Federally Qualified Health Center / Rural Health Clinic Prospective Payment System Plus Reimbursement Methodology

Review and Research Report

Submitted by:

JSI Research & Training Institute, Inc.

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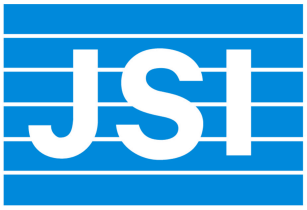

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EXECUTIVE SUMMARY

Over the past several years, the Department of Health Care Policy and Financing (the Department) has laid the foundation for increasing its ability to link health care expenditures with health outcomes and value. The Department is interested in using the opportunity presented by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requirements related to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) reimbursement to further this strategic goal. CHIPRA requires state Children's Health Insurance Programs to adopt a prospective payment system for FQHCs/RHCs. The Department received a grant from the Centers for Medicare and Medicaid Services (CMS) to assist with implementing the PPS requirement in Colorado's CHIP program (called CHP+) and has engaged JSI Research and Training Institute, Inc. (JSI) to assist with the process.

The Department intends to develop a rate methodology for FQHCs and RHCs tentatively referred to as PPS Plus, which will go beyond the current prospective payment system used in Medicaid to provide quality/outcome incentives in the state CHP+ and Medicaid programs. The four incentive domains identified by the Department are health outcomes, patient access to and satisfaction with care, and cost containment.

In order to inform the state's approach to CHIPRA PPS implementation, JSI conducted research on CHIPRA PPS implementation, value-based purchasing, and Colorado's current programs and systems. The research included a review of pertinent reports and articles; research into Colorado's payment methodologies, quality initiatives, and value-based strategies; input from key stakeholders including FQHCs, RHCS, their state associations and Medicaid/CHP+ managed care organizations (MCOs); and key informant interviews with national experts and state Medicaid/CHIP programs to identify pertinent national trends and understand the experience of other states with PPS implementation in CHIP and value-based purchasing strategies and methodologies.

PPS Requirements and Implementation

Federal requirements state that FQHCs and RHCs must be reimbursed at a set minimum rate for services they provide to Medicaid clients. The Budget Improvement and Protection Act (BIPA) of 2001 established a per-visit payment floor for FQHCs/RHCS based on the average of their 1999 and 2000 costs. This base minimum, inflated by the Medicare Economic Index has not kept up with health care costs experienced by FQHCs/RHCs. BIPA also permits states to establish an Alternative Payment Methodology (APM) for FQHC and RHC services, as long as it is agreed to by FQHC/RHC providers and is not less than what the FQHCs/RHCs would receive under BIPA PPS. Colorado has established an alternative payment methodology (APM) for paying FQHCs and RHC which is based on FQHC/RHC reasonable costs. CHIPRA requires states to apply PPS methodology in Medicaid to their CHIPs effective October 1, 2009.

Various challenges exist within the current PPS system and methodologies that should be considered in the development of the PPS Plus methodology. Challenges experienced in other states include difficulty converting service-level data to FQHC/RHC encounters upon which PPS payment is made, and identification of a methodology for providing a "wraparound" payment to

FQHCs/RHCs for the difference between the fee-for-service or capitation payments they receive from CHIP MCOs, and their encounter rates. None of the states included in our research, with the exception of Oregon, chose to include a value-based purchasing component as part of their PPS implementation. Oregon includes costs related to medical home in the APM calculation for individual health centers, and is currently developing more comprehensive payment reform for FQHCs, including potential use of a capitated payment as part of the APM methodology. Other states interviewed did have value-based purchasing initiatives but they were implemented independent of PPS payment methods.

Conversations with local stakeholders and Department staff identified additional challenges related to Colorado's desire to move to a PPS Plus methodology. These include technical issues related to the capture of service level data to support quality measurement within MMIS, and the fact that Colorado's Medicaid PPS reimbursement methodology varies across provider types. The difference between the BIPA PPS minimum and the APM varies greatly by individual providers, both within and across provider types. Thus, the implementation of a PPS Plus methodology is likely to impact both provider types and individual providers very differently. Additionally, the fact that a very small portion of FQHC/RHC patients are enrolled in CHP+ may result in limited FQHC/RHC interest in payment incentives limited to CHP+ patients.

Value-Based Purchasing

There is a growing recognition at the national and state levels that fundamental changes are required in existing payment systems to deliver high quality care at reasonable costs. The major payment alternatives to the fee-for-service (FFS) system are episode based or bundled payments, and global payments. New types of episode based payment systems are being developed to combine payments across multiple providers, from physician practices to hospitals.

Because of the growing emphasis on health system improvements, states are using financial incentives to encourage the development and spread of medical homes and Accountable Care Organizations (ACOs). State Medicaid programs are increasingly using blended approaches that combine payment incentives for medical homes with pay-for-performance. The advantage of using this blended approach is that the state is promoting greater care coordination and quality improvement across practices, while concurrently providing targeted incentives to achieve higher rates of preventive services or desired clinical outcomes. Some experts believe that states will increasingly use shared savings approaches or targeted incentives for cost reductions along with incentives for medical home and pay for performance.[1]

The most important challenges to payment system reform include:

- ***Agreement on the objectives of payment reform*** and the establishment of specific targets to meet those objectives.
- ***Inadequate quality metrics or health information technology systems to routinely track and report health outcomes***. The use of value-based incentives has been limited by the availability of scientifically validated measures of health outcomes across a wide spectrum of health conditions. In addition, many primary care clinics do not routinely collect process or outcomes data, and others lack an ability to report these data.

- ***Provider acceptability and variability***. Payment reforms are difficult to implement without the support of primary care clinics and their physician leadership. Furthermore, primary care clinics are differentially positioned to make changes in their care systems and in their billing and HIT (health information technology) infrastructure.
- ***Financing of payments***. Efforts to encourage medical home and ACO development require a significant up front investment by clinics and states, leading to greater emphasis on payment for efficiency-related performance targets that produce short term savings.
- ***Evaluation infrastructure.*** Both states and individual clinics need an evaluation system in place to determine whether the incentive payment systems are having their desired effects. This can be addressed by developing a statewide, centralized data reporting and evaluation system.

State and national experts that were interviewed all sought to devise new payment methodologies for health care that will enhance the quality and efficiency of state and local health systems. There is a growing recognition that delivery system reform and payment reform are inextricably linked. Among states involved in payment reform, there is a growing interest in coordinating payment reform, delivery system reform, and in leveraging federal resources to support these efforts.

Colorado's Current Value-based Efforts

The Department has embraced a vision and strategic direction that include support for the medical home model and payment reform focusing on the value of care provided. Its efforts are very much aligned with the efforts of the Federal government and other states. The Department currently uses numerous indicators to assess processes that are documented to have an impact on health outcomes and a smaller number that measure health outcomes themselves. In addition, the Department currently tracks indicators related to cost containment, patient access and satisfaction at the program and health plan level.

In order to maximize the impact of the PPS Plus methodology, the Department should ensure alignment of PPS Plus with the State's Medical Home Initiative and Accountable Care Collaborative (ACC) efforts. These initiatives already include value-based payments to support medical home (a payment per ambulatory care visit for Children under the Medical Home Initiative, and a per member per month payment, and future plans for a shared savings approach under the ACC), which could be further strengthened through PPS Plus.

Several challenges need to be addressed in order to ensure the use of the measures to support PPS Plus value-based payments, including:

- Ensuring that the data to support selected measures is readily collected and analyzed at the FQHC/RHC provider level. If Medicaid claims data is used, challenges related to submission of detailed FQHC/RHC visit data through MMIS must be resolved.
- Defining a limited set of measures so that providers can focus their efforts.
- Ensuring measures are aligned with those required from other payers such as Meaningful Use standards, and, for FQHCs, their grant-required measures.
- Ensuring that the measure design takes into account the assignment of enrollees and the FQHC/RHC's ability to impact the measure within the eligibility span of the enrollee.

- Accounting for the variability among FQHC/RHC practices in the ability to engage in value-based purchasing through the development of a range or tiers of measures (and incentives).

Next Steps

As the Department moves forward with developing the PPS Plus methodology, it is critical that the there is agreement within the Department and among stakeholders regarding the overriding objectives of PPS Plus. This is especially critical given that the original PPS methodology was developed to ensure a relationship between Medicaid reimbursements and the actual cost of care, whereas PPS Plus creates a shift to a value-based framework. The PPS Plus methodology will also need to take into account the variation in provider readiness and ability to engage in value-based purchasing.

The next steps for the project include identification of specific options for the PPS Plus methodology, in addition to an analysis of gaps between current systems/processes and those that would be required for various methodology options. The information presented in this report will be critical to identifying options that can be supported by Colorado's systems and structures, meet Federal requirements, and be acceptable to both the Department and FQHCs/RHCs.

INTRODUCTION

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires state Children's Health Insurance Programs (CHIPs) to adopt a prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) participating in CHIP. CHIPRA requires that, effective October 1, 2009, states pay FQHCs and RHCs the BIPA (Benefits Improvement and Protection Act of 2000) PPS minimum or a rate developed under an alternative payment methodology (APM). The Colorado Department of Health Care Policy and Financing (the Department) is interested in using this opportunity to develop a rate methodology for FQHCs and RHCs beyond the PPS minimum which will provide incentives in the state CHIP and Medicaid programs. The four quality incentive domains identified by the Department are enrollee health outcomes, patient access to and satisfaction with care, and cost containment. This alternative payment methodology is tentatively referred to as "PPS Plus."

The Department received a grant from the Centers for Medicare and Medicaid Services (CMS) to assist with implementing the PPS requirement in Colorado's CHIP program (called CHP+) as described above, and has engaged JSI Research and Training Institute, Inc. (JSI) to assist with the process.

National Context
There is a growing consensus at the national level shared by the State of Colorado that the health care system redesign should be organized around the Institute for Healthcare Improvement (IHI) Triple Aims, which include:

- Improving the health of a defined population;
- Enhancing the patient care experience (including quality, access, and reliability); and
- Reducing or least controlling the costs of care.

To achieve the Triple Aims, payment systems must be revised to reward the delivery of high quality and efficient care. This represents a significant departure from existing fee-for-service payment systems, which pay based on volume of services regardless of their quality or efficiency. Development of a PPS Plus methodology provides an opportunity to better align the payment methodology for Medicaid and CHP+ providers with the Department's strategic direction.

State Context
Over the past several years, Colorado has laid the foundation for increasing its ability to link health care expenditures with health outcomes and value. These efforts grew out of the recommendations made by the Blue Ribbon Commission for Health Care Reform in January of 2008, charged with identifying strategies to expand health care coverage and reducing health care costs for Coloradans.[2] Governor Ritter's administration secured the passage of a series of legislative initiatives conceptualized as the "building blocks" of health care reform, including expansion of children's health care coverage, increased reimbursement for providers, increased transparency and accountability, and identification of strategies to expand access to cost effective health care. Colorado has adopted the Institute for Healthcare Improvement's Triple Aims to guide its payment and delivery system reforms.

These reforms, coupled with planning for the implementation of provisions from the Affordable Care Act, have laid the foundation for other value-based initiatives within Colorado. The reforms include the Medical Home Initiative, the establishment of the Center for Improving Value in Health Care, the All-Payer Claims Database currently in implementation, and the Accountable Care Collaborative.

Departmental Vision[3]
The Department's current vision is "to improve access to cost-effective, quality health care services for Coloradans." Key management goals support a movement toward value-based purchasing. These goals include:

- Reduce inappropriate and avoidable utilization of services;
- Tie metrics to expected outcomes for every contact; and
- Tie payment policies and mechanisms to expected outcomes.

Implementation of a PPS *Plus* methodology is consistent with these management goals and with three of the five objectives in the Department's five-year strategic plan:

- Improving health outcomes,
- Increasing access to health care, and
- Containing health care costs.

The Department's strategic plan calls for provider payments to be increasingly linked to outcomes. The target percentage of provider payments linked to outcomes in FY2010-11 is .75 percent, while the target by FY2014-15 is 5 percent. The goal for improving access to health care is to increase the percent of Medicaid clients who have a medical homes or a "focal point of care" from 50 percent to 100 percent. In terms of containing health care costs, the goals include implementing payment reform for FQHCs and scaling the Accountable Care Collaborative to the entire state by FY2012-2013.

Moving Toward PPS Plus
Incentive programs work best when providers are measured and incentivized consistently across programs. Given the objectives of the PPS Plus methodology, it is important to understand other related Departmental initiatives, including the Colorado Medical Home Initiative, the Accountable Care Collaborative, the degree to which the PPS *Plus* methodology might build synergy with these initiatives, and opportunities to use the same measures and indicators.

In order for PPS Plus to be successful it must 1) meet Federal requirements for FQHC/RHC payment methodologies, 2) identify a value-based payment or incentive that methodologically sound and based on valid and actionable measures, and 3) be agreed to by the FQHC/RHC providers.

