



State Strategies to Develop Value-Based Payment Methodologies for Federally Qualified Health Centers

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Federally Qualified Health Centers

Federally qualified health centers (FQHCs) are safety net providers that deliver a wide range of outpatient services primarily to complex and vulnerable populations, including Medicaid enrollees and the uninsured. Some FQHCs serve specialized populations, such as migrant workers and individuals experiencing homelessness.

Health Center Program grantees and look-alikes are eligible to apply to the Centers for Medicare & Medicaid Services (CMS) for FQHC status after the Health Resources and Services Administration (HRSA) certifies that they meet Health Center Program requirements as authorized under Section 330 of the Public Health Services Act.

FQHCs receive reimbursement from Medicaid through the Prospective Payment System (PPS). PPS and opportunities to develop value-based payment methodologies are explored in the Value-Based Payment Methodology Development section of this toolkit.

Sources: CMS, "Federally Qualified Health Center," January 2017. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-Work-MLN/MLNProducts/Downloads/fqhcfactsheet.pdf>; (2) Public Health Service Act, 42 U.S.C. §254b.

Recent state Medicaid initiatives have demonstrated that delivery system reforms, when coupled with value-based payment (VBP) methodologies, can reduce costs and increase health care system capacity to provide efficient, high-quality care.¹ Federally qualified health centers (FQHCs), which are critical safety net providers for more than 12 million Medicaid beneficiaries,² often have been excluded from participating in payment reform initiatives due to complexities in federal reimbursement requirements.

Under Section 1902(bb) of the Social Security Act,³ Medicaid programs must reimburse FQHCs either through the Prospective Payment System (PPS), which requires states to set cost-based, per-visit payment rates for individual clinics, or through a qualifying alternative payment methodology (APM). APMs must reimburse FQHCs at least as much as they would receive under PPS, and be agreed to by each clinic.^{4,5} Recently, states have begun to demonstrate that they can effectively engage FQHCs in VBP reform, implementing VBP methodologies through either a qualifying APM under Section 1902(bb),

or through another Medicaid authority.

VBP methodologies reward providers for improving both healthcare quality and efficiency. For FQHCs, adoption of a VBP methodology can mean the ability to:

- Support more team-based, integrated care;
- Better leverage scarce resources (such as clinicians' time);
- Provide interventions (such as care coordination and care transitions) that can improve the health of complex populations and address social determinants of health;⁶ and
- Impact cost and quality of care provided directly by the FQHC, as well as across the health system.

Defining Terms

*Value-based Payment Methodology**: a methodology that rewards providers for quality and efficiency over volume of care delivered, and is tied to performance measures. VBP methodologies can be implemented using a number of Medicaid authorities.

Alternative Payment Methodology (APM): a methodology, which can be value-based, specifically implemented for FQHCs under Section 1902(bb) of the Social Security Act. APMs must reimburse FQHCs at least as much as they would receive under PPS, and be agreed to by each clinic.

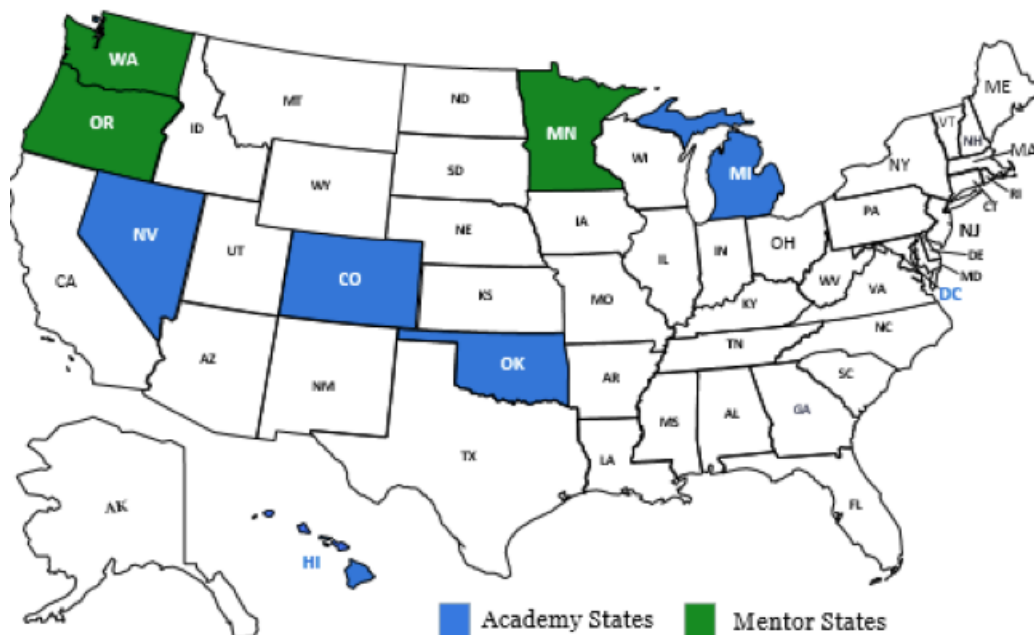
*As defined by the [Health Care Payment Learning and Action Network](#).

