates using the RHC cost reports and other relevant data. Rebasing will be done only for clinics that chose the APM.

TN# 11-16B
Supersedes
TN# 08-010

Approval Date

JAN 11 2012

Effective Date 7/7/11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

II. Clinic Services (cont.)

RHCs receiving their initial designation after January 1, 2001, are paid an average encounter rate of other clinics located in the same or adjacent area with a similar case load, on an interim basis until the clinic's first Medicare-audited cost report is available.

Once the audited report for the clinic's first year is available, the new clinic's encounter rate is set at 100 percent of its costs as defined in the cost report. The new RHC will receive this rate for the remainder of the calendar year during which the audited cost report became available, and will receive annual increases thereafter consistent with the payment methodology (PPS or APM) chosen by the clinic.

An adjustment will be made to a clinic's encounter rate if the clinic can show that they have experienced a valid change in scope of service.

A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of service will occur: if (1) the clinic adds or drops any service that meets the definition of RHC service as defined in section 1905(a)(2)(B) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as described in the State Plan Amendment.

The clinic is responsible for notifying the RHC Program Manager in writing of any changes during the calendar year, no later than 60 days after the effective date of the change. Within 60 days of notification, the State will verify the change meets the definition of change of scope of service.

If the change represents an increase in scope of service, the State will recalculate the base encounter rate on an interim basis by increasing it by the average statewide cost per encounter as detailed in the most recent rebasing of other clinics that provide the service.

This interim rate will be effective the date the new service is implemented and fully available to Medicaid clients. Once the clinic can demonstrate its true costs of providing the service, it must submit adequate documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary, and adjust the interim rate by the accepted cost per encounter to establish a final encounter rate.

If the change represents a decrease in scope of service, the State will recalculate the base encounter rate by decreasing it by the average cost per encounter detailed in the clinic's most recent rebasing.

TN# 11-16B
Supersedes
TN# 08-010

Approval Date

JAN 11 2012

Effective Date 7/7/11

Appendix D: Relevant State Alternative Payment Methodology Research

Matrix Notes:

- Matrix serves as a learning tool to investigate other state FQHC/RHC alternative payment models through the lens of Washington’s values and key details to assist in the development of payment methodology options. It is important to recognize each state is unique and one cannot directly apply another state’s model as their own.
- Matrix used for discussion purposes, hence short hand language.

Values/Details: ↓	State : →	Oregon	Maryland	Minnesota
Value: Develop a payment model which moves 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.		<p>Based on the desire to meet the needs of a robust person centered medical home and to move away from churning visits.</p> <p>Converts PPS into a bundled, PMPM rate. MCO or CCO will pay a PMPM rate comparable to any primary care provider.</p> <p>State pays wraparound based on prior year’s wraparound. State have PCPCH Institute and PCPCH incentive payments to all providers based on own tiered system.</p>	<p>Based on a desire to include FQHCs within All Payer PCMH Model 2.0, contingent on accepting new APM. FQHCs have to apply and meet minimum criteria. Provides a guiding framework for a desired state.</p>	<p>Based in desire to build robust PCMHs. Allow flexibility. Total Cost of Care.</p>
Payment model should also encourage innovative payment practices and provide an opportunity for shared risk and shared savings, while not compromising ability to manage contracts.		<p>It is a bridge to get to total value based pay. The payment model is facilitating the ability to capture “real” total cost of care. CHCs don’t have to “pay back” PMPM if more than cost per visit.</p> <p>CHCs still maintain contracting abilities with CCOs/MCOs. Those contracts are heavily influenced by CCO goals, measures.</p> <p>Shared savings with other providers such as hospitals and specialists is not directly associated with APM, however CCOs aim to redirect dollars both to the systems that need it most and that achieve savings via the risk pool.</p>	<p>Stage two of APM enables shared savings:</p> <p>Calculation of fixed PMPM is based on the first four rates paid for assigned patients served or attributed during last 12 months of available data from Stage 1 period.</p> <p>No FFS payment for Medical PPS visits. Some bill above for services outside of Medical PPS scope.</p> <p>Shared savings with MCOs based on a predetermined formula against pre-set targets.</p> <p>Rates in Stage 1 and Stage 2 continue to be “improved” by the MIE.</p>	<p>Partnered with 2008 reforms and is a critical component of SIM Testing grant, since an early HCDS Virtual ACO is an urban set of FQHCs.</p> <p>FQHCs are a critical part of Hennepin, shared savings across the table.</p> <p>Based on TCC at state level.</p> <p>Shared savings is based on quality metric reporting and performance.</p> <p>Need more info re: contracts.</p>