In order to inform the state's approach to CHIPRA PPS implementation, JSI conducted research on CHIPRA PPS implementation in CHIP, value-based purchasing, and Colorado's current programs and systems. The research included:

- Identification and review of relevant published reports and articles at the national level;

- Research into Colorado's payment methodologies, quality initiatives, and value-based strategies, including document review and interviews with key Department staff;
- Key informant interviews with national experts to identify pertinent national trends, and to assist in identifying states with which to conduct in-depth interviews; and
- Key informant interviews with state Medicaid/CHIP programs to understand their experience with PPS implementation in CHIP and value-based purchasing strategies and methodologies.

A more detailed description of the research methodology and list of key informant interviews can be found Appendices D, E, and F.

This report summarizes JSI's research into other states' experience with implementing PPS CHIPRA requirements in their CHIP program, and additionally details their experience with the development and implementation of value-based purchasing strategies. Input received from identified stakeholders in Colorado, including Federally Qualified Health Centers, Rural Health Clinics and their state associations, and CHP+ and Medicaid managed care organizations in Colorado as part of the process is included in relevant sections of this report, and summarized in a separate document included in Appendix I.

The report is organized into four sections:

- **PPS Requirements and Implementation**: This section outlines federal requirements, discusses research findings on approaches used by various states, and outlines Colorado's current and past approaches.
- **Value-Based Purchasing**: This section describes emerging national trends, discusses research findings on efforts in specific states, and reviews implications for development of Colorado's PPS Plus methodology.
- **Colorado's Current Value-based Efforts**: This section summarizes Colorado's current efforts and their potential relationship to the PPS Plus methodology.
- **Conclusion:** This section summarizes the implications and next steps for PPS Plus development.

The information in this report provides a foundation for next steps in the project; next steps include the development of PPS Plus payment methodology options and a gap analysis of current systems and processes compared to those required for PPS Plus implementation. It will also inform the development of an implementation pilot for the methodology ultimately selected by the Department.

PROSPECTIVE PAYMENT SYSTEM REQUIREMENTS AND IMPLEMENTATION

Federal Background And Requirements

BIPA Requirements

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 created a Medicaid Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The PPS system for Medicaid became effective on January 1, 2001, and replaced traditional cost-based reimbursement.

Prior to enactment of the Balanced Budget Act (BBA) in 1997, state Medicaid programs were required to reimburse FQHCs/RHCs 100 percent of their reasonable costs. Medicare regulations governed the types of costs that were allowable, and each state developed their own reasonable costs definitions based on those regulations. Cost-based reimbursement for FQHCs/RHCs was meant to ensure that Federal Section 330 grant dollars, which were intended to offset the costs of uninsured patients, were not used to subsidize Medicaid reimbursements. Under the BBA and subsequent amendments enacted in 1999, states were not required to pay FQHCs/RHCs a minimum Medicaid reimbursement. PPS was enacted in order to avoid the subsidization of Medicaid losses from other sources, including the Section 330 Public Health Service (PHS) Act grants that FQHCs receive to provide care to uninsured patients. The PPS re-establishes a minimum payment rate.[4]

The PPS established a floor reimbursement rate based on fiscal year 1999 and 2000 reasonable costs, adjusted annually by the Medicare Economic Index (MEI) for primary care. It also has a provision to adjust rates based on changes in scope of services and to determine rates for FQHC/RHCs established after 1999. The PPS system, unlike cost-based reimbursement, establishes the FQHC/RHC payment rate for a service prior to the service actually being delivered and, beyond the initial rate, is not based on the provider's actual costs. PPS also differs from fee-for-service based payments in that the payment is not based on the amounts charged for services, but is an encounter based (all-inclusive) rate.

BIPA PPS Minimum

Federal requirements state that FQHCs and RHCs must be reimbursed at a set minimum rate for services they provide to Medicaid clients. In order to establish a Medicaid PPS minimum, reasonable cost per visit rates for FY1999 and FY2000 were used as the baseline. The average of each FQHC's FY1999 and FY2000 reasonable cost per visit rates were used to establish a unique encounter rate for each FQHC/RHC. The BIPA PPS methodology established a per-visit payment floor. However, the PPS may be less favorable to FQHCs and RHCs in the Medicaid program than cost-based reimbursement. This base minimum, inflated by the MEI (typically under 2 percent and less than the actual increase in medical cost), has not kept up with health care costs experienced by FQHCs/RHCs. In many instances, the BIPA PPS is lower than FQHCs'/RHCs' reasonable costs on a per visit/encounter basis.

Alternative Payment Methodology

BIPA establishes a payment floor, which hereafter referred to as the BIPA PPS. However, an Alternative Payment Methodology (APM) is also permitted for FQHC and RHC services**.** For example, states may opt to continue the reasonable cost reimbursement system if it does not pay less than what the FQHCs/RHCs would receive under BIPA PPS. Whichever methodology the state chooses, individual FQHC/RHC rates cannot be below their calculated BIPA PPS rate for that fiscal year.

The caveat in implementing a PPS is that all affected FQHCs and RHCs have to agree to the APM for the APM to be used statewide. If all of the FQHCs/RHCs do not agree to the APM, the APM can then only be applied to the FQHCs/RHCs that have agreed to the methodology, and the BIPA PPS must be applied to those that do not agree to the APM. Also, the APM rate cannot exceed any applicable upper payment limit provisions.[5]

Under an APM the state must develop a process to provide proof that the payment rate is not below the BIPA PPS for that fiscal year. The state plan needs to provide this assurance, but does not need describe the actual rate calculation used by the state. In most cases, the process is described in state regulations.

CHIPRA Requirements

The Children's Health Insurance Program Reauthorization Act (CHIPRA) was enacted in February of 2000. In addition to reauthorizing and expanding the current State Children's Health Insurance Program, it requires a PPS rate to be established by the state CHIP programs for FQHCs and RHCs.

Section 503 of CHIPRA is relevant to Colorado, as it deals with "separate" CHIP plans (i.e., non-Medicaid expansions). Section 503 requires that states reimburse FQHCs using a PPS or APM based on one of three methods summarized in the table below.

Table 1. State Options for Implementing PPS in CHIP

Option	Advantages	Disadvantages	Considerations
Adopt Medicaid BIPA PPS rate	Minimizes implementation burdens where state is already using Medicaid PPS	Any problems/ challenges with Medicaid PPS rates extended to CHIP	Services provided under Medicaid and CHIP programs must be reasonably similar
Construct separate CHIP PPS Rates	Allows methodology to reflect any programmatic differences between CHIP and Medicaid	Requires development and maintenance of separate rates and potentially separate implementation systems	Initial rates based on average cost per visit of CHIP services in 1999 and 2000. Inflated annually by MEI
Use an Alternative Payment Methodology	Can minimize implementation burdens where state is already using an APM and chooses the same APM for CHIP	May require development and maintenance of separate rates, implementation systems	May be the same or different from the existing Medicaid APM. FQHCs/ RHCs must agree to the APM, which cannot be lower than the BIPA PPS. The APM must be described in the approved CHIP state plan.

Supplemental Payments
States that operate CHIP or Medicaid programs in which FQHCs and RHCs are contracted providers of managed care organizations (MCOs) are required to ensure that payments made to FQHCs/RHCs are not less than PPS or APM rates. If so, the states are required to make supplemental payments to the FQHCs/RHCs as needed. If the total amount paid by the MCO to the FQHC/RHC for CHIP patients is less than what they would have been paid under the established PPS, the state must make the supplemental payments directly to the FQHCs/RHCs in the amount of the difference, or develop an APM that allows for the payment to be made through the MCO.

The state is required to make a determination of the estimated difference and a supplemental payment at least every four months. The CHIP state plan should be amended to include a description of the supplemental payment methodology. States must perform a final reconciliation at least every 12 months to ensure that FQHCs/RHCs that contract with Medicaid MCOs get their required supplemental amounts as calculated under the BIPA methodology.

Because FQHCs/RHCS receive supplemental payments, there is sometimes concern that MCOs will lower the rates they pay to FQHCs/RHCs. In order to address this concern, states can amend their MCO contracts to include provisions requiring that FQHC and RHC subcontractors are paid a rate similar to non-FQHC and RHC subcontractors or are actuarially based.[6]

Retroactive Payments
Colorado is among a number of states that delayed the CHIP PPS implementation beyond the October 1, 2009 deadline. These states are required to make PPS-based payments to FQHCs/RHCs retroactive to October 1, 2009.

New Health Centers
Under CHIPRA, newly designated FQHCs and RHCs, as well as existing FQHCs and RHCs that are new to CHIP, must have initial per-visit payment rates established. This is done either by reference to payments made to other FQHCs and RHCs in the same or adjacent areas with similar caseloads, or (in the absence of such other clinics) through cost reporting methods. After the initial year, payment for states using the BIPA PPS must be set using the same Medicare Economic Index method used for established FQHCs and RHCs.[7]

Adjustments
States must establish a method by which payment rates can be revised to reflect change of scope. This method must be described in the state Medicaid plan. The adjustment does not happen automatically; the state can either require the FQHC/RHC to inform the state of a change in scope for the fiscal year, or the state itself can take on the responsibility for identifying changes in scope. Changes in scope include: "change in the type, intensity, duration, and/or amount of services. In making such an adjustment, state agencies must add on the cost of new FQHC/RHC services even if these services do not require a face-to-face visit with a FQHC/RHC provider, e.g., laboratory, x-rays, drugs, outreach, case management, transportation, etc."[8]

Colorado Approach To PPS Under Medicaid

Colorado, in response to the BIPA and advocacy on behalf of the FQHCs in the state, established an alternative payment methodology (APM) for paying FQHCs and RHCs. Colorado's APM is linked to providers' reasonable costs. On an annual basis, the Department calculates both the providers' APM rate and the BIPA PPS rate, and pays the provider the higher of the two rates. The APM methodology varies across provider types, as discussed below.

Federally Qualified Health Centers

Until September 1, 2009, Colorado's APM required FQHCs to be paid the higher of the BIPA minimum (the average of 1999-2000 costs per encounter inflated by the MEI annually) and the APM. As of September1, 2009 FQHC rates are set at the midpoint between the BIPA PPS and APM rates as part of state budget cutting measures.

The establishment of the APM rate involves several steps. The APM is calculated from Medicaid cost reports submitted by each FQHC and audited by a contractor of the Department.

- Each FQHC's APM is determined by comparing:
  - The current year encounter rate as reported in the cost report (inflated by the MEI)
  - The clinic's base encounter rate, (inflated annually by the MEI). A base encounter rate is established (rebased) every three years and is the inflated weighted average of the encounter rates for the previous three years.
- The **lesser** of these two rates is the FQHCs APM rate.
- The APM is compared with the FQHC's BIPA PPS minimum rate (inflated annually by the MEI).
- The **midpoin**t between the APM and the BIPA PPS rates is the effective payment rate for the following year.

For the majority of (but not all) FQHCs, the result is an encounter rate higher than the BIPA PPS minimum rate, but lower than their current year cost per encounter. The process is the same for Colorado's only hospital-based FQHC, Denver Health and Hospital Authority (DHHA), except that DHHA files a Medicare/Medicaid Hospital Cost Report (which includes the FQHC as a cost center with overhead allocation), rather than a Medicaid cost report. Furthermore, the effective date of the rates is different.

The difference between the APM and the BIPA PPS rate varies greatly across FQHCs. Based on an analysis of the most recent available cost reports for all non-hospital FQHCs, the difference between the APM and BIPA PPS rates was on average $26.35,[1] ranging from $2.13 per encounter to $76.8 per encounter. The difference between the FQHC's current year calculated rate (inflated) and current year inflated base rate was $11.07 on average, ranging from $6.17 to $60.12. For all but three FQHCs the current year inflated rate was higher than the inflated base rate.

[1] This is the average of the difference identified for each FQHC. It is not a weighted average and does not take into account the number of encounters at each FQHC.

Rural Health Clinics (RHCs)
Colorado also pays RHCs the higher of the BIPA PPS rate (inflated annually by the MEI), or an APM. However, the RHC APM methodology is different than that used for FQHCs and is different for different RHC types.

Hospital-Based Rural Health Clinics with less than 50 beds. The Department establishes an encounter rate for hospital-based RHCs with less than 50 beds based on reasonable costs, as documented in the RHC's most recent Medicare cost report. Their effective encounter rate is the higher of the BIPA PPS rate and the encounter rate documented on the Medicare cost report for the year, inflated by the MEI.

Freestanding RHCs and Hospital-Based RHCs with 50 or more beds. Under Colorado Medicaid, all free-standing RHCs and hospital-based RHCs with fifty (50) or more beds are paid the higher of the BIPA PPS minimum or the Medicare Upper Payment Limit. Medicare establishes a Medicare upper payment limit that applies to all RHCs (it is not clinic-specific).

Generally speaking, RHCs rates are not very high in comparison to the FQHC rates, despite the inflation index. This is in part because the MEI has been below actual inflation rates and steadily decreasing over the past few years. Furthermore, hospital-based RHCs with less than 50 beds almost always have higher reimbursement rates than free-standing RHCs, since encounter rates for the former are based on actual costs, including an allocation of hospital overhead costs as well as direct clinic costs.