This toolkit is designed to support state Medicaid policymakers in implementing value-based APMs for FQHCs. Based on lessons learned from states during the National Academy for State Health Policy’s (NASHP) Value-Based Payment Reform Academy, the toolkit provides background information, considerations, and state strategies that address the following topics:

- Stakeholder engagement;
- VBP methodology development;
- Measurement and reporting; and
- FQHC readiness and practice transformation

NASHP’s Value-Based Payment Reform Academy

NASHP’s [Value-Based Payment Reform Academy](#) supported six states (CO, HI, DC, MI, NV, OK) in developing and implementing value-based payment methodologies for FQHCs, with an emphasis on supporting high-quality, efficient care. State teams included leaders from Medicaid, the state’s primary care association, and at least one FQHC. Some states also engaged their state health departments. NASHP also worked with three leading “mentor” states to provide technical assistance to the Academy.



Stakeholder Engagement

FQHCs typically serve a high volume of Medicaid patients and provide a wide array of services including primary and preventive care, behavioral health and oral health care. FQHCs that participate in the Health Center Program, authorized under Section 330 of the Public Health Service Act,⁷ must meet specific programmatic requirements, such as reporting to the Health Resources and Services Administration (HRSA) on Uniform Data System⁸ measures and quality improvement initiatives.⁹ With a focus on quality and a holistic approach to care, FQHCs are often well positioned to participate in state VBP reform initiatives.

In spite of these strengths, FQHCs may also face resource constraints that can make transitioning to a VBP methodology challenging. For instance, FQHCs that participate in the Health Center Program are required to offer care to underserved populations regardless of insurance or ability to pay,¹⁰ which can make it difficult to predict revenue. For state policymakers, engaging stakeholders who are knowledgeable about unique FQHC financial and operational features can help facilitate the development of a VBP methodology that is mutually beneficial for the state Medicaid agency and for FQHCs. The following section on stakeholder engagement discusses key considerations and promising strategies based on lessons learned from states during NASHP's Value-Based Payment Reform Academy.

Key considerations for engaging stakeholders include:

- Identify core stakeholders;
- Articulate a vision and shared goals;
- Employ a variety of communication strategies to ensure FQHC support;
- Develop collaborative processes to help foster trust and transparency; and
- Assess and adapt stakeholder engagement as the project evolves.

Key Considerations

Identify core stakeholders.

State agencies: Developing a VBP methodology requires engagement across numerous state agencies and offices. States may want to include staff who are knowledgeable about FQHCs and PPS from the outset to identify potential policy barriers and challenges. Early contact with state staff who have expertise in measurement, data analytics, managed care contracting, and other policy and operations issues will help facilitate development. States may also want to include a representative from the state's Department of Health to provide input on how components of a VBP methodology could impact workforce issues, prevention strategies, and efforts that target social determinants of health.

Primary care associations (PCA): State teams participating in the NASHP Academy all included their states' PCAs in their core planning team. PCAs are state or regional non-profit organizations that provide training and technical assistance to safety net providers. PCAs can be critical partners to Medicaid agencies; they have significant expertise in FQHC financial and clinical operations and serve as a convener of FQHCs in the state. As development progresses, PCAs can help FQHCs understand value-based purchasing and their capacity for participating in VBP methodologies.¹¹

FQHC executive and clinical leaders: Executive-level staff offer perspectives on how to overcome FQHC-level fiscal and operational challenges in the transition to a VBP methodology. Clinical champions can be important ambassadors in outreach with their professional peers and can provide insight into how practice workflows may need to change to effectively implement a new payment methodology.

Consumers and patients: Most FQHCs are required to have at least 50 percent patient participation on their boards, and will likely have patient/consumer leaders with an understanding of their clinics' patient priorities who bring a consumer focus to planning.

Articulate a vision and shared goals.

Articulating a vision and shared goals allows stakeholders to work from a common foundation and can help overcome barriers. States may want to formalize their shared vision and goals through a charter or work plan. **Colorado** stakeholders formalized their goals through a statement of shared intent,¹² which listed key design decisions and included a timeline for additional decision-making.

Employ a variety of communication strategies to ensure FQHC support.

States can use a variety of communication strategies to engage FQHCs and encourage buy-in from practices:

- Early identification and outreach to FQHCs that are interested in payment reform can provide the foundation for ongoing engagement. In **Hawaii**, for example, the state's PCA convenes a subcommittee on value-based purchasing, offering a forum for these FQHCs to provide feedback on the development of the state's VBP methodology.
- Targeted educational materials and activities about value-based purchasing and practice transformation can prepare stakeholders for more meaningful participation. Both **Michigan** and **Oklahoma** provided FQHCs with ongoing training and education on VBP reform at PCA meetings.
- Letters of interest (LOI) or requests for information that document state officials' thinking and direction can be helpful tools to educate target audiences, gauge level of interest, and identify engaged FQHCs and leaders. FQHCs that responded to **Colorado's** LOI¹³ provided input into the development of the state's proposed VBP methodology and received additional resources and support to prepare them for implementation.

Develop collaborative processes to help foster trust and transparency.

Several NASHP Academy states reported that developing relationships with their states' PCAs and FQHC communities was a key factor in successful planning. **Washington, DC's** Medicaid agency, for example, created a continuous feedback loop to provide information to and receive comments from PCA leaders, FQHCs, and managed care plans through regular meetings with each stakeholder group. **Nevada** created subcommittees, which included leadership from each Medicaid bureau and its PCA, that each focused on a core element of VBP methodology design (e.g., attribution of patients to providers). Subcommittees were responsible for researching potential policy options and presenting their recommendations to the team of core stakeholders.

