National Academy for State Health Policy
Value-Based Payment Reform Academy

Comparison of Oregon and Washington's Medicaid Alternative Payment Methodologies for FQHCs

	Oregon	Washington
Implementation Status	Implemented in March 2013 after approval of the State Plan Amendment was granted by CMS in 2012.	Implemented on July 1, 2017. After CMS review a State Plan Amendment was not required.
Participation	As of June 2017, 12 federally qualified health centers (FQHCs) and 1 rural health clinic (RHC) are participating.	As of June 2017, 16 FQHCs and 1 RHC are participating.
Provider Participation Criteria	• 3-year commitment. • 30-day emergency exit for FQHCs and RHCs. • All Medicaid patients (FFS and Managed Care) included in attribution at all clinic sites. • Medical services are included in the APM (mental health, dental, OB are carved out of the rate for now). • FQHCs/RHCs agree to Accountability Plan, which is an agreement between health centers and state outlining goals and metrics. • FQHCs/RHCs agree to participate in learning community activities several times a year to discuss the promising clinical practices available, as well as what is challenging, under a more flexible approach to payment.	• 5-year commitment. • FQHCs and RHCs retain the right to opt out of APM4 and continue to receive encounter-based payment. • All Medicaid Managed Care Organization (MCO) beneficiaries assigned to the FQHC or RHC are included; no FFS beneficiaries are included. MCO assignment is reported in member months. • All encounter eligible services included in the Apple Health (Managed Care) contract are included, primarily this includes medical, low level behavioral health and some maternity support services. • Participation is determined by the FQHC and RHC, and is based on completing CY2015 reconciliation.
	• Per member, per month payment (PMPM) based on each clinic's historical PPS payments and Day 1 patient panel established through an 18-month lookback (see attribution section).	• PMPM based on a baseline conversion rate. o APM4 baseline = CY2015 APM 3[1] rate times CY2015 Encounter divided by Member Months.

Payment Model	• FQHC APM rates are adjusted annually by the Medicare Economic Index (MEI).
	• Each health center has two rates, one for managed care beneficiaries and one for FFS beneficiaries:
	  o Managed Care: Health centers negotiates payment rate and methodology with managed care plan as they would do previously. State "wrap-around" payment is paid as a PMPM, called the "wrap-cap" rate.
	  o FFS: Medicaid pays each health center a PMPM rate approximately equivalent to its full PPS rate.
	• Rates are not linked to quality.
	• Reconciliation to PPS is done quarterly but any required settlement is resolved annually to ensure that each clinic receives total payments *at least* equivalent to what they would have under PPS.
		• Baseline PMPM rate is carried forward in future years.
		  o PMPM is trended by MEI..
		• Rate is linked to quality improvement of a subset of the Washington State Common Measure set.
		  o Each FQHC or RHC competes against their prior performance year to retain the full PMPM each fiscal year.
		  o Non-performance will result in reduced payment through prospective adjustment, but will not be less than PPS/APM3.
		  o FQHCs or RHCs may earn back the full benefit of their baseline PMPM trended by the MEI in future years.
		• FQHCs and RHCs will receive no less than PPS/APM3.
		• Reconciliation to PPS/APM3 is done annually to ensure that each FQHC and RHC receives total payments *at least* equivalent to what they would have received under PPS/APM3.

Attribution	• APM is paid on patients who establish care with the clinic through an in-person visit with a licensed clinician.
	  o Each clinic's panel was initially established with a "Day 1 list" of active patients, which included all Medicaid patients who had a visit in the 18-months prior to implementation. Lists were generated by health centers, reviewed by the state, and adjusted for patients served elsewhere or no longer eligible for Medicaid.
	• Patients are removed from the APM panel if the patient accesses primary care at another clinic or has not had a visit or Care STEP (see measurement section) in an 8-quarter lookback period.
		• Attribution is based on reported beneficiary rosters from MCOs.
		  o MCOs assign patients to FQHCs, which is then reported to Medicaid. Medicaid PMPM payments are based on these rosters.

	• New patients are added to the APM panel, or back to the panel when removed, if they have a visit with a licensed clinician (physician, midlevel provider, nurse, or licensed clinical social worker) at the FQHC.	
Measurement	APM Measures: 1. Colorectal Cancer Screening 2. Depression Screening and Follow-up 3. Diabetes Poor Control 4. Hypertension Control 5. Childhood Immunizations 6. Timeliness of Prenatal Care 7. Tobacco Screening and Cessation 8. Weight Control (Adults) 9. Weight Control (Children) 10. Patient Experience: % of patients who would recommend their care team to family/friends Oregon also collects Care STEPs quarterly. Care STEPs are non-billable patient encounters such as participation in a support group, a telephonic visit, coordinating care, etc. Data is tracked through electronic medical records.	APM Measures: 1. Comprehensive Diabetes Care- Poor HbA1c Control (>9%) 2. Comprehensive Diabetes Care- Blood Pressure Control (<140/90) 3. Controlling High Blood Pressure (<140/90) 4. Antidepressant Medication Management a. Effective Acute Phase Treatment b. Effective Continuation Phase Treatment (6 months) 5. Childhood Immunization Status- Combo 10 6. Well-Child Visits in the 3rd, 4th, 5th, and 6th years of life 7. Medication Management for people with Asthma: Medication Compliance 50% a. (Ages 5-11) b. (Ages 12-18)
Results	Program evaluation results show confirmed budget neutrality with a slight decline in face-to-face visits. Inpatient and emergency room utilization also declined.	Results not yet available.

[1] The APM 3 rate = the 2008 encounter reimbursement rate, increased annually by a Washington specific healthcare index and inflated by 2009-2010 MEI.