JSI was provided with rate determination data on thirty-two RHCs (of the fifty four reported by the Colorado Rural Health Center as being certified in Colorado). Based on an analysis of the eleven hospital-based and twenty one free-standing RHCs:

- The difference between the APM and BIPA PPS rates for hospital-based RHCs was on average $7.08, ranging from $3.66 to $72.00. It is important to note that, for five of the thirteen RHCs, the BIPA PPS rate was a higher than the alternative payment rate.
- The difference between the APM and BIPA PPS rates for freestanding RHCs was on average $-4.90 (negative, because for eleven free-standing RHCs, the BIPA PPS rate is higher than the alternative rate), ranging from $0 to $20.67 above PPS, and $0 to $25.08 below PPS. For eight RHCs the two rates were the same.

The differences between the APM and the BIPA PPS rate were greater for RHCs than for FQHCs due to the differences in rate methodology between RHC provider types.

Defining Encounters
FQHCs/RHCs are paid their established per-visit encounter rate for qualifying visits. To qualify for the payment, the visit must be an FQHC or RHC service, and must be provided by an eligible provider. There are differences in eligible services and providers between FQHCs and RCHs. Both FQHCs and RHCS encounters include those provided by a physician assistant, clinical psychologist, clinical social worker, nurse practitioner, or nurse midwife (as defined in their respective practice acts). Additionally, FQHC encounters, but not RHC encounters, include

those provided by physicians, dentists, and visiting nurses. A visit is defined as a face-to-face encounter between a client and provider who is providing an FQHC/RHC service. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location count as one visit, except when the client experiences an illness or injury after the first visit that requires additional diagnosis or treatment. A medical encounter and a dental encounter on the same day and at the same location are counted as two separate visits.[9]

Payment Flow for FQHCs and RHCs in Medicaid

Payment for FQHCs/RHCs is based upon an encounter rather than individual services. This is different from traditional fee-for-service payment in which providers receive payment for each service provided during a visit or encounter. FQHCs/RHCs are paid their encounter rate for each patient visit regardless of the specific services provided in that encounter.

The Department is required to ensure FQHCs/RHCs are paid their established PPS encounter rate for Medicaid and CHP+. Medicaid's historic and current implementation of FQHC encounter rate payment provides important background for the development of a system under CHP+. Approximately 80 percent of Colorado's Medicaid clients are seen in fee-for-service program managed by the Department. About 20 percent of Colorado's Medicaid clients participate, on a voluntary basis, in Medicaid managed care. FQHCs/RHCs currently receive payment directly from the Department and, for managed care clients, through MCOs (such as Denver Health Medical Plan or Colorado Access).

Payments made directly from the Department (HCPF). FQHCs/RHCs bill the Department directly for services provided to Medicaid enrollees in the fee-for-service program. This process takes place through the Medicaid Management Information System (MMIS) on an institutional claim form (UB04). Because FQHCs/RHCs are paid on an encounter basis, the MMIS system is set up to pay FQHCs/RHCs based on a revenue code, rather than on a CPT (procedure) code. When FQHCs/RHCs submit their claims, the system identifies the revenue code and pays the first CPT code based on the FQHCs/RHCs encounter rate. Subsequent CPT codes are denied in order to prevent over-payment.

While this approach is effective in ensuring appropriate payment by the Department, it negatively impacts the availability of administrative data that might be used for developing quality measures. Because MMIS automatically denies all CPT codes beyond the first code, FQHCs/RCHS receive multiple denials for any claim submitted with more than one code. Some FQHCs and RHCs have opted to include only one procedure code in order to avoid the manual process of verifying and clearing the "erroneous" denials that result from using multiple codes for a visit. As a result, the claims submitted do not fully reflect the level of services provided as part of the encounter. Other FQHCs have programmed their patient accounts management systems to ignore subsequent denials where the revenue code was accepted. Under all of those scenarios, the limited completeness of the data submitted through and retained with the MMIS should be considered in the selection of any payment methodology that relies on administrative claims data.

The Department has made efforts in the past to match claims submitted through MMIS with encounter data submitted. However, doing so is challenging due to the default systems configurations of the MMIS. While it is possible to revise the MMIS to allow for submission of additional CPT codes, Department staff report that such a change in the foreseeable future is unlikely given multiple higher-priority changes needed in the system and current budget limitations.[10]

Payment through MCOs. The Department is required to ensure FQHCs/RHCS are paid their PPS encounter rate for Medicaid services, including when services are provided under contract with an MCO. In Colorado, MCOs pay FQHCs/RHCs their encounter rates at the time of service and submit a reconciliation request to the Department on a monthly basis. The process works as follows: MCOs are initially paid a capitation amount based on average fee-for-service cost and utilization for physician services, which are generally lower than FQHC/RHC encounter rates. Medicaid MCOs pay FQHCs/RHCS on an encounter basis, at their established encounter rates. Contracted MCOs submit monthly requests for wrap-around payments to the Department for the difference between their capitated amount and the amount they paid to FQHCs at their actual encounter rate.

Current CHP+ Payment Systems

Currently all CHP+ services are provided through managed care arrangements. Five managed care organizations (MCOs) offer CHP+ plans (Colorado Access, Rocky Mountain Health Plans, Colorado Choice Health Plans, Denver Health Medical Plan, Kaiser Permanente). All CHP+ applicants must choose a Managed Care Organization (MCO). In addition, there is a state managed care network (administered by Colorado Access) in which pregnant women are enrolled, as well as all CHP+ children upon initial enrollment. All CHP+ children must choose an MCO, but it can take up to 6 weeks after CHP+ enrollment for a child to be enrolled. During this period children are not unable to access all services (for example Dental services). Not all provider participate in both the State managed care network and the CHP+ MCOs.

The CHP+ program establishes a statewide capitation rate based on actuarial analysis of past utilization and cost experience. Each MCO is paid the blended per-member-per-month capitation amount. CHP+ MCOs pay their contracted providers according to capitation rates and/or fee schedules that they have established and negotiated. Because FQHC/RHC PPS rates have not been required in CHP+ in the past, CHP+ MCOs and the managed care network have not set up CHP+ provider payment systems to pay on an encounter basis. In order to pay on an encounter basis, an MCO must be able to identify a set of services that qualify as an encounter (as well as services that do not), and to pay each contracted provider their encounter rate. Alternatively, the CHP+ MCOs could continue paying FQHCs/RHCs as they do currently, in which case the Department would be responsible for ensuring FQHCs/RHCs receive the difference between the MCO payment and the provider's established PPS rate, either directly or through the MCO.

Both Denver Health and Colorado Access, which operates the state managed care network for CHP+ in addition to its own CHP+ plan, have the ability to process and pay claims on an encounter basis within Medicaid, and would be able to extend those systems to CHP+.

However, it would take some time and resources to implement the necessary system changes. Additionally, Colorado Access initially built its CHP+ capitation rates for some FQHCs to reflect their Medicaid encounter rates. This ability could extend to the state managed care network, as Colorado Access is contracted by the Department to administer the state managed care network and make payments on behalf of the Department.

Because FQHCs/RHCs are currently reimbursed by CHP+ MCOs under the same processes as all other contracted providers, they submit detailed information about services provided for each CHP+ claim. The issues related to collection of service level information for claims processed through MMIS do not currently exist within the CHP+ system.

CHP+ Dental services are delivered through Delta Dental of Colorado, which includes FQHCs in its networks, and providers are currently paid at a rate negotiated between Delta Dental and the FQHCs.

Systems Challenges with Current Methodologies
Various challenges exist within the current PPS payment systems and methodologies that should be considered in the development of the PPS Plus methodology.

Data Challenges. As discussed above, the technical issues related to payment of encounters through the Medicaid MMIS system limits the availability of service level data that would be used to develop quality measures. The Department has tried in the past to merge clinical data submitted by providers with MMIS data, but has had limited success in matching data fields. Another challenge with using MMIS data to understand quality of care provided on a site-by-site basis is that most FQHCs have only one Medicaid provider number for their entire organization, making it difficult to distinguish between service delivery sites or individual providers.

Variance in Reimbursement. The current Medicaid PPS reimbursement methodology varies across provider types. Furthermore, the difference between the BIPA PPS minimum and the APM varies greatly by individual providers, both within and across provider types. Thus, the implementation of a PPS Plus methodology is likely to impact both provider types and individual providers very differently. The following table summarizes the various ways that FQHCs and RHCs are currently reimbursed and the range of payment amounts.

Table 2. FQHC and RHC Current Payment Mechanisms in Medicaid and CHP+

	FQHC	Hospital Based FQHC	Free-Standing RHC	Hospital-based RHC
PPS methodology	Midpoint of PPS or APM. APM based on Medicaid cost report	Midpoint of PPS or APM. APM based on Medicaid/ Medicare cost report	Higher of BIPA PPS or the Medicare rate (Medicare UPL for RHCs)	< 50 beds: Higher of PPS or APM, APM based on Medicare allowable costs from most current audited Medicare cost report = >50 Beds: Higher of PPS or APM, APM based on Medicare UPL
PPS Amount or range	$210.24 - $131.82		$78.07 (Medicare UPL) to $103.25	$103.51 - $173.27
APM variance from BIPA minimum	$26.35 (range of $2.30 - $76.79)		$4.90. Range of $0 to $25.08. For 11 the BIPA PPS is higher than the APM, for 8 it is the same, for 2 the APM is higher.	$7.08. Range of $3.63 to $72.48. For 5 PPS is the higher rate, for 8 the APM is higher.
Medicaid FFS	Encounter rate paid by HCPF through MMIS, billed on the UB04. No requirement to bill procedure codes; MMIS does not capture CPT detail.		Encounter rate paid by HCPF through MMIS	Encounter rate paid by HCPF through MMIS
Medicaid MCO	Only those contracted by Rocky Mountain Health Plan, Denver Health Medical Plan. Encounter rate paid by contracting MCO	FQHC Encounter rate paid by DHMP	Would apply only to FQHCs contracted by RMHP. More data needed.	Would apply only to FQHCs contracted by RMHP. More data needed
CHP+ State Managed Care Network	Paid at state FFS rates	Paid at state FFS rates	Paid at FFS rates	Paid at FFS rates
CHP+ MCO	Paid according to contract with MCO	Paid according to contract with DHMP MCO	Paid according to contract with MCO	Paid according to contract with MCO

Findings From Other States Regarding PPS Implementation

As described in the methodology section above, the JSI team conducted key informant interviews with eight states (in-depth interviews with seven states and a brief interview with Michigan) in order to better understand models and related challenges for implementing the CHPRA PPS requirement. The table below summarizes the characteristics of the sates interviewed.

Table 3. Characteristics of States Interviewed on PPS Implementation[11]

State	CHIPRA PPS Implemented	CHIP Program Type	CHIP/ Medicaid Rate Methodology (PPS or APM)	Type of APM
AZ	Yes	Separate	Both[3]	Annual PPS adjusted by PSI
PA	No[2]	Separate	APM	BIPA PPS with wrap paid through MCOs
KS	Yes	Separate	Both[3]	Cost-based (in interim 90 percent reasonable costs)
TX	Yes	Separate	APM	PPS + Flat 1.5 percent
NY	Yes	Separate	BIPA PPS	Really BIPA PPS but considered APM because wraparounds go through MCOs
CA	Yes[2] (as of January 2011)	Combination	Both[3]	Cost-based reimbursement for certain waiver programs
MN	Yes (paying PPS prior to CHIPRA)	Combination	Both[3]	PPS + Flat 2 percent
MI	No	Combination	APM	PPS + additional payment for specific services

PPS Implementation Themes

The following themes emerged from national research and state interviews:

Decision to adopt same methodology for CHIP as used for Medicaid. All the states interviewed followed this approach. Using the same methodology meant that the new payment system for CHIP integrated easily with existing program structure and philosophy. Implementation was greatly simplified for the state, MCOs, and providers when following this approach. The state did not need to establish or maintain separate rates, and MCOs and providers only had to keep track of one set of rates. Most states adopted the same methodology without conducting much data analysis. PA did conduct an in-depth actuarial based study, but in the end found negligible

[2] Pennsylvania and California, like Colorado received a grant from CMS to facilitate implementation of the CHIPRA PPS provisions

[3] FQHCs and/or RHCs are able to choose the BIPA PPS or the APM.

difference in the projected rates for CHIP when compared to Medicaid, even with some difference in the benefits. None of the states interviewed, including PA, chose to modify their existing Medicaid PPS methodology as part of their CHIPRA implementation.

*Smaller providers may not be interested in implementation***.** CHIP clients account for a small proportion of FQHC and RHC clientele and revenue. For example, in New York RHCs did not serve CHIP clients at all. The implementation burden and expense of changing billing systems for these providers may not be worth the small additional revenue stream. This may be especially true for the process of identifying encounters retroactively to the October 1, 2009 CHIPRA implementation date. Several states interviewed found that small providers did not engage in the process of determining or submitting payment requests for retroactive payment.