Assess and adapt stakeholder engagement as the project evolves.

As VBP methodology development gains momentum, states may need to engage additional stakeholder groups, such as state legislators, managed care organizations (if applicable), and the state's Medicaid Advisory Committee to educate a broader audience and build support for the model. States can also convene public hearings and conduct focus groups to gather feedback from broader audiences, or to get more granular feedback from specific perspectives. States are also required to provide a public notice and comment period for any changes to payment methodologies that require a state plan amendment (SPA).

Value-Based Payment Methodology Development

States are increasingly demonstrating that VBP reform for FQHCs is not only possible, but can be beneficial for both state Medicaid agencies and FQHCs. However, VBP methodologies vary widely, and can have different implications for both providers and payers. The CMS Health Care Payment Learning and Action Network (HCP LAN) developed a useful framework for understanding VBP methodologies, organized by increasing clinical and financial risk.¹⁴ The framework categorizes payment methodologies across four categories, from lowest to highest risk:

- Category 1: Fee for service (FFS) with no link to quality/value;¹⁵
- Category 2: FFS with a link to quality/value (e.g., pay for reporting/performance, supplemental payments for care coordination);
- Category 3: FFS with potential for upside shared savings and/or downside risk (based on performance on key cost and quality benchmarks); and

- Category 4: Population-based payments (e.g., per member per month (PMPM) payments for a defined set of services linked to quality outcomes).¹⁶

The following section on VBP methodology development and implementation provides an overview of select, active Medicaid FQHC VBP methodologies, followed by key considerations and promising strategies based on lessons learned from states during NASHP's Value-Based Payment Reform Academy.

Key considerations for VBP methodology development and implementation include:

- Adhere to specific federal requirements when implementing a VBP methodology under FQHC state plan authority;
- Identify opportunities for additional flexibility using other state Medicaid authorities;
- Leverage Medicaid managed care contracts to support VBP methodologies;
- Design a VBP methodology based on state-specific context, capacity, and alignment with other Medicaid initiatives;
- Consider how to manage and adjust for risk under the VBP methodology; and
- Develop an accurate attribution methodology that aligns with the goals of the selected VBP methodology.

States are using diverse Medicaid authorities to implement VBP methodologies in alignment with the HCP LAN framework, as described in Table 1. Regardless of the Medicaid authority, state policymakers report that early engagement with the Centers for Medicare & Medicaid Services (CMS) during the planning process can help troubleshoot concerns related to federal requirements for FQHC reimbursement.

Prospective Payment System Requirements

[Section 1902\(bb\) of the Social Security Act](#) requires that state Medicaid programs reimburse FQHCs through the Prospective Payment System (PPS), which sets minimum per visit rates for each FQHC, inclusive of all sites. PPS rates vary among FQHCs and are based on each FQHC's average cost per visit rate.

States can pursue value-based APMs with FQHCs within federal parameters as long as individual FQHCs agree to the APM and each clinic's total payments are equivalent to or higher than the total payments they would receive through PPS.

For more information on PPS, please see <http://www.nachc.org/wp-content/uploads/2016/02/PPS-One-Pager-noask-Final.pdf>.

Table 1. Overview of Select State VBP Methodologies for FQHCs

Payment Methodology	Patient Attribution	Payment and Quality Incentives	Impact on Service Delivery
Washington, DC: Pay for Performance through FQHC State Plan Amendment (SPA)¹⁷			
<p>FQHCs can elect to be reimbursed for FQHC services through PPS or through an alternative payment methodology (APM) that pays at least PPS on a per encounter basis.</p> <p>FQHCs that opt into the APM can also earn supplemental performance-based payments (P4P) drawn from a bonus funding pool.¹⁸</p>	<p>Retrospective: at least one visit during the performance period.</p>	<p>To receive supplemental payments, FQHCs must achieve performance in the 75th percentile or greater, or significantly improve from previous year on nine quality measures, including expanded after-hours care, all-cause readmissions, and preventable hospitalizations.</p>	<p>Performance measures emphasize access to care, care coordination, and reducing unnecessary admissions.</p>
Ohio Comprehensive Primary Care (CPC) Program: Supplemental PMPM and Shared Savings through a Primary Care Case Management SPA^{19, 20}			
<p>Underlying reimbursement for FQHC services does not change.</p> <p>FQHCs participating in CPC receive supplemental PMPM payments tiered based on patient acuity.</p> <p>FQHCs with at least 60,000 attributed member months per calendar year are eligible for shared savings conditional on meeting cost and quality targets. Practices can share in up to 65 percent of savings.</p>	<p>Supplemental PMPM payment: Patient attribution is prospective, based on patient choice, plurality of visits in past 24 months, and other factors (e.g., location).</p> <p>Shared Savings: Attribution is retrospective.</p>	<p>To receive supplemental PMPM payments and shared savings, practices must meet “Activity Requirements” and “pass” 50 percent of the 25 clinical quality and efficiency measures.^{21, 22}</p> <p>Additionally, to receive shared savings, FQHCs must meet total cost of care (TCoC) targets or improve their performance on TCoC targets from the baseline year. TCoC excludes some services (waiver services, oral health, vision, transportation; long-term care costs after 90 days).</p>	<p>“Activity Requirements” focus on service delivery changes, such as supporting 24/7 access to care, risk stratification, population health management, and use of team-based care models.²³</p>