Values/Details: ↓	State : →	Oregon	Maryland	Minnesota
New APM will be simple, fair, transparent, trustworthy and inexpensive to administer.		<p>This is in the eyes of the beholder. On both sides the new APM pilot has been a huge undertaking. It is trying to move toward all of these goals, but is not there yet.</p> <p>The state has noted that this is actually costing more than in the past.</p>	Not known yet.	Need more information.
<p>The APM will support increased uniformity of payment for similar services across clinics and will be actuarially sound.</p> <p>Payments should be predictable and comply with federal requirements.</p>		PMPM is not yet actuarially sound.	Should, due to alignment with “all-payer” PCMH model.	Desire to move there with SIM testing.
<p>Agree to a shared statewide measure set with improved data capacity, and strive towards improved, more robust risk adjustment.</p>		<p>CCO have a set of measures they are held accountable for and since CHCs are key delivery system component, especially for Medicaid.</p> <p>So measures are applied at the CHC level.</p> <p>Coordinated Care Model is going to be applied to PEB and eventually the exchange.</p> <p>Oregon has developed a dashboard to better capture “touches” as well as note the behavioral and socio-economic impacts of health that are barriers to inform risk adjustment.</p> <p>CCOs requirements around certain data to capture is evolving to try to have the appropriate data to risk adjust for behavioral-socio economic barriers (e.g. homelessness).</p>	<p>Collaboration with MCOs and the State to tackle high priority issues within your population (not uniform yet):</p> <p>Low VBP/HEDIS targets,</p> <p>State SHIP targets,</p> <p>Agreed upon UDS improvement targets,</p> <p>Lower rates of readmissions or unnecessary use of ED services.</p>	<p>Specific measures in SPA.</p> <p>All payers and providers have to report same measures.</p> <p>Recognize need to risk adjust.</p> <p>Compare FQHCs to each other not to other practices.</p>
<p>Training and Supports for practice transformation (Quality improvement, HIT/HIE, capacity at clinic level, workforce training).</p>		<p>Oregon use 2703 health home dollars to support incentives to achieve PCPCH tiers (Oregon has their own tiers).</p> <p>Oregon’s CCO measures are tied to a risk pool, one of the measures is # of members assigned to PCPCH home (dollars are increased when tier is higher).</p> <p>PCPCH Institute is open to all delivery sites.</p>	<p>Yes, robust PCCM-like administrative case management fee, inclusion in statewide health information exchange and state support to be “in-network” for QHPs.</p> <p>Additional dollars on top of PPS to incent more robust and innovative practices.</p>	Yes

Values/Details: ↓	State: →	Oregon	Maryland	Minnesota
This is an evolutionary process, aligned with health innovation planning and movement toward more integrated delivery of care.		<p>FQHC driven and instigated by shifting environment, get in front of the curve pre-2014. 2014 might create changes.</p> <p>PCMH and payment reform is a principle of Oregon's Health System transformation development of CCOs. State and FQHCs saw this as a way for CHCs to best support these goals.</p>	<p>2 phases.</p> <p>Tied directly into SIM SHCIP.</p>	<p>Very closely tied with state health reform and SIM testing.</p>
All relevant parties will maintain open and honest lines of communication throughout this process and beyond, especially when changes in statute, state plan and/or waiver are under consideration. Building a culture of collaboration.		<p>Oregon has a Safety New Advisory Committee that meets quarterly to discuss on going issues (FQHCs, RHCs, Community based clinics, MCOs (I think) and State).</p> <p>FQHCs and State meet regularly regarding APM pilot.</p> <p>Development of Health Systems Transformation and revisions of 1115 waiver prompted monthly check-ins with the State to discuss impact on PPS, change in scope, etc.</p>	<p>There are hopes for this to create a better relationship.</p>	<p>Unknown</p>
Payment model will incentivize participation, however participation will be optional.		<p>OPCA is working to get FQHCs "house in order" to prepare those for entry into APM.</p> <p>State is researching.</p>	<p>Yes, through PPS +incentives, participation means "in-network" with QHPs, etc.</p>	<p>Yes</p>

Values/Details: ↓	State: →	Oregon	Maryland	Minnesota
Payment Details:				
Describe mechanism through which this APM will be developed (SPA, waiver, other).		<p>SPA (Oregon does have an 1115 waiver and there are discussions around revisions to waiver post 2014).</p>	<p>CMMI</p> <p>SPA</p>	<p>CMMI</p> <p>SPA</p>
Describe reconciliation process.		<p>Reconciliation is done to make sure PPS floor is not fallen through, but does not prompt recoupment.</p>	<p>Desire to move off (would have to confirm).</p>	
What services are included in payment model? (i.e. all carved in, mental health, dental and/or OB carved out).		<p>Physical health (intention to roll in behavioral health next year).</p>		

Values/Details: ↓	State: →	Oregon	Maryland	Minnesota
Payment Details:				
Are there any components not already noted above that should be considered to understand how the uniqueness of the state eased this process or created barriers?		Very robust and built out health reform over many years.	A lot of angst between groups.	Very robust and built out health reform over many years.
What is/was the existing payment structure/methodology? (i.e. FFS plus incentives, capitation, role of managed care organizations).		Stated in first box.		
Timeline and scale of implementation of payment model reform.		Currently 3 pilot CHCs, desire to roll out to addition 3-5 this year. Desire for 1-2 CCOs to take on all payments.	Two phases.	