Involving stakeholders is important. As NACHC found, "developing a payment methodology that works well for all parties requires a collaborative effort between the State agency, FQHCs, the State Primary Care Association and managed care plans."[12] In JSI's findings, states that had active stakeholder involvement, especially from the Primary Care Associations (PCAs) that represent FQHCs, found the collaboration to enhance implementation. New York found it very helpful to have the PCA involvement, as "they understand the issues that FQHCs usually have and have a good understanding of how reimbursements work." The states found it easier to talk to one organization representing stakeholders than to all FQHCs and RHCs involved. Similarly, regular communication between the state and MCOs is critical to developing and implementing a payment methodology. The National Association of Community Health Centers' 2010 report found that such communication "…is essential to ensure potential issues are worked out prior to implementation date." Several of the states noted that RHCs were not as involved in the process, nor as vocal in expressing their opinions about adoption and implementation of CHIPRA requirements. The primary reason given for their lack of involvement was not having a "single voice" in the way the primary care associations provide for FQHCs. As noted earlier, the number of CHIP patients and the effect on revenues is much less for individual RHCs.

*Even with the same rate and methodology, different processes required in CHIP***.** States with separate CHIP programs often use different MCO networks and billing systems than their Medicaid program. The separate structure necessitates the development of process within the CHIP billing and payment systems in order to accommodate the encounter-based payment required by PPS. While the encounter rate paid to each FQHC/RHC is the same under Medicaid and CHIP, both the processes for determining which services under CHIP constitute an encounter and the process for ensuring payment at the encounter rate varied considerably across the CHIP programs for those states included in the interviews. All of the parties involved (state agencies, MCOs and FQHCs/RHCs) will need to make some changes to their systems to ensure appropriate payments and tracking. These changes need to be planned for in order to avoid implementation delays. Common challenges encountered by those states included in the interviews, as well as their approaches to addressing those challenges are outlined below:

*Establishing what constitutes an encounter under CHIP***.** Payment for CHIP services prior to CHIPRA implementation was primarily through MCOs on a fee-for-service or capitation basis. In most cases MCOs were paid by the state on a capitation basis. CHIP providers (including

FQHCs/RHCs) were paid a per-member-per-month capitation or on a fee-for-service basis through submission of professional claim forms with detailed visit information. Thus, states had to devise mechanisms to identify the services that constituted an encounter and triggered payment. The mechanisms identified had to avoid paying for services that might have been paid for under a FFS agreement (such as a stand-alone lab test), and that did not constitute an encounter. States took two approaches to addressing the encounter issue: 1) they continued the current billing and payment practices through MCOs, and identified encounters based on information submitted to the state from MCOs and/or FQHC/RHCs, or 2) they changed the systems used by MCOs to file and process claims on an encounter basis.

*Ensuring payment at encounter rate***.** States interviewed had two overall strategies for making wrap-around payments: through MCOs or directly from the state to the FQHCs/RHCs. All of the processes used included an administrative process for ensuring that FQHCs/RHCs were paid their encounter rate. In some cases the state bore the administrative burden of identifying encounters provided by FQHCs, payments made by MCOs for those encounters, and the balance due to FQHCs/RHCs. In other cases, FQHCs or MCOs were responsible for identifying and generating a report of encounters. Where MCOs are identifying encounters, states provide specific definitions of encounters to MCOs, and MCOs have had to configure their systems to recognize and pay on those encounters. Some states developing a special code to identify PPS reimbursable encounters, while others created a database to accept claim data and, using a specific algorithm, identify the number of encounters provided.

States were cognizant of the need to minimize the lag time between service provision and full reimbursement, due to the cash flow challenges that a long lag time can cause. In particular, timely payment/wrap-around was a primary concern for stakeholders. Although the approaches used varied greatly across states, each state reported that implemented approaches were deemed acceptable by the state and FQHCs/RHCs, perhaps reflecting the stakeholder's involvement in developing the methodology. Specific examples of state strategies for identifying encounters and ensuring PPS payment include:

- New York: FQHCs submit encounter data to the state. Encounters are identified through their practice management systems and information about payment received from the MCOs. The department calculates the difference between what was paid to the FQHC and what the payment should be under PPS, and sends the difference to the FQHCs through the MCO in the form of a payment voucher.
- Texas: There is no wrap in the CHIP program. FQHCs/RHCs bill MCOs for CHIP on an encounter basis. The experience information that is used to set CHIP rates with MCOs includes the encounter rates, so the MCO contract capitation rate with the state is based upon the CHIP encounter rates. For Dental services only, CHIP services are paid at the negotiated rate, and the Dental vendor submits monthly reports of services provided and payment. These are verified by each FQHC, and submitted to the Department. A wrap-around payment is provided to the FQHC through the dental vendor.
- California: FQHCs/RHCS are paid by capitation or fee-for-service rates by MCOs; therefore, MCOs do not have to track encounters. FQHCs/RHCS also bill the state for each encounter on a specific code (Code 19). FQHCs/RHCs provide the state with information about their payment agreements and visits with each MCO, and the state

develops a blended rate that is paid for each Code 19 submitted (as long as the related claim was fully adjudicated by the MCO). The Code 19 payments and MCO payments together equal the FQHC/RHC PPS rate for the encounters delivered. There is an annual reconciliation to address under/overpayment.

- Kansas: MCOs pay FQHCs fee-for-service, and submit data monthly to the state. The state identifies encounters on a claim by claim basis through a SQL database, and calculates a wrap around payment for the difference between MCO payments and the encounter rate. Because Kansas's PPS is a cost-based rate for FQHCs, a settlement is performed annually to reconcile to the FQHCs actual costs.

Implications for Value-Based Purchasing

None of the states interviewed above chose to include a value-based purchasing component as part of their CHIPRA PPS implementation. However, Oregon, which already paid PPS rates in CHIP, is currently in the process of including a value-based component in its alternative payment methodology for both Medicaid and CHIP. More information on Oregon's efforts is included in the next section of the report.

VALUE-BASED PURCHASING

National Landscape for Payment Models

There is a growing recognition at the national and state levels that fundamental changes are required in existing payment systems to deliver high quality care at reasonable costs.[13] [14]
The major payment alternatives to the fee-for-service (FFS) system are episode based or bundled payments, and global payments.[15] [16] Under a system using bundled payments, provider groups are paid a fixed amount for a defined episode of care (often tied to treatment of a specific condition like diabetes care). The Medicare diagnosis related payment system for hospitals is the most prominent example of a bundled payment system. New types of episode based payment systems are being developed to combine payments across multiple providers, from physician practices to hospitals. As hospitals represent the largest single component of health care costs, they are important to include in bundled payment systems.

Global Payment/Capitated Systems
Under global payment/capitated payment systems, health providers are paid a predetermined fixed budget for covering all services provided to patients over a fixed period of time. Health providers can retain all the saving when expenses fall below the budget. Global payments can be applied to specific services, such as primary care, or they can cover a broad range of services. Capitated payment systems have been used in managed care contracts for several decades, including Medicaid managed care programs. Earlier generations of global payment systems were criticized for encouraging adverse selection and under treatment. To address selection problems, current global payment systems use more sophisticated risk adjustment mechanisms than existed in earlier forms of capitation.

Pay for Performance
The national and state governments are experimenting with a variety of incremental payment models that rely on fee-for-service payment arrangements but modify them in order to improve the quality and efficiency of care. The most widely used incentive reimbursement method among state Medicaid programs is pay for performance.[17] [18] In ***pay for performance (P4P)* systems**, individual providers or provider groups are paid for meeting quality metrics over a specified time period. The most common approach to P4P is to pay providers a bonus payment for meeting quality metrics or thresholds. Nonpayment for preventable adverse events (sometimes known as "never events" and withholds have also been used to discourage adverse events or practices. Although early P4P programs have largely used quality metrics, they have begun to incorporate measures of physician practice efficiency, such as generic drug use and emergency department utilization. Several limitations of existing of P4P programs have been widely discussed including, among others, inaccurate quality metrics and incentives levels of payment that are too low to change provider behavior.

Gain sharing/shared saving
These approaches are increasingly being discussed as an option for state Medicaid programs in order to improve the efficiency of care. In these approaches, a fixed budget is set based upon predicted costs for a specific period of time. At the end of the time period, any savings below

projected costs are shared between the provider group and the payer or health plan.[19] These shared savings approaches are designed to give provider groups incentives for efficiency improvements, such as reducing avoidable emergency department visits or hospitals readmissions. Provider groups assume no more risk than under a fee-for-service model, but have the potential to achieve an upside gain. Some experts believe that shared savings approaches must institute access and quality incentives to prevent the risks of under treatment. A shared savings approach has recently been recommended by the Congressional Budget Office for Medicare the by 2009 Massachusetts Payment Commission as a transition strategy to more comprehensive payment reform.

Medical Home

Because of the growing emphasis in health policy on health system improvements, states are using financial incentives to encourage the development and spread of medical homes. Many states are seeking to make medical homes available to all or large segments of their Medicaid populations. The primary care medical home or health care home is being widely supported because of the advantages described in the literature, including:[20]

- Primary care-oriented health systems generate lower cost, higher quality, and fewer disparities.
- The NCQA standards for medical home are based upon the Chronic Care Model, which has been heavily evaluated and found to improve quality.
- Primary care supply is declining nationwide and shortages will continue without changes in the organization of primary care practice.
- Medical home demonstrations and evaluations have shown promising results in terms of improving quality and reducing costs (e.g. reducing emergency department visits and inpatient utilization).

The advantage of incenting the development of medical home or accountable care organizations (ACOs) is that the incentives are designed to improve the primary care system or the care system overall rather than specific clinical practices or outcomes. The assumption is that by fostering the development of medical homes, a state is promoting broad system transformation, not just specific clinical improvements. The medical home is explicitly linked to health systems transformation, as the NCQA standards are based upon Ed Wagner's Chronic Care Model.

Accountable Care Organizations (ACOs)

ACOs are integrated networks that combine primary care clinics, specialists, and hospitals in communities or regions. As described by Fisher and colleagues, ACOs are designed to have the responsibility and accountability for driving efficiency and quality in a community's health care system. According to Fisher, ACOs should have strong primary care practices or medical homes as a foundation.[21] ACOs could be paid on a fee-for-service basis; however, they would be more effective if paid through episode-based or global payments. ACOs are an important complement to medical homes, as they address the problems of care coordination and care transitions across provider settings that plague the health care system.

State Medicaid programs are increasingly using blended approaches that combine payment incentives for medical homes with pay-for-performance. The advantage of using this blended

approach is that the state is promoting greater care coordination and quality improves across practices, while concurrently providing targeted incentives to achieve higher rates of preventive services or specific clinical outcomes. Some experts believe that states will increasingly use shared savings approaches or targeted incentives for cost reductions along with incentives for medical home and pay for performance.[22]

The implementation of even incremental changes in payment systems like those for medical homes presents a number of challenges for state Medicaid agencies, health plans, and provider groups. Among the most important challenges are:

- ***Agreement on the objectives of payment reform***. Although states can use the Triple Aims as a general guide to delivery system and payment reform, they need to set specific objectives for their payment reforms that are feasible to achieve. Many states are trying to target payment reforms where they can have the greatest impacts. Having a high return on investment is especially important in the current fiscally constrained state budget environment.
- ***Inadequate quality metrics or health information technology systems to routinely track and report health outcomes***. The use of value-based incentives has been limited by the availability of scientifically validated measures of health outcomes. In addition, many primary care clinics do not routinely collect process or outcomes data, and others lack an ability to report these data.
- ***Provider acceptability and variability***. Payment reforms are difficult to implement without the support of primary care clinics and their physician leadership. It is also helpful if they share a commitment to the systems improvements that payment reform is designed to encourage. Provider variability is also a challenge to implementing payment reform, as primary care clinics are differentially positioned to make changes in their care systems and in their billing and HIT (health information technology) infrastructure. This provider variability raises questions about uniform provider participation and the phasing of payment reforms.
- ***Financing of payments***. The blended payment systems being implemented to encourage medical home and ACO development require a significant up front investment by clinics and the state. For example, many states are budgeting added payments for medical homes that are cost neutral due to project savings in years three to five. The financing issue is leading to greater emphasis on payment for efficiency-related performance targets that produce short term savings. The investments in clinic infrastructure for medical homes are even more of a burden in single versus multi-payer incentive-based payment systems, as clinics do not want to invest in separate systems for different payers.
- ***Evaluation infrastructure.*** Both states and individual clinics need an evaluation system in place to determine whether the incentive payment systems are having their desired effects. This can be addressed similarly to the methods of North Carolina's CCN program, by developing a statewide, centralized data reporting and evaluation system.

Although the Patient Protection and Affordable Care Act (ACA) does not include a comprehensive approach to payment reform, it provisions encourage health system transformation and provides support to demonstrate various payment reform models.[23] The newly established Center for Medical Innovation in the Center for Medicare and Medicaid Services (CMS) is explicitly designed to improve the delivery system and explore new

approaches to payment in order to have better quality of care and coverage affordability. Its director, Dr. Berwick, has recently stated that the Innovation Center will, "ultimately scale new care and payment models that improve and sustain the Medicare and Medicaid/CHIP programs for our beneficiaries and ultimately the healthcare system at large."[24] The ACA provides financial support for primary care transformation by increasing the federal matching rate for chronic care medical homes and by increasing payments levels for certain primary care services. In addition, the ACA creates a variety of grant opportunities for states seeking to test payment reform models in Medicaid or Medicare populations, including: development of pediatric ACOs, community health teams to support medical homes, home care models (Medicare), ACOs, and bundled payment models for certain conditions.