Minnesota Integrated Health Partnerships (IHP): Shared Savings through a Primary Care Case Management SPA ^{24, 25}			
<p>Underlying reimbursement for FQHC services does not change.</p> <p>Through Minnesota’s accountable care organizations (ACOs) initiative, IHPs can choose upside risk only, and share in savings if TCoC and quality targets are achieved, or upside <i>and</i> downside risk.</p> <p>The FQHC Urban Health Network (FUHN), an IHP consisting of 10 FQHCs, takes on upside risk only.</p>	<p>Retrospective: At least one visit during the performance period; if multiple providers, patient is attributed based on the preponderance of claims for specific services, such as primary care or Behavioral Health Home.</p>	<p>IHPs report on 40 quality measures in the following areas:</p> <ul style="list-style-type: none"> • Prevention and screening; • Effectiveness of care for at-risk populations; • Behavioral health; • Access to care; • Patient-centered care; • Patient safety; and • Meaningful use. ²⁶ <p>TCoC includes primary care, some mental health, chemical dependency, vision, and inpatient and outpatient hospital services. ²⁷</p>	<p>Quality measures emphasize prevention, access to care, behavioral health, and patient-centered care.</p>
Massachusetts MassHealth Statewide ACO Program: Shared Savings/Shared Risk through 1115 Delivery System Reform Incentive Payment (DSRIP) Waiver ^{28, 29}			
<p>There are three different ACO organizational models.</p> <p>Community Care Cooperative (C3), made up of 15 FQHCs, is a Primary Care ACO that contracts directly with the state. Under this model, underlying reimbursement for FQHC services does not change.</p> <p>Primary Care ACOs are eligible for shared savings or shared losses based on their performance on TCoC and quality measures.</p>	<p>MassHealth members are assigned through one of two ways:</p> <ol style="list-style-type: none"> 1. If a MassHealth member selects a primary care provider (PCP), (s)he will be attributed to the PCP’s ACO; or 2. If a MassHealth member does not select a PCP, MassHealth will assign him/her, through a process known as special assignment, based on existing primary care relationships as of October 2017. ³⁰ 	<p>Primary Care ACOs must report on 38 quality measures in the following areas:</p> <ul style="list-style-type: none"> • Prevention and wellness; • Chronic disease management; • Behavioral health and substance abuse; • Long-term services and supports; • Integrated care; and • Avoidable utilization. <p>TCoC includes all services in the Massachusetts Medicaid managed care program, including physical and behavioral health. Long-term services and supports will be included starting in Year 2. TCoC excludes home and community based services.</p>	<p>ACOs commit to a number of practice transformation activities, including prevention and wellness initiatives, disease management and care coordination, and improved use of health information technology and health information exchange, among other provisions.</p>

Washington: PMPM through Medicaid Managed Care ^{31, 32}			
<p>PMPM payment rate, known in the state as APM4, is calculated based on a clinic’s APM3rate and encounters in a 12-month look-back period.</p> <p>PMPM includes all FQHC services that are carved into Apple Health. Services include medical and some behavioral health and maternity support services.</p> <p>Only managed care beneficiaries are included.</p>	<p>Prospective: Based on beneficiaries’ assigned or chosen primary care providers.</p>	<p>FQHCs report on seven measures³³ that align with those used in Apple Health, the states managed care program.</p> <p>After a baseline year, participating clinics that do not meet quality targets on the seven measures may have their PMPM rates decreased in future years. However, total FQHC reimbursement will never drop below what the clinic would have received under PPS, in adherence with federal regulations.</p>	<p>Quality measures emphasize prevention and chronic disease management.</p> <p>Practices are encouraged to focus on team-based care and population health management.</p>

Key Considerations

Adhere to specific federal requirements when implementing a VBP methodology under FQHC state plan authority.

Any VBP methodology developed under the FQHC state plan authority must continue to meet federal PPS requirements. Payments made through a Medicaid FQHC SPA must be tied to the delivery of FQHC services. While states can incentivize quality, a state may not pay FQHCs less than what they would have earned under PPS. Arrangements that put clinics at risk to receive less revenue than under PPS are inconsistent with Section 1902(bb) of the Social Security Act.³⁴

Washington, DC’s pay for performance methodology for FQHCs was approved by CMS in September 2017 through a FQHC SPA.³⁵ FQHCs that elect to participate in the APM are eligible to receive a supplemental performance-based payment if they perform at or above a target threshold, or if they improve their performance from the baseline year on nine required measures.³⁶

Identify opportunities for additional flexibility using other state Medicaid authorities.