State and national experts that were interviewed all sought to devise new payment methodologies for health care that will enhance the quality and efficiency of regional health systems. There is a growing recognition that delivery system reform and payment reform are inextricably linked. Many states like Colorado are benchmarking their practices against other states. A number of states are developing or planning to establish plans for comprehensive payment reform that will work to achieve the IHI's Triple Aims. Among states involved in payment reform, there is a growing interest in coordinating payment reform, delivery system reform, and in leveraging federal resources to support these efforts.

State Level Payment Reforms and Value-Based Payment

This section provides a review of some of the state level payment reforms that are relevant to Colorado's payment systems for Medicaid and CHIP, followed by descriptions of the incentive payment reforms being implemented in six states.

Pay for Performance

Pay for performance has been widely implemented by state Medicaid programs, as well as by private payers. Although there is strong support for rewarding providers based upon their performance, the evaluation results from these programs have been mixed. There are, however, examples of successful pay for performance programs among public and private payers. Oklahoma's *Sooner Care Choice,* a primary care case management (PCCM) program, is considered to be one of the more effective public P4P programs. The state's P4P program provides bonus payments, averaging approximately $2,800 per provider, to physicians for completing early periodic screening, diagnostic, and treatment requirements for children (EPSDT). Since program implementation in 1997, the state has seen its EPSDT rates improve by over 20 percent.

To address the limitations of existing P4P programs, states have redesigned their programs based on well established, evidence based practices in order to enhance their effectiveness. This is done by increasing the level of bonus payments (where possible) to have a stronger effects on provider behavior, and by targeting programs to clinical areas and services where they have the potential to have a high return of investment (ROI). Recently, states and other payers have been moving to incorporate targets along with financial incentives for medical homes.

Medical Home and Payment System Reform

Since 2006, forty states have developed policies to advance medical homes for Medicaid and CHIP beneficiaries.[25] The design and certification standards for medical homes vary across states, including the six interviewed. Vermont has adopted legislation to provide every Vermonter with a medical home, including all Medicaid beneficiaries. Similarly, Pennsylvania is working on a regional and multi-payer basis to develop medical home models based explicitly on the Wagner Chronic Disease Model. Washington is another state working on a multi-payer demonstration. States such as North Carolina, Minnesota, and Massachusetts have focused their initial efforts on developing medical homes for their Medicaid beneficiaries. Minnesota is unique in that it is targeting medical home development on Medicaid patients with chronic disease.

States also use a variety of certification standards for medical homes. Many states rely on the NCQA standards for medical home certification, though other states such as Minnesota, Oregon and North Carolina use their own standards for defining a medical home.

In addition to payment reforms, states are supporting the medical home in a number of ways. They are working with foundations and other groups to provide technical assistance, supplying care managers, and providing HIT and other infrastructure support. Through its Blue Print for Health, Vermont is providing community health teams to support the patient engagement in its medical home model. North Carolina's CCN model is providing care managers for many small practices and operates HIT infrastructure support for practices on a statewide basis.

States are using different payment models to support medical homes, though all are modifications of existing fee-for-service models. Several states have modeled the costs to operate a medical home, and have found it requires additional resources in the practice setting. These additional resources include PCP and care team member time on traditionally non-billable activities, care management, and HIT infrastructure development.[26] Several states have made lump sum payments to cover some of these initial costs of establishing a medical home. Payers in some regions of Pennsylvania are paying as much as $30,000 per practice in a lump sum to support the infrastructure required for a medical home.[27]

Most of the states implementing medical home models use one of the following payment methods to support the ongoing costs of being a medical home:[28][29]

- Fee-for-service with discrete new codes. In this approach, new codes are added for services not traditionally reimbursed by fee-for-service payment systems. In one example, Oklahoma's Sooner Care added two new procedure codes for afterhours care and behavioral health screening.
- Fee-for-service with higher payment levels. In this approach used by New York, the per-visit rate is increased for certain services.
- Fee-for-service with per-member-per-month fee. This approach relies upon existing payment systems and adds a per-member-per-month fee (or a per-member-per-year payment) for care coordination and other otherwise unreimbursed services. North Carolina's CCN program includes a per-member-per-month payment for care coordination, in addition to providing care managers for primary care practices.

- Fee-for-service with per member per month (PMPM) fees and P4P. This model combines a PMPM care coordination payment with pay for performance. This model has been endorsed by the Patient Centered Primary Care Collaborative (PCPCC), though it has not yet been adopted by a state Medicaid program.
- Fee-for-service with per-member-per-month and shared savings. A per-member care coordination payment can be combined with a shared savings approach. This is approach has been used in Alabama since 2004 in its Patient First program. Alabama pays per-member-per-month fee to providers in its primary care case management for meeting nine practice characteristics such as EPSDT participation, Vaccines for Children program participation, Medical Home CME completion, and provision of around-the-clock coverage seven days a week. The state shares 50 percent of savings from the program with primary care practices; Alabama returned $5.7 million to participating providers in 2007.

One of the challenges to implementing medical homes in state systems is to determine an appropriate financing method of covering the initial state outlays. Economic modeling of the costs of medical homes demonstrates that it takes several years of operation before a typical medical home shows a positive return on investment. This means that public and private payers may need to make an upfront investment at a time when state funds are highly constrained. To address this financing issue, the Medical Director of Washington's Medicaid program recommended that medical home programs be combined with pay for performance that targets efficiency improvement with a short term positive return on investment (e.g. incenting the substitution of generic drugs).

Payment for Medical Home in Medicaid Managed Care

States with significant Medicaid managed care population have incorporated medical home language into their managed care procurements.[30] This involves adjusting their performance standards and capitation rates to reflect these new expectations. Managed care contracts can use similar methods as those described above to support the ongoing costs of being a medical home. In some regions, providers with managed care contracts may already be complying with some of the requirements for being a medical home.

Payment for Community Networks as a Step Towards ACOs

Several states have developed community care networks that build upon medical homes but seek to integrate care on a community basis. The best known of these programs is Community Care Network (CNN) of North Carolina.[31] Under this program, providers are required to form networks that include primary care, safety net, and specialty care providers in collaboration with the local health departments, departments of social services, and hospitals. The nonprofit networks in CNN receive a PMPM fee to implement population management strategies (such as disease and care management, population stratification, preventive services and coordination across delivery settings). As described above, the individual practices also receive a PMPM fee for serving as a medical home. Other states such as Vermont and Alabama are moving to a similar network models.

Community networks like CCN represent a step in developing an infrastructure for developing an ACO model. Community networks and ACOs can start out using a fee-for-service model, which, over time, could be supplemented with shared savings and P4P. North Carolina officials indicate an interest in using CCN as the basis for ACO development in the state.

Based upon a review of the literature and interviews with state officials, the following general trends are emerging:

- States have been moving from quality-based pay for performance systems to incentive-based payment systems designed to encourage medical home and ACO development.
- Medical homes are the current focus of many state reform efforts, though there is a strong emerging interest in ACO development. The interest in ACOs results from the fact that payment reform must address inpatient treatment as well as primary care in order to effect change across the health care delivery system.
- Many states are moving to blended payment models that combine FFS with pay for performance and shared savings. Because of the growing imperative of cost control, many states are exploring shared savings approaches along with efficiency targets.
- Finally, states and private payers are trying to develop the capacities in primary care clinics and community networks for more comprehensive payment and delivery system changes in the years to come.

FHQC Involvement in Payment Reforms

FQHCs have been involved in designing and participating in many of the payment reforms described above. Although FQHCs are paid in a different manner than other Medicaid providers, they have received incentive payments on top of their federally mandated payments. In all of the states that we interviewed, with the exception of Oregon, FHQCs were eligible for incentives for performance improvements and participation in medical home-related activities, which they received in addition to their encounter based payments. Typically, FQHCs or individual providers received either a PMPM payment for each client enrolled in a medical home, or bonus payments for meeting specific quality or cost targets.

Oregon is the exception in that it has incorporated P4P and medical home payments in its APM for FQHCs. It currently allows health centers to cover the costs of unbillable services related to medical home to be included in its APM. The state of Oregon is moving to an APM system in which the FHQCs will receive a yearly capitated fee for each client of a clinic. The capitated payment will be based in part on the total costs of patient care so that clinics can share in the savings produced by lower emergency department visits or hospital readmissions. One complication in designing the system is that the clinics may still have to collect encounter data to ensure that they are receiving reimbursement equal to that under PPS. Participation in the global payment system will be voluntary under the APM so that clinics can develop the necessary care systems and billing infrastructure before moving to the new payment system. The Medicaid managed care plans are expected to adopt a similar methodology. According to Craig Hostetler of the Oregon Primary Care Association, the PCA is spearheading payment reform in order to reduce the financial barriers to more effective integrated care that exist in current payment arrangements.

Implications of National and State Experiences for Colorado

The national and state experiences suggest several broad approaches for designing incentive based payment systems for Medicaid and CHP+ in Colorado. On the broadest level, Colorado has the option of either incorporating incentive payments within its APM, or having a separate value-based payment system that applies to FQHC and rural health centers, in addition to other Medicaid providers. The use of incentives within the APM may make it more difficult to use specific payment methodologies such as shared savings and capitation, as these payment systems would need to be reconciled with PPS or an APM.

Within these two broad approaches, there are a number of different payments methods that can be used to promote health system improvement and cost reductions. States are increasingly using different combinations of PMPM supplements to FFS, P4P, shared savings, and capitation.

Our review has four major implications for designing a CHP+ and Medicaid incentive based payment system for Colorado:

- Evidence suggests that incentives must be large enough to change provider behavior in a meaningful way. As discussed above, the difference between the BIPA PPS and the APM in Colorado varies greatly. For those providers for whom the difference is minimal, use of that difference is not likely to be an effective incentive on its own, especially within CHP+ where there are a smaller number of encounters. This means that alternative budgeting and financing methods must be considered. Payment methods such as shared savings and capitation put more dollars on the table than would otherwise be available.
- Given the state financial situation in Colorado, incentives should be designed to produce short-term savings, which could be potentially shared between the participating clinics and the state. This means using P4P to promote efficiency improvements that have an immediate and high ROI. The Medical Director in Washington State recommended two targets with an immediate and high ROI: incenting providers to achieve high rates of generic drug substitution and increasing the compliance rates for diabetes and heart disease related medications.
- States are involved in multiple payment reform efforts and demonstrations related to the medical home, P4P, care transitions and ACOs. State policymakers should make an effort to use consistent payment methodologies, as well as cost and quality metrics in order to send a consistent message to provider groups. State policymakers also need to be aware of the potential administrative burdens on clinics that results from different program requirement across programs and payers.
- States need to take into account the variability in provider capacity to move to new care systems and payment methodologies. Colorado may want to convey a clear, long term message of its policy intent to move away from a cost, encounter based payment system to alternative payment arrangement, while at the same time allowing individual clinics the flexibility in the implementation of these new payment systems.

COLORADO'S CURRENT VALUE-BASED INITIATIVES

The Department has embraced a vision and strategic direction that include support for the medical home model and payment reform focusing on the value of care provided. Its efforts are very much aligned with the efforts of the Federal government and other states, discussed above. In order to maximize the impact of the PPS Plus methodology, Colorado should ensure that it is aligned with the State's Medical Home Initiative and Accountable Care Collaborative (ACC) efforts. Specifically, the PPS Plus methodology should:

- Use payment methods and incentives that are consistent with those used in the Medical Home Initiative and ACC;
- Use metrics that are the same or substantively similar to those used in other Colorado initiatives to minimize the burden of collecting slightly different metrics; and;
- Design the methodology so that it can be part multi-payer efforts.

This section summarizes the current value-based payment initiatives in Colorado, and their implications for PPS Plus methodology development.

Colorado Medical Home Initiative

The Colorado Medical Home Initiative was implemented beginning in August of 2008 to meet the requirement of Colorado Senate Bill 07-130 to maximize the enrollment of Colorado Children served by Medicaid and SCHIP in medical homes. Currently there ere over 300 practices (700 providers) participating. The initiative is a mechanism for increasing access to providers, applying consistent care standards, and supporting families, communities and providers.[32] Medical homes must address seven components in Colorado's Medical Home standards: comprehensive care, continuity of care, coordinated care, family centered care, accessible care, compassionate care and culturally-competent care. Because the program focuses on Medicaid and CHP+ children, the majority of whom are healthy, the emphasis is on increasing utilization of preventive and well care. Preliminary data demonstrate that medical homes have been effective; children in a medical home show the following differences from children that are not in a medical home:

- Children are more likely to have a well-child visit (72 percent vs. 27 percent of children not in a medical home);
- Children are less likely to have visited an emergency room for a non-life threatening condition; and
- Children have lower median medical costs ($787 vs. $1,000); this statistic includes children with chronic conditions.

In the Medicaid program, providers are able to become Colorado Medical Homes via certification by the Department. The Department, Colorado Child Healthcare Access Program (CCHAP), and Family Voices of Colorado provide assistance to interested providers in obtaining and maintaining their certification.

Payment Incentives
Once certified, primary care physician providers are eligible for lump sum incentive payment for each well child visit provided to children up to six visits, paid quarterly. Under CHP+ the payment is $21 per visit, and under Medicaid it is $10 per well visit for children 0-4 years old, and $40 for children over four years old. Under Medicaid, the payment is made directly by the Department, based on specific procedure or diagnosis codes. Under CHP+, MCOs make the payment to the providers. Because MCOs receive a pre-established amount, the actual amount of the incentive has varied dependent on the actual number of eligible visits provided to enrollees. In addition to these monetary incentives, medical home-certified providers can access a provider helpline, access a searchable medical home provider database, and access additional materials and resources.

There have been several challenges including FQHCs/RHCs in the Medical Home Initiative under Medicaid.

- An initial inquiry to CMS indicated that it was not permissible for the Department to pay FQHCs/RHCs the per-visit incentive on top of their Medicaid encounter rates, although CMS has since allowed other states to do so.
- Because payments are made based on CPT codes (for well child visit), and because of the Medicaid MMIS system limitations described above it is very possible that many FQHCs/RHCs are not consistently submitting the CPT codes that would trigger the incentive payment. This makes it difficult for them to receive the payment, even if they do enroll.
- The infrastructure requirements of obtaining the certification, along with the requirement that certification be renewed annually per delivery site, has been perceived as too burdensome by some providers.

Nonetheless, Denver Health has obtained Medical Home Certification from the Department, as have several RHCs. However, the RHCs certified as medical homes are not able to receive the per-visit payment if they bill on an encounter basis. Under CHP+ there is no medical home certification required because all CHP+ services are delivered through a managed care program. Colorado Access reports that it is making payments to its providers (including FQHCs/RHCs) for visits that qualify for the incentive. However, the payments have not yet been coupled with information that allows providers to link the payment with specific visits, nor have they been coupled with information that compares medical home visits with a baseline that might link the incentive to changes in practice.

Quality Indicators for a Medical Home:
While no quality indicators are collected specific to the Colorado Medical Home Initiative, there are quality measures relevant to Medical Home in the HEDIS data for the Medicaid and CHP+ program through which the Medical Home Initiative is implemented.

Accountable Care Collaborative[33]

The recently launched Accountable Care Collaborative (ACC) illustrates the Department's focus on improving health outcomes and controlling costs. The ACC is intended to provide a

mechanism for moving away from a fee-based payment system to one that proactively addresses clients' health needs and coordinates care, while at the same time reducing inappropriate use of health care services.

The ACC program will enroll Colorado's fee-for-service clients (Medicaid clients not currently enrolled in managed care programs). Its objectives are to:

- Expand access to comprehensive primary care;
- Provide a focal point of care/medical home for all members including coordinated and integrated access to specialty, inpatient and other services;
- Ensure a positive member and provider experience and promote member and provider engagement.

The ACC also includes the development of statewide data and analytics functionality to support data sharing and the measurement of health care costs and outcome indicators. The ACC is implemented through the Regional Care Collaborative Organizations (RCCOs) designated for each of seven regions across the state. RCCOs are expected to use data to support providers and members, bring down costs, and improve health outcomes from care delivered. RCCOs must have plans to monitor their own performance and that of their provider networks, and quickly integrate this information into their system of care, adjusting as needed. The Department will support them in these efforts.

FQHCs/RHCs can engage in the ACO as Primary Care Medical Providers (PCMPs) within an RCCO. In order to qualify as a PCMP with an RCCO, providers must be enrolled as a Colorado Medicaid provider; serve as the Client's dedicated source of primary, preventive, and sick medical care; and be committed to specific principles of the Medical Home model identified by the ACC (Appendix B**).** The requirements most related to the domains of the proposed PPS Plus methodology are summarized in Table 4 on page 34.

Payment Methodology under the ACC

The funding rationale for the ACC Program is based on the system savings that can be used to support the care coordination and practice models of the ACC. In the initial phase of the program, per-member-per-month payments are available to the Regional Care Collaborative Organizations and Primary Care Medical Providers. These payments are in addition to the FFS payments currently in place. PCMPs receive a $4 PMPM during the initial phase of the pilot. The PMPM is reduced to $3 during the expansion phase (July 2012), with the opportunity to earn $1 PMPM dependent on the meeting of specific utilization targets at the RCCO level. RCCOs may develop their own incentive measures for compensating PCMPs. The initial measurement areas for incentive payments are broken into two target levels and based on improvement over the regional FFS baseline per 1,000 enrollees for three utilization measures: 1) emergency room visits, 2) hospital re-admission, and 3) outpatient service utilization of MRIs, CT Scans and x-rays. Additionally, there is an opportunity for RCCOs and PCMP to share in any savings the Department achieves beyond budget neutrality, although the methodology for a shared savings component is still under development.

At this time there is no programmatic interface between the ACC and Medical Home Initiative, and providers certified through the Colorado Medical Home inititive who also participate in the the ACC as PRMPs are eligible for both the ACC PMPM and the medical home well-visit bump.

The following table summarizes ACC PCMP requirements and Medical Home Initiative Standards related to the desired PPS Plus Domains of health outcomes, patient access, patient satisfaction and cost containment.

Table 4. PPS Plus Components shared by ACC and Medical Home Initiative

PPS Plus Domain	ACC Medical Home model requirements of PCMPs	Colorado Medical Home Standards/ Provider Requirements
Health Outcomes	Willing to accept accountability for patient outcomes, committed to initiating and tracking continuous performance and process improvement activities, and using practice improvement techniques	Implementation of evidence-based guidelines, age appropriate preventive care and screening, and implementation of CQI plan that references medical home standards/components.
Patient Access	24/7 phone coverage with access to a clinician that can triage; extended daytime and weekend hours; appointment scheduling within 48 hours for urgent care, 10 days for symptomatic, non-urgent care and 45 days for non-symptomatic routine care; short waiting times in reception area.	24/7 access to a provider or trained triage service; a personal provider for children/families; appointments made based on condition; availability of same day appointments where needed
Patient Satisfaction	Willing to accept accountability for the Member/family experience	Specific standards related to family centeredness, cultural competence, and compassionate
Cost Containment	Committed to operational and fiscal efficiency	Not addressed

Quality Indicators

In addition to reporting on the three utilization measures, RCCOs are expected to report on a dashboard of health outcomes and cost containment measure. Examples specifically cited in the RFP are measures related to the Department's priority areas of dental caries, depression, obesity, and tobacco use; expenditures on certain categories of costs (such as durable medical equipment); and ability of members to access and use services. These measures, however, are not initially tied to the payment methodology, although they could ostensibly be indicators for cost savings.

Measures to Support Value-Based Component of PPS Plus Methodology

As discussed in the findings on national value-based initiatives, it is critical that provider incentives be aligned across initiatives in order to provide incentives for change. Because the PPS Plus methodology will incorporate a value-based component in the PPS payment

methodology, it is critical to understand the current quality initiatives and measures used within the Department. In identifying quality indicators and metrics to be used for PPS Plus, the Department should consider, in addition to the metrics used for the Medical Home Initiative and those being developed for the ACC, the other quality indicators currently gathered by the Department.

The Department has identified several criteria for acceptable measures to be used in PPS Plus:

- The data needed to assess performance on the measure must be available;
- The measure itself must have face and construct reliability; and
- The indicator must be acceptable to stakeholders in that it is relevant/beneficial for the clients served, reasonable, and amenable to impact through factors that are under the control of the FQHCs/RHCs.

The Department currently collects over 80 quality or health outcome measures across multiple programs and nearly 200 program - specific measures. The Department is in the process of soliciting feedback across its programs on which measures are most meaningful,[34] and has mapped these measures with Meaningful Use and CHIPRA requirements, as well as the Department's 2010 HEDIS measures and Balanced Score Card**.**

The Department currently uses numerous measures to assess processes that are documented to have an impact on health outcomes, and a smaller number that measure health outcomes themselves. In addition, the Department currently tracks indicators related to cost containment, patient access and satisfaction at the program and health plan level. These measures are discussed in more detail in Appendix C.

There are several challenges that would need to be addressed in order to ensure the use of the measures to support PPS Plus value-based payments, including:

- Ensuring that the data is collected and readily analyzed at the FQHC/RHC provider level. Where data is collected at the health plan level, this would include the ability to aggregate pertaining to individual providers across health plan data sets.
- If Medicaid claims data is used, ensuring challenges related to submission of detailed FQHC/RHC visit data through MMIS are resolved.

In terms of the validity and acceptability of measures, the following stakeholder recommendations should be considered:

- A limited set of measures should be used, so that providers can focus their efforts.
- The selected measures should be aligned with nationally recognized measures, and with those required from other payers such as Meaningful Use standards, and, for FQHCs, their grant-required measures.
- Measure construct must take into account the assignment of enrollees and the FQHC/RHC's ability to impact the measure within the eligibility span of the enrollee.
- The measures should not be designed to require that FQHCs/RHCS can report on and earn incentives on all measures from the beginning. Rather, there should be a range or tiers of measures (and incentives) that FQHCs/RHCs could work toward achieving.

CONCLUSION

The Department's efforts to align provider payment mechanisms with quality and cost outcomes are consistent with both ongoing National initiatives and state level efforts to move towards payment methodologies that promote quality-based and cost effective care delivery models, such a the medical home and accountable care models. The development of a PPS Plus methodology provides a unique opportunity to better align payment methodology for FQHC/RHC providers with this new strategic direction.

There are several challenges to including a quality component within a PPS methodology. First, because Federal regulations require that any new rate under an alternative payment methodology be at least as high as the BIPA PPS rate for each FQHC/RHCs, the PPS Plus methodology continues to have a strong tie to the very cost and service-based framework that the Department is hoping to move away from. Additionally, the wide variation in the difference between existing and therefore projected APM and BIPA PPS rates among Colorado FQHC/RHCs makes it difficult to design a new APM that would have an equitable impact, or provide a comparable incentive, across multiple providers. Finally, the small percent of FQHC/RHC patients that are enrolled in CHP+ means that any methodology that applies only to that population pool may not provide enough of an incentive to pay for the types of systems changes needed to earn the defined incentives.

One way to mitigate these challenges is to ensure that the selected PPS Plus methodology and associated incentives are consistent with other incentives being used in Colorado Colorado, such as Colorado's Medical Home Initiative and ACC, and with nationally recognized measures likely to be adopted by Medicare, commercial payers, and Colorado Medicaid. Further, the Department could consider increasing the funds available for the incentive program. Strategies used by states to support medical home and other value-based purchasing that could be leveraged for PPS Plus include:

- Justifying additional up-front payments to build medical home infrastructure by demonstrating cost neutrality over the first few years of the program through changes in utilization across the spectrum of providers, for example, reduced emergency utilization and preventable admissions.
- Incorporating measures that relate to cost containment or increased efficiency (such as increased use of generic drugs, for example) to help achieve greater savings in the short term within the primary care arena.
- Linking the APM to shared savings at the system level.
- Leveraging other available funds, including the Chronic Care Medical Home grants from CMS, meaningful use incentives, and other Federal grant programs supporting medical homes.

As the Department moves forward with developing the PPS Plus methodology, it is critical that the there is agreement within the Department and among stakeholders regarding the overriding objectives of PPS Plus. This is especially critical given that the original PPS methodology was developed to ensure a relationship between Medicaid reimbursements and the actual cost of care, whereas PPS Plus creates a shift to a value-based framework. The PPS Plus methodology will

also need to take into account the variation in provider readiness to engage in value-based purchasing.

The next steps for the project include identification of specific options for the PPS Plus methodology, in addition to an analysis of gaps between current systems/processes and those that would be required for various methodology options. The information presented in this report will be critical to identifying options that can be supported by Colorado's existing systems and structures, meet Federal requirements, and be acceptable to both the Department and FQHCs/RHCs.

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CHIPRA PPS for FQHCs and RHCs Transition Grant

APPENDIX A: PPS Plus Research Methodology

In order to inform the State's approach to CHIPRA PPS implementation, JSI's conducted research on CHIPRA PPS implementation in CHIP, value based purchasing, and Colorado's current programs and systems. The research included:

- Identification of relevant published reports and articles at the national level;
- Key informant interviews with national experts to identify pertinent national trends, and to assist with the identification of states with which to conduct more in-depth interviews;
- Key informant interviews with state Medicaid/CHIP programs to understand their experience with PPS implementation in CHIP and with value-based purchasing methodologies; and
- Research into Colorado's current and payment methodologies, quality initiatives, and value based strategies, including document review and interviews with key Department staff.

A more detailed description of the research methodology is included below.

Prospective Payment System and Value-Based Purchasing Key Informant Interviews

As part of the research into CHPRA PPS implementation and value based purchasing the JSI team conducted key informant interviews with state representatives and national experts. Interview guides were developed to lead the discussions, and are included in Appendix G. State selection and development of the interview guide was also informed by Colorado's initial discussions with Department personnel, by the knowledge of members of JSI's project team with particular expertise in PPS and value based methodologies, and by findings from literature review and conversations with representatives of the National Association of Community Health Centers.