As Table 1 illustrates, states are engaging FQHCs in VBP methodologies through a number of authorities, including SPAs for primary care case management (PCCM) and health homes, as well as 1115 Demonstration waivers:

- Minnesota** implemented its Integrated Health Partnerships (IHP), a Medicaid ACO initiative, through an approved PCCM SPA. The SPA describes how TCoC, quality targets, and shared savings are calculated, and outlines provider participation criteria. The IHP model was developed to give independent or smaller practices, as well as FQHCs, the opportunity to participate in VBP methodologies by offering the option to take on upside risk only.³⁷

- **Massachusetts** began its statewide ACO program in March 2018 as part of its five-year 1115 Medicaid Demonstration waiver.³⁸ The ACO program has three different organizational structures; one of which is a Primary Care ACO. Primary Care ACOs are eligible for shared savings or shared losses based on their performance on TCoC and quality measures. The state has contracted with 17 ACOs to participate in the initiative, including [Community Care Cooperative](#), a Primary Care ACO formed by 15 FQHCs. Massachusetts' ACO program is designed to improve care quality and patient experience, while reducing costs through better integration and coordination of physical health, behavioral health and long term care.³⁹

States may also combine multiple VBP methodologies. FQHCs in **Ohio**, for example, are eligible to participate in Ohio Medicaid's Comprehensive Primary Care (CPC) Program, authorized under an approved PCCM SPA.⁴⁰ Through CPC, FQHCs receive supplemental PMPM payments for meeting activity requirements and other clinical quality and efficiency measures. Large FQHCs are eligible to receive shared savings if they also achieve cost thresholds. PMPM payments and any shared savings payments are in addition to reimbursement for FQHC services.⁴¹

Leverage Medicaid managed care contracts to support VBP methodologies.

Washington implemented a PMPM VBP methodology in July of 2017 for Medicaid managed care beneficiaries, and included FQHCs in its [Paying for Value](#) strategy. The state retains the responsibility for managing attribution (based on beneficiary assignment to managed care plans), calculating FQHC performance on quality measures, and calculating PMPM rates for individual FQHCs.⁴² If states do not currently require managed care plans to pay FQHCs their full PPS rates, Medicaid agencies need to continue to make wrap-around payments⁴³ to ensure FQHCs are reimbursed at their full PPS rate per encounter.

Design a VBP methodology based on state-specific context, capacity, and alignment with other Medicaid initiatives. No single VBP methodology will be appropriate for every state's goals. Factors to consider when designing and implementing a VBP methodology include:

- **Small and/or rural FQHCs:** It may be challenging to reliably calculate payment rates or performance on cost and quality measures for small or rural clinics with small numbers of Medicaid patients. States may want to set minimum Medicaid patient requirements for practice participation, or develop tiered VBP options to accommodate smaller clinics.
- **State staff and infrastructure capacity:** Medicaid agencies need capacity to attribute patients to practices, calculate payments, and collect and analyze data to determine practice performance on quality and cost measures. States may need additional capacity to support provider transformation, including providing data to participating practices. Anticipating internal staff and infrastructure needs to perform these and other functions can help ensure a smoother development and implementation process.
- **State resources:** VBP methodologies, such as performance-based supplemental payments, can require states to make payments above PPS rates in order to create incentives for providers to focus on quality improvement and practice change. States will need to consider the impact of these upfront investments, calculating the return on investment in primary care, and any opportunities to leverage additional funds, such as through Medicaid Section 1115 [Delivery System Reform Incentive Payment \(DSRIP\) waivers](#).
- **Alignment with other initiatives:** FQHCs participate in delivery system transformation efforts, such as [patient-centered medical homes](#) (PCMHs), [health homes](#), and [ACOs](#). Policymakers will want to review how FQHC-specific reforms align with current initiatives in order to minimize additional burdens—both on state staff administering these initiatives and FQHCs participating in multiple efforts.

Consider how to manage and adjust for risk under VBP methodologies.

VBP methodologies can be designed to allow practices to share in savings (upside risk), to shoulder some part of costs if cost targets are exceeded (downside risk), or both. PPS statutory requirements do not permit FQHC payment methodologies that include downside risk under the FQHC state plan authority. At least one state—**Massachusetts**—is implementing payment methodologies with downside risk through an 1115 Demonstration waiver.

Policymakers should consider the readiness of FQHCs to take on and manage risk, given the challenges of undercapitalization, limited data capacity, and the impact of smaller patient panels especially in rural areas.⁴⁴ TCoC calculations in downside risk models frequently include services delivered outside of FQHCs (e.g., emergency department and hospital utilization). Some FQHC representatives who participated in the Academy expressed concern about the extent to which their clinics could influence the cost and quality of care delivered outside the clinic walls. States noted the importance of developing TCoC methodologies and quality measures that present clear opportunities to impact cost and quality of care leveraging the unique strengths of FQHCs.

States may also want to consider risk adjustment when structuring VBP methodologies to account for differences between participating providers that can influence cost and quality outcomes, such as patient acuity. FQHC representatives in the Academy expressed a particular interest in adjusting for social determinants of health due to their populations' complex socioeconomic needs. Risk adjustment that takes these kinds of factors into account is just emerging, but could present an alternative way to assess acuity among complex populations that FQHCs commonly serve.⁴⁵

Develop an accurate attribution methodology that aligns with the goals of the selected VBP methodology.

Attribution, the process of assigning patients to a participating FQHC for the purposes of tracking both payment and quality measurement can be complex.⁴⁶ States must decide whether to attribute patients to practices retrospectively, prospectively, or a hybrid of both:

- **Retrospective attribution** assigns patients to providers or practices by looking back at claims and utilization during a defined performance period, enabling state policymakers to identify improvements across the attributed population during a specific performance period.
- **Prospective attribution** uses historic claims data, patient choice, and other factors to assign patients prior to a performance period. Prospective attribution can be used to create a “day one” list of patients, with additional patients attributed on a rolling or monthly basis going forward based on a qualifying claim or event.