CHIPRA PPS Interviews

The JSI team conducted key informant interviews with representatives of eight states. The main issues covered in the interviews were rate development, reimbursement systems and any related issues, including those related to MCO involvement, and best practices and challenges related to implementing PPS under CHIP. JSI identified states similar to Colorado, or with relevant experience that would inform Colorado's CHIPRA implementation. Criteria for state selection included:

- Operation of separate CHIP and Medicaid programs
- Significant CHIP and/or Medicaid MCO involvement
- Geography and demography similar to Colorado
- Recent CHIPRA PPS Implementation status
    - One state was included (Pennsylvania) specifically because of its receiving a CMS CHIPRA Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics Transition Grant

The states originally selected for interviews were Arizona, Kansas, Mississippi, New York, Pennsylvania, and Texas. JSI was unable to obtain an interview with Mississippi, despite multiple contacts by both the Department and JSI. In the course of scheduling interviews related to value based purchasing JSI had the opportunity to interview representatives from Minnesota,

Michigan and California. The conversation with Michigan was abbreviated, thus a full analysis of their state methodology is not included below.

In all cases except California, interviews were conducted with staff at the state CHIP office with responsibility for CHIPRA PPS implementations. In most cases representatives from the state Medicaid program responsible for PPS implementation were also involved in the interviews. For California the key informant was the PPS lead at the California Primary Care Association, and not a state representative

Value Based Purchasing Interviews

JSI conducted key informant interviews with state officials as well as with several national experts. The main issues covered in the interviews were incentive payments, particularly around pay for performance, medical homes, shared savings, and ACOs. The interviews explored the history of these payment reforms and specific payment methodologies, the implementation challenges, financing issues, and efforts to coordinate them with provisions of the Patient Protection and Affordable Care Act (PPACA). Interviews were supplemented with a comprehensive literature review on state payment reform using academic articles; recent state payment reports; and finally reports and webinars written by national groups (including, but not limited to: the National Academy for State Health Policy, the Center for Health Care Strategies, the Integrated Health Care Association, the National Association for Community Health Centers, and the National Council Quality Assurance).

Washington, Pennsylvania, Minnesota, Vermont and North Carolina were interviewed on the issues of value based purchasing and payment reform. These states were selected because they have a national reputation for playing an active role in developing new payment methodologies related to pay for performance (PFP), medical homes, shared savings, and accountable care organizations (ACOs). The national experts interviewed complemented the interviews with states, and included Michael Bailit (Bailit Health Purchasing); Kip Piper (Health Results Group, LLC); Deborah Bachrach (Center for Health Care Strategies); and Mary Takach (National Academy for State Health Policy), to name a few.

Colorado Specific Research

The identification of feasible alternatives for a PPS Plus methodology requires a thorough understanding of current regulations and processes related to FQHC/RHC rate development and payment, and of quality initiatives and value-based purchasing strategies currently being pursued or considered by the Department, Colorado MCOs, FQHCs and RHCS, as well as CMS and private payers. JSI's approach to gathering the necessary background information and stakeholder perspectives included review of relevant materials, as well as structured interviews with Department staff and stakeholders.

Colorado- specific materials reviewed include:

- State FQHC and RHC regulations, including those related to payment methodologies
- FQHC and RHC cost report forms, rate calculation sheets and summaries
- Relevant portions of the Department's website, and of the CHP+ website
- Specific portions of MCO contracts related to quality initiatives and metrics
- The Department's strategic plan

- Documents related to the Departments health promotion and quality initiatives and metrics in Medicaid and CHP+, including reports on annual HEDIS and CAHPS results and recommendations from workgroups such as the Performance Measure Advisory Workgroup
- Documents related to the Departments Accountable Care Collaborative
- Documents related to Colorado Medical Home Initiative and related certification

Interviews were held with Department subject matter experts in the following areas:

- Medicaid and CHP+ rate setting
- FQHC/RHC Rates
- Medical Home Initiative
- Department quality measures and initiatives
- The Accountable Care Collaborative
- The Center for Improving Value in Health Care (all payer claims database)

In addition to the materials review and interviews mentioned above, stakeholder meetings also informed JSI's understanding of existing methodologies and initiatives. While the primary focus of stakeholder meetings was to gain the stakeholders' perspective on development of a PPS Plus methodology, these meetings also served to clarify how current methodologies and quality initiatives work from the perspective of FQHCs/RHCs and MCOs. They also assisted JSI in understanding past processes related to encounter payment within Medicaid Manage Care, and to understand systems issues pertaining to past and current payment methodologies and systems. Lists of meetings and participants are included in Appendices D-F.

APPENDIX B: Regional Care Collaborative Organizations for the Accountable Care Collaborative Program - PCMP Requirements

(Colorado Department of Health Care Policy and Financing, Request for Proposals RFP # HCPFKQ1102RCCO)

In order to enter into a written agreement as a Primary Care Medical Provider (PCMP) in the Accountable Care Collaborative (ACC) Program, the Regional Care Collaborative Organization (RCCO) shall ensure that the following criteria are met:

A PCMP Practice shall:

1. Be an enrolled Colorado Medicaid provider.
2. Be either:
   a. Certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children program, **or**
   b. An FQHC, RHC, clinic, or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.
3. Act as the dedicated source of primary care for Members and be capable of delivering the majority of the Members' comprehensive primary, preventive, and sick medical care.
4. Be committed to the following principles of the Medical Home model:
   a. The care provided is:
      i. Member/family-centered;
      ii. Whole-person oriented and comprehensive;
      iii. Coordinated and integrated;
      iv. Provided in partnership with the Member and promotes Member self-management;
      v. Outcomes-focused;
      vi. Consistently provided by the same provider as often as possible so a trusting relationship can develop; and
      vii. Provided in a culturally competent and linguistically sensitive manner.

   b. The PCMP Practice is:
      i. Accessible, aiming to meet high access-to-care standards such as:
         1. 24/7 phone coverage with access to a clinician that can triage;
         2. Extended daytime and weekend hours;
         3. Appointment scheduling within 48 hours for urgent care, 10 days for symptomatic, non-urgent care and 45 days for non- symptomatic routine care; and
         4. Short waiting times in reception area.
      ii. Committed to operational and fiscal efficiency.
      iii. Able and willing to coordinate with the RCCO on medical management, care coordination, and case management of Members.
      iii. Committed to initiating and tracking continuous performance and process improvement activities, such as improving tracking and follow-up on

diagnostic tests, improving care transitions, and improving care coordination with specialists and other Medicaid providers, etc.

iv. Willing to use proven practice and process improvement tools (assessments, visit agendas, screenings, Member self-management tools and plans, etc.).

v. Willing to spend the time to teach Members about their health conditions and the appropriate use of the health care system as well as inspire confidence and empowerment in Members' health care ownership.

vi. Focused on fostering a culture of constant improvement and continuous learning.

vii. Willing to accept accountability for outcomes and the Member/family experience.

viii. Able to give Members and designated family members easy access to their medical records when requested.

iv. Committed to working as a partner with the RCCO in providing the highest level of care to Members. This commitment includes data-sharing, access to medical records when requested, cooperation on referrals, participation in performance improvement activities and initiatives, willingness to give feedback and potentially participate on committees and provide clinical expertise, and use the data available to the practice to better manage Members and their health needs.

Each individual PCMP or Pod shall:

1. Be an enrolled Colorado Medicaid provider.
2. Be either:
    a. Certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children program, **or**
    b. An individual physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.
3. Act as the dedicated primary care provider for Members and be capable of delivering the majority of the Members' comprehensive primary, preventive, and sick medical care.
4. Be committed to the principles of the Medical Home model described in Item #4 above.

APPENDIX C: Availability of Measures for PPS Plus Domains

The Department has identified several criteria for acceptable measures to be used in PPS Plus*:*

- The data needed to assess performance on the measure must be available
- The measure itself must have face and construct reliability, and
- the indicator must be acceptable to stakeholders in that it is relevant/beneficial for the clients served, reasonable in, and amenable to impact through factors that are under the control of the FQHCs/RHCs.

The Department currently collects over 80 quality or health outcome measures across multiple programs and nearly 200 program or department-specific measures. The Department is in the process of soliciting feedback across departments on which measures are most meaningful,[35] and has mapped these measures with Meaningful Use and CHIPRA requirements, as well as the Department's 2010 HEDIS measures and Balances Score Card**.** The measures include client satisfaction, utilization, and quality improvement measures, as well as numerous health outcome or process indicators.

Health Outcomes

The vast majority of the indicators collected by the Department currently are related to specific disease conditions or health status and outcomes. The major clinical areas addressed include alcohol and drug dependence, asthma, behavioral health, circulatory health (heart disease, stroke, etc), diabetes, inpatient and long term care indicators, child health, and tobacco. The Department is also implementing efforts around CDOT (Caries, Depression, Obesity, Tobacco) measures, which are more focused on community-level intervention and population health.

Health process and outcome measures are collected at the program (Medicaid or CHP+) level, and not currently reported by provider or provider type. For Medicaid many of the measures are based primarily on claims data which, as discussed above, may not be fully representative of FQHC/RHC data because of MMIS limitations regarding submission of comprehensive visit data on FQHC/RHC encounter forms. The Department is working with its contracted plans to develop begin developing a plan for administering incentives based on population health improvement objectives, with the objective of tying performance measures to distribution of incentive pools. The Department gathers additional quality data through HEDIS indicators at the health plan level. The ability to generate indicators at the FQHC/RHC provider level would require aggregation across the various HMOs that an individual FQHC/RHC provider contracts with, or analysis of the aggregate data set.

All FQHCs report on prevention and chronic disease management measures as part of their Federal reporting requirements, and are working toward collection of Meaningful Use indicators. Some RHCs track prevention and chronic disease management measures as part of an internal quality improvement initiative, and/or, for hospital-based RHCs, as part of the hospital's quality improvement process, but there is no consistent set of measures across RHCs.

Patient Access
The Department currently measures the percent of clients with a usual source of care, adults' access to preventive/ambulatory health services, the percent of women receiving timely care, the percent of EPSDT eligibles receiving preventive dental services, and children and adolescents' access to primary care practitioners. This data is currently collected at the program (e.g. specific to Medicaid and CHP+ clients) and health plan level. Many of these indicators are based on claims data and face the same MMIS challenges noted above.

Many FQHCs collect data on patient access, as do some RHCs. However, there is no consistent measure currently in use across all FQHCs/RHCs. Typically this data is collected across payer categories, and is not analyzed by patient insurance category.

Patient Satisfaction
The Department currently gathers data on client satisfaction with care through the Consumer Assessment of Healthcare Provider and Systems (CAHPS) health plan survey, which is analyzed at the health plan level. The sampling strategy poses the same challenge described above for the HEDIS data in using the data for FQHC/RHC-specific measures or incentives.

FQHCs/RHCs gather patient satisfaction data, but do not typically use validated questions or tools for doing so. Typically this data is collected across payer categories, and is not analyzed by patient insurance category.

Cost Containment
The Department currently analyzes the cost per client for CHP+. The Department also tracks utilization data, such as ambulatory care, emergency room and inpatient utilization, admissions for ambulatory care sensitive conditions, generic drug utilization, and the frequency of selected procedures. These indicators are not routinely analyzed by provider type, and do not identify system savings or costs related to primary care delivery. FQHCs/RHCs capture data related to their costs and use the data to make business decisions. However, there are no cost containment indicators used consistently among FQHCs/RHCs.

In summary, a number of Department initiatives are underway to measure domains that are part of the proposed PPS *Plus* framework. Furthermore, there are several initiatives currently underway in Colorado that will facilitate future collection and use of claims and electronic health record data for quality measurement and incentives, including the development of the All Payers Claims Database.

However, the current efforts are not specific to FQHC/RHC providers, and may require a different sampling or data collection strategy to be used to allocate incentives under PPS Plus. Those with most direct relevance, including the ACC, are currently under development.