Developing criteria for patient attribution is methodology-dependent. VBP methodologies that include hospitals and larger health systems can incorporate factors such as hospital and emergency department use, health home enrollment, and plurality of primary care visits in the attribution process or algorithm. For FQHC-specific methodologies, attribution can be tied more closely to primary care and clinic-related utilization. If states include only managed care beneficiaries in their methodologies, they can consider using the chosen or assigned primary care provider on managed care plan rosters to attribute patients to FQHCs.

The attribution model can affect aspects of measurement and payment. Retrospective attribution can involve data lags due to claims run-out periods, affecting payment for savings tied to cost and outcomes. Prospective attribution models risk making payments to practices for patients no longer on a practice panel during the performance period. Reconciliation of patient rosters may be needed.⁴⁷

Measurement and Reporting

Tying payment to quality is an essential feature of VBP methodologies. Different types of quality measures can be tied to payment, including outcome, process, structural, and patient experience measures.⁴⁸ Measures may be state-driven or nationally-validated through organizations such as the [National Quality Forum](#) or the [Consumer Assessment of Healthcare Providers and Systems \(CAHPS\)](#). The following section on measuring performance discusses key considerations and promising strategies based on lessons learned from states during NASHP's Value-Based Payment Reform Academy.

Key considerations to measure performance include:

- Consider a diverse set of process, structural, and outcome measures to track both practice transformation and quality improvement;
- Align measures (both in selection and measure specifications) across state initiatives to enable policymakers and providers to focus on key priorities;
- Select measures that create accountability for practices to improve patients' overall health; and
- Track changes in how and what care is delivered.

Key Considerations

Consider a diverse set of process, structural, and outcome measures to track both practice transformation and quality improvement.

Process and structural measures can help states understand whether VBP methodologies improve clinic capacity (e.g., the presence of multi-disciplinary care teams) and increasing uptake of key practices (e.g., follow-up after hospital admissions). Outcome measures, which indicate changes in individual or population health, are multifactorial and can take time to improve. States may want to decrease the number of structural and process measures and increase the number of outcome measures over time, as system transformation and quality improvement capacity matures.

When selecting measures, it is important to consider that some FQHCs may need to transform their coding and billing practices and/or add new staff to ensure they accurately capture all the services they provide. Complete utilization data is necessary for Medicaid to accurately measure practice performance on selected cost and quality measures. Under the PPS, FQHCs receive reimbursement as long as they provide at least one eligible service that generates a billable encounter. Some Academy states expressed concern that FQHCs may not be capturing all services rendered during one encounter or that all services may not be included in the claim to Medicaid or managed care plans.

Examples of Different Types of Performance Measures

Process measures: Measures that assess whether an action took place.

- **NQF 0032:** Percent of female patients age 21-64 that received cervical cancer screening
- **NQF 0057:** Percent of diabetes patients age 18-75 that received a HbA1c test

Structural measures: Measures conditions or infrastructure of a practice.

- Patient-centered medical home certification
- Adoption of electronic health records

Outcome measures: Measures results of health care services provided to patients.

- **NQF 0059:** Percent of diabetes patients 18-75 that has HbA1c levels over 9% indicating poor control
- **NQF 0711:** Percent of patients 18 and older that show remission of depression within six months

Patient experience measures: Measures how patients perceive their care.

- **CAHPS question:** How quickly could you get an appointment?
- **CAHPS question:** How often has the provider's office talked to you about your prescriptions with you?

Source: National Quality Forum. "ABCs of Measurement." Accessed November 15, 2017. https://www.qualityforum.org/Measuring_Performance/ABCs_of_Measurement.aspx, as seen in Rachel Yalowich and Kitty Purington, *Utilizing Measures in Value-Based Purchasing to Incentivize Integrated Care* (Portland, ME: National Academy for State Health Policy, 2017).

Align measures (both in selection and measure specifications) across state initiatives to enable policymakers and providers to focus on key priorities.

States engaged in other Medicaid VBP and delivery system transformation work, such as [PCMHs](#), [health homes](#), and [ACOs](#) will have measurement strategies in place that can be leveraged. Aligning measures across programs can send a consistent message to providers on a state's quality improvement priorities and reduce provider burden. When selecting measures, states can draw from the Centers for Medicare & Medicaid Services (CMS) [Adult](#) and [Child](#) Core sets. FQHCs also report on 16 clinical quality measures to the Uniform Data System —Health Resources and Services Administration's (HRSA) [health center measure set](#) — another potential resource that state policymakers can consider using to maximize both state and clinic resources.

Moreover, the use of consistent measurement specifications (key definitions, numerators, denominators, etc.) across programs can also reduce the burden on providers and Medicaid staff to track, analyze, and report on FQHC performance on these measures. Many of HRSA's UDS measures have been revised to align with CMS measure specifications for 2017.⁴⁹

- **Washington, DC** has nine measures for its FQHC pay-for-performance methodology. Four of the nine measures align with its [Health Home program](#) for Medicaid beneficiaries with three or more chronic conditions.
- **Oregon** requires that FQHCs participating in its FQHC APM Pilot report on a set of seven measures that align with [Coordinated Care Organization \(CCO\) measures](#).⁵⁰ While these measures are not tied directly to FQHC payments under the pilot, the state reports that because of this alignment FQHCs have been able to focus their quality improvement efforts on measures that are important to CCOs. This has allowed some FQHCs to negotiate other VBP arrangements with CCOs.⁵¹
- **Washington** aligned quality measures used in its FQHC VBP methodology with those in its Apple Health managed care program.⁵²

Select measures that create accountability for practices to improve patients' overall health.

By changing how care is delivered, FQHCs have the capacity to impact cost and quality for services they provide directly (such as improving diabetes management), and for patient outcomes that involve the broader health system (such as reducing unnecessary emergency department utilization). States can help promote this accountability by selecting a diverse set of measures that includes primary care prevention and chronic care measures, as well as outcome measures that indicate improved care management and coordination, such as decreased emergency department utilization and inpatient readmissions. Early discussions with stakeholders about these issues is critical to developing a shared vision of accountability for health care outcomes.

- **Washington, DC** includes a diverse mix of access and process measures as well as outcome measures, such as preventable hospitalizations and reduced inpatient readmissions, in its FQHC pay-for-performance methodology.⁵³

2017 UDS Clinical Performance Measures

- Diabetes: Hemoglobin A1c poor control
- Controlling high blood pressure
- Low birth weight
- Early entry into prenatal care
- Childhood Immunization Status (CIS)
- Cervical cancer screening
- Weight assessment and counseling for nutrition and physical activity for children and adolescents
- Body mass index (BMI) screening and follow-up
- Tobacco use: Screening and cessation intervention
- Use of appropriate medications for asthma
- Coronary artery disease (CAD): lipid therapy
- Vascular disease (IVD): Use of aspirin or another antiplatelet
- Colorectal cancer screening
- Screening for depression and follow-up plan
- HIV linkage to care
- Dental sealants for children, ages 6-9

Source: Health Resources & Services Administration, "Uniform Data System (UDS) Resources," accessed September 29, 2017, <https://bphc.hrsa.gov/datareporting/reporting/index.html>.

- One of **Minnesota's** Integrated Health Partnerships (IHPs), the FQHC Urban Health Network (FUHN), is an ACO consisting of 10 FQHCs. Like other IHPs, they are accountable for reducing total cost of care and improving quality. Illustrating the impact that FQHCs can have across the system of care, FUHN was able to decrease emergency department visits among its attributed patients by 27 percent between 2012 and 2015.⁵⁴

Track changes in how and what care is delivered.

As noted earlier, FQHCs may not be in the practice of documenting all services provided in each patient encounter in their own payment systems or in Medicaid claims. To monitor underutilization and assess changes in how care is delivered, some states track utilization of non-billable patient contacts, such as patient outreach (phone calls, text messages, use of electronic health record online patient portal), care coordination, and group visits or patient education. **Oregon** measures these interactions with patients, which it calls [Care STEPs](#). While certain encounters are recorded automatically, Oregon providers manually document the majority of the Care STEPs in their FQHCs' electronic health record systems.⁵⁵ FQHCs submit Care STEPs reports to the state quarterly.⁵⁶ **Colorado** is planning to incorporate similar measures in the VBP methodology it is developing.

Oregon Care STEPs

New visit types

- Home visit billable encounter*
- E-visit*
- Telemedicine encounter*
- Telephone visit*
- Home visit non-billable encounter

Coordination and integration

- Information management
- Coordinating care: Dental
- Clinical follow-up and transitions
- Warm hand-off
- Transportation assistance

Education, wellness, and community support

- Health education supportive counseling
- Education provided in a group setting
- Support group participant
- Exercise class participant

Outreach and engagement

- Flowsheet-screening tools*
- Panel management outreach
- Case management
- Accessing community resource

*Denotes an encounter that is automatically recorded as a Care STEP in the patient's electronic health record.

FQHC Readiness and Practice Transformation

For FQHCs, transitioning to a VBP methodology often requires additional infrastructure and investment, such as enhanced IT and quality improvement capacity, as well as clinical and workflow changes, including team-based care, population-based management, and care coordination. FQHCs may also need to change how clinicians and other staff work together and with community partners to improve quality and efficiency.

While challenging, the transition to a VBP methodology offers benefits to practices, including the opportunity to support team-based care models that can improve health care quality and enhance workforce retention, and the potential for increased revenue. Depending on staffing, IT capacity, and available financial resources, FQHCs will vary in how quickly they can transform their practices. Not all FQHCs in a state need to be ready to launch at the same time. States may find it beneficial to pilot a VBP methodology with a few FQHCs and refine the methodology as necessary. The following section on FQHC readiness and practice transformation discusses key considerations and promising strategies based on lessons learned from states during NASHP's Value-Based Payment Reform Academy.

Key considerations for FQHC readiness and practice transformation include:

- Engage the primary care association (PCA) to provide clinician and staff education, training, and resources;
- Assess FQHC interest and readiness in the early stages of VBP methodology development; and

- Consider FQHCs' short- and long-term financial, information technology (IT), and staff capacities when preparing for implementation.

Key Considerations

A Engage the PCA to provide clinician and staff education, training, and resources.

PCAs are state or regional entities that provide training and technical assistance to safety net providers. PCAs are an important partner for states and serve as a conduit for outreach and education about value-based purchasing to FQHCs. PCAs can also assist states in assessing FQHC capacity to take on various VBP methodologies. For example, value-based purchasing has been a board-level priority for PCAs in both **Colorado** and **Michigan**, and the PCAs have provided technical assistance to FQHCs on the topic. The PCA in **Hawaii** has also educated its members to increase understanding of VBP methodology development and implementation.

FQHC Readiness Considerations

- Does the FQHC have a vision for care delivery that cannot be achieved under the current payment structure?
- How will a VBP methodology free up a FQHC to provide more robust, patient-centered, and team-based care?
- Is the leadership team stable?
- Has the FQHC considered its capacity to train staff on a new model of care delivery and workflows?
- How much experience does the FQHC have with quality improvement and performance measurement?

Source: Laura Sisulak. "Clinic Readiness, Preparation, and Support." PowerPoint, National Academy for State Health Policy's Value Based Payment Reform Academy Closing Meeting, July 26, 2017. https://nashp.org/wp-content/uploads/2017/11/OPCA_FQHC-Resources-and-Supports_-2017.pdf.

The PCA can provide support to FQHCs as they transition to a VBP methodology. The **Oregon** PCA developed the [Advanced Care Model learning collaborative](#) in partnership with FQHCs and the Medicaid agency to help practices transition to the state's VBP methodology. As part of this learning collaborative, FQHCs have access to practice transformation and implementation support through on-site technical assistance, webinars, networking, and strategic planning.

Assess FQHC interest and readiness in the early stages of VBP methodology development.

Readiness assessments can help states identify which FQHCs have the capacity to implement a VBP methodology and pinpoint where the state and PCA should provide technical assistance to help increase FQHC capacity. Several FQHC-specific readiness tools are available, including the [NACHC Payment Reform Readiness Assessment Tool](#), the [Health Management Associates Value-Based Payment Assessment Tool](#) (developed in partnership with the Washington, DC, one of the state teams participating in NASHP's Academy), and the [University of Iowa Value-Based Care Assessment Tool](#), which was developed specifically for rural health providers.

Consider FQHCs' short- and long-term financial, IT, and staff capacities when preparing for implementation.

In addition to having a clear vision for practice transformation, FQHCs should also assess their financial readiness, IT capacity, and staffing needs. Both states and FQHCs may benefit from a participation agreement that clearly identifies the state's and the FQHC's expectations.⁵⁷

Financial readiness:

Prior to adopting a VBP methodology, FQHCs may consider:

- Days cash on hand
- Available financial resources to support necessary practice transformation efforts
- Payer mix, including:
 - Number of Medicaid lives. It may be challenging to participate in payment reform if the FQHC serves fewer than 1,000 active Medicaid patients
 - Amount of visit-based revenue the practice will continue to generate

- Average Medicaid visits per patient, per year
 - Stability of historical utilization
 - Stability/predictability of patient population
 - Low visit rate per patient, per year
- Reimbursement from other payers tied to quality

For states implementing a VBP methodology under a FQHC state plan amendment, it is important to note that FQHC participation is voluntary.⁵⁸ FQHCs may revert back to PPS if participation causes them financial distress. States will want to have a process for FQHCs to exit the methodology without incurring financial hardships or impacting patient care.

Data and health IT capacity: States and FQHCs require accurate, timely data to calculate practice performance on quality and/or cost targets. States typically use claims or encounter data to calculate measures tied to payment, but may require additional reporting from FQHCs on outcome-based quality measures or other types of clinic-based measures. As FQHCs take on more complex VBP methodologies, they will need increasingly robust health IT and analytics capacity to support quality improvement initiatives, perform population health management activities, maintain attribution lists, facilitate coordinated care, and report data as required by state participation agreements. Health Center Controlled Networks (HCCNs) — groups of health centers working together to address health information technology challenges — are active in 38 states⁵⁹ and are used by about 70 percent of health centers.⁶⁰ Partnership with a HCCN may help to leverage limited FQHC resources and provide technical assistance, particularly related to data analysis to support quality measurement and improvement.⁶¹

Staffing needs: Participation in a VBP methodology requires FQHC leadership to have a clear strategic vision and strong commitment to changing care delivery through new clinical and workflow processes. It may also require additional training or investment in new types of staff, such as care coordinators or community health workers. FQHCs interested in participating in a VBP methodology may need to assess:

- Their board's commitment;
- Stability of leadership team;
- Capacity for and history of change management;
- Any competing priorities (new electronic health record systems, new practice sites and services, etc.); and
- Capacity of operations, clinical, and quality improvement staff, as well as staff training opportunities. Participation may require:
 - Implementing a new payment system, understanding new billing and reporting processes, managing attributed patient lists;
 - Adapting to new clinical care processes, working with internal or external care managers, incorporating data into clinical work flows, identifying and formalizing partnerships with community providers;
 - Developing and integrating internal and external reporting on key indicators (e.g., measurement, cost, access);
 - Implementing new quality improvement processes or rapid cycle improvement strategies; and
 - Working with state and community partners to influence upstream utilization.

Conclusion

Both states and FQHCs have many things to gain by engaging in the development of VBP methodologies. VBP methodologies reward providers for improving both health care quality and efficiency. They can incentivize FQHCs to dedicate resources toward developing patient-centered approaches to care delivery that can address social determinants and, ultimately, improve health outcomes.

For states, value-based purchasing is an important policy lever to contain the growth of health care costs and improve quality of care. Including FQHCs in delivery system and payment reforms can help state policymakers improve care and reduce costs for some of their states' most vulnerable populations who live in underserved areas and align state priorities for quality improvement across Medicaid providers. States are demonstrating that by engaging new stakeholders and understanding the special considerations around FQHC payment, these critical providers can be included in key state innovations.

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