APPENDIX D: State Key Informant Interviews

Type	State	Informant	Organization	Date
PPS	Pennsylvania	Peter Adams	Pennsylvania Insurance Department	12/30/2010
PPS	Minnesota	Richard Tester, Phyllis Krautbauer	Minnesota Department of Human Services	1/14/2011
PPS	Arizona	Victoria Burns	Arizona Health Care Cost Containment System	1/14/2011
PPS	California	Elia Gallardo	California Primary Care Association	1/21/2011
PPS	Texas	Chris Dockal, Kevin Holter	Texas Health and Human Services Commission	1/20/2011
PPS	New York	John Gahan, Rick Nair (PPS), Ralph Bielefeldt, Glenn Coons	New York Department of Health	1/14/2011
PPS	Kansas	Ron Smith	Kansas Health Policy Authority	1/26/2011
PPS	Michigan	Susan Yontz	Michigan Department of Community Health	2/3/2011
VBP	Minnesota	Vicki Kunerth	Performance Measurement Quality Improvement	1/26/2011
VBP	North Carolina	Denise Levis	Community Care North Carolina	1/28/2011
VBP	Pennsylvania	Phil Magistro	State Government HIT Coordinator, Governor's Office of Health Care Reform	1/27/2011
VBP	Minnesota	Ross Owen	Care Delivery Reform, Minnesota Department of Human Services, Health Services and Medical Management Division	1/19/2011
VBP	Washington	Dr. Jeff Thompson	Medical Director for State Medicaid	2/2/2011
VBP	Oregon	Craig Hostetler	Oregon Primary Care Association	2/9/2011

APPENDIX E: National and Department Key Informant Interviews

Type	Informant	Organization	Date
National Key Informant	Dawn McKinney	National Association of Community Health Centers	12/13/2010
National Key Informant	Kip Piper	Sellers Dorsey	12/13/2010
National Key Informant	Michael Bailit	Bailit Consulting	12/14/2010
National Key Informant	Deborah Bachrach	Center for Health Care Strategies	1/21/2011
National Key Informant	Mary Takach	National Academy for State Health Policy	2/3/2011
Department Key Informants	Jed Ziegenhagen – Current FQHC/RHC Methodology	Department of Health Care Policy and Financing	12/27/2010
Department Key Informants	Gina Robinson, Amy Scangarella – Medical Homes Jim Iacino, Jerry Smallwood – ACOs Amy Scangarella, Valerie Baker- Easley, Lisa Waugh – CDOT measures	Department of Health Care Policy and Financing	12/28/2010
Department Key Informants	Sean-Casey King, Jeremy Tipton – PPS Plus Methodology Jenny Nate – CIVHC	Department of Health Care Policy and Financing	12/29/2010

APPENDIX F: Stakeholder Interviews

Organization	Interviewees	Date
Colorado Community Health Network Rate Meeting	John Sanistevan, Salud Family Health Centers Pete Leibig, Clinica Family Health Services Annette Franta, Mountain Family Health Centers Polly Anderson, CCHN Annette Kowal, CCHN Katie Jacobson, CCHN	12/6/2010
CHP+ MCO Monthly Meeting	Leslie Powers, Delta Dental Ha Houng, Kaiser Permanente Stephanie Denning, Kaiser Permanente Bethany Himes, Colorado Access Carrie Bandell, Colorado Access Jenni Sargent, Colorado Access Lynn Borup, Colorado Choice Reyna Garcia, Colorado Access Jackie Hudson, Rocky Mountain Health Plans	12/14/2011
Colorado Rural Health Center and Rural Health Clinics	Michelle Mills, CRHC Sara Schmitt, CRHC Aicia Haywood, CRHC Matt Guy, CRHC Kathryn Steele, CRHC Terry Miller, Rocky Ford Health Center Jenny Halligan, Parke Health Center	12/22/2011
Colorado Community Health Network Rate Meeting	Polly Anderson, CCHN	1/3/2011
Colorado Community Health Network - FQHC Fiscal Representatives	Bob Cunningham, MCPN Mandi Weed, Valley Wide Health Services Tom Littleton, Clinica Family Health Services Lana Barnes, Clinica Family Health Serivces Annette Franta, Mountain Family Health Centers Polly Anderson, CCHN Katie Jacobson, CCHN	1/19/2011
Colorado Community Health Network - FQHC Clinical Representatives	Pat Tellez, MCPN Chris Tonozzi, Mountain Family Health Centers Hilary Dryden, Clinica Family Health Center Katie Jacobson, CCHN Polly Anderson, CCHN Jessica Sanchez, CCHN	1/19/2011
Colorado Access	Bethany Himes, Gretchen McGinnis, Phil Reed, Gary Smith, Julie McNamara, Jennifer Zigment	1/20/2011
Colorado Community	Pete Leibig, Clinica Family Health Services	1/26/2011

Health Network Rate Meeting	Tom Littleton, Clinica Family Health Services Pam McManus, Peak Vista Polly Andersen, CCHN Katie Jacobson, CCHN	
Denver Health Medical Plan	Craig Gurule, Ron Aguilar, Mary Pinkney, Brenda Tejada	1/27/2011
Colorado Community Managed Care Network	Dan Tuteur	2/2/2011
Colorado Rural Health Center	Lou Ann Wilroy, Tommy Barnhart	2/4/2011

APPENDIX G: Key Informant Interview Guides

Key Informant Interview Guide: CHIP Prospective Payment System (PPS) Implementation

Goal:
To understand the methodologies used
To understand the transition from MA (Medicaid) only PPS to PPS for both MA and CHIP

Questions:
Methodologies

1. What is your methodology for establishing the FQHC and RHC rates?
    - How are costs established?
        - What is included/excluded in reasonable costs?
        - Are there cost thresholds in total or for specific items such administrative and overhead costs?
        - Are there productivity thresholds for determining cost per encounter?
    - For MA
    - For CHIP
2. Did you exclude or limit certain services? If so, what was your reasoning?
3. Did you design any aspects of your CHIP PPS differently than the MA one?
    - And if so, which and why?
    - If there are differences in methodology, do the rates differ?
    - If rates do differ, is that a problem?
4. What is your process for delivering payment for MA and CHIP?
    - Does it go through MCOs?
    - Is it also paid directly to Centers?
    - What is the process for these two scenarios?
5. Updating rates for both programs:
    - What is your process for updating rates?
    - What is your timeline for updating rates?
    - What are the parameters under which rates would be updated?
6. What are the reasons your state does/does not use the same methodology for CHIP and MA?
7. How did you accommodate FQHC and RHC rate requirements?
8. Which components of your methodology work best, and which are most problematic?
9. What does your rate look like?
10. Did your state overhaul the MA rate due to the CHIP PPS rate implementation?
    - If so, what was the reason for doing that?
    - What are the benefits of your new MA rate?
    - What does your MA rate look like?

CHIP PPS transition

11. Lessons learned, including:
    - Best practices
    - Transition to a new rate and its effect on the State, Centers, MCOs, and clients?

- Stakeholder involvement
- Other implementation issues

12. System requirements:
    - Changes required to implement a new methodology or switch CHIP to a MA methodology.
    - Are there other system issues of which we should be aware?
    - Did you encounter billing/payment system challenges; if so, what did you do to overcome them?
13. Were there any implementation issues that were unique to FQHCs and RHCs respectively?
14. Were there any processes that you used to engage RHCs specifically that were helpful?
15. What are the benefits and challenges of transitioning to a PPS model?
    - Programmatically
    - Operationally
16. New starts:
    - What is your process for implementing them?
    - What is your process for establishing a rate for them?
    - What has been your experience with new starts, vs. existing centers (rate setting, PPS implementation issues, harder-easier, etc.)
17. Wraparound payments:
    - How does this process work in your state?
    - What are the pros and cons of wraparound from your and the MCO perspectives?
    - How well do you feel the wraparound service works in general in your state and what are some issues CO should keep in mind?
18. Has the implementation of the new CHIP rates resulted in changes in how services are delivered?
    - For FQHCs and RHCs specifically
    - What are the intended and unintended consequences?
19. What did your state do to maximize administrative efficiencies and facilitate more rapid compliance with the CHIP FQHC PPS requirements?
20. What percentage of your MA and CHIP population do these requirements affect?
21. If CHIP only contracts with a few FQHCs, does this produce a large implementation burden?
22. Could you send us documentation of what you implemented?
23. Is there anything else you feel would be helpful to our analysis?

<u>For states with separate CHIP plans</u>

24. Which of the 3 options below (per February 4, 2010 SHO) did your state implement for paying Centers and why?
    - Adopt the same payment amounts already in place for MA (this assumes a very similar service mix for the two programs)
    - Develop a CHIP-specific PPS rate
    - An APM (assuming each individual RHC and FQHC to which this applied agreed to the methodology)

Key Informant Interview Guide: Value-Based Incentives in Medicaid/CHIP

[Before speaking with State, verify whether Medicaid/CHIP are combined or separate, review what programs the state had reported in 2007, and review where state is in relation to medical home and ACO initiatives so that questions can be tailored accordingly.]

Goal of Interview: To highlight for the State of Colorado best practices and potential pitfalls related to adoption and implementation of value-based purchasing within Medicaid and CHIP.

Definition: Value-based incentives are broadly defined as a wide variety of payments (or penalties) that a provider, health plan or hospital can receive through achieving certain goals most often in the areas of quality, cost containment, patient satisfaction and/or access to care.

Questions:

1. What is your overall strategy for transforming the delivery system for patients in Medicaid and CHIP?

2. What goals do you have or are you considering implementing to use financial incentives to achieve these goals?

3. Can you describe the nature and structure of the incentive payment program(s) in your state Medicaid and/or CHIP programs?
    a. Are incentives for Medicaid, CHIP or both?
    b. Methods used: bonus, differential reimbursement, penalty, withhold, auto-assignment, public reporting, other?
    c. Performance targets or performance relative to peers?
    d. If there are different incentives for Medicaid and CHIP, how has this affected effectiveness of or participation in the incentive program?
    e. Are there any other value-based incentives or changes to the current program that the state is exploring for the future?

4. Medical Home
    a. How are incentive payments tied to the designation of medical home?
    b. Do you have future plans to promote or incentivize medical home for Medicaid or CHIP?
    c. What system is used for certifying medical home (JCAHO, NCQA, other)? Why was this system chosen?
    d. (see Question #12 which may fit best here)

5. Who receives the incentive payments (individual physicians, managed care organizations, health plans)?
    a. If there is more than one source, how is the payment allocated between MCO's and providers. How is the "pass through" payment structured?
    b. To what degree are FQHCs and RHCs part of the organizations/practices that receive incentive payments?

   c. How does the incentive payment paid to FQHCs and RHCs relate to the PPS per-visit minimum they receive?

6. How does the state control/manage expenditure for the incentive program (capped budget, projected savings, etc.)?

7. Does the party receiving the incentive assume any risk (ex. insurance risk with global payments) or is it only upside potential?

8. What indicators/measures are used?
   a. How do you ensure accuracy and reliability of the indicators?
   b. How is the data for the indicators collected (admin data, chart reviews conducted by state, chart reviews conducted by MCOs, hybrid method… etc.)
   c. How have you overcome challenges with data inaccuracy or lack of confidence in data that is frequently associated with using administrative data for incentive payments?
   d. Did the state or providers make additions to data tracking systems to account for value-based measures? Did centers add data tracking capability to be able to report on these measures?
   e. If system changes were needed, what were they specifically, who was responsible for making changes, and who paid?
   f. Are there any best practices that you would highlight related to how measures/indicators were selected?
   g. Are there any best practices that you would highlight related to how measures/indicators have been implemented?

9. How are incentive payments determined?
   a. Frequency of data reporting
      i. How does the data get reported (directly from providers, via MCOs, via Medicaid quality entity, or something else)?
   b. Who analyzes the data?

10. How big is the incentive payment relative to the base payment for services (%)?
    a. And relative to FQHC/RHC rate (if they are different)

11. Have these incentives driven behavior change?
    a. What have been key success factors in implementing incentive payments?
    b. What are some of the hurdles you have encountered in implementing incentive payments?

12. Are there differences in rates or requirements for Medicaid vs. CHIP?

13. How does the fact that FQHCs/RHCS are paid a per-visit PPS/APM rate factor into your incentive structure?

a. Were there any specific considerations in implementing value-based incentives in FQHC's or RHC's?
b. Is there any scenario where it would be possible to actually pay below PPS if the FQHCs did not achieve quality indicators?
c. How do you account for rural issues? Including a possibly different provider mix; insufficient reporting mechanisms?

12. Are there coordination efforts going on in your state to align other activities, such as medical home, accountable care organizations, shared savings, national quality reporting efforts, EHR implementation and meaningful use with value-based purchasing?

For Shared Savings Programs

a. Does the state have plans to implement Accountable Care Organizations (ACOs) and/or shared savings arrangements?
b. How are benchmarks determined (ex. For Medicare, it is 3-year-average of FFS payments for beneficiaries assigned)?
c. What % of savings is delivered back to the ACO/providers?
d. How was this agreement negotiated?

14. Do you have any additional advice for Colorado as Medicaid and CHIP payment reform moves to embrace best practices for driving high quality and cost-effective health care?

15. Do you have any additional advice for Colorado as Medicaid and CHIP payment reform moves to embrace best practices for driving high quality and cost-effective health care?

APPENDIX H: State Summaries

Washington

Washington is focusing efforts on developing incentives for the medical home; and state officials are considering combining traditional pay for performance with some form of capitation.

History and Payment Methodology:

In March 2008, legislatures passed Chapter No. 2008-295, which established medical homes in Washington. Legislators determined that the medical home is the best delivery system for patient-centered, comprehensive approaches to health care. In the law, the legislature provided financial incentives to primary care providers that adopted the medical home model, and a collaborative program to assist with the implementation of the medical home model. Several pilot projects are being tested to determine which medical home model is most appropriate and which payment methodology is most appropriate for the medical home. These pilots are led by the Washington State Health Care Authority, and co-sponsored by the State Medicaid program and Puget Sound Health Alliance. In the pilots for medical home models, the following have been implemented: a medical home that integrates primary care with mental health and substance abuse; a medical home that collaborates with FQHCs on providing care for disabled patients who qualify for SSI, and a randomized trial that enrolls patients in different data management plans. In the pilots for payment methodology, multiple strategies are under consideration, including: pay for primary care through a capitation fee, pay for performance and other incentive-based mechanisms, diagnosis Related Groups (DRG) and case management fees, ambulatory Patient Groups (APG) and risk factor adjustments, base payment and incentives for quality, and capitation and risk factor adjustment.

Pennsylvania

Pennsylvania is developing a multi-payer payment model for medical homes within a regional chronic care framework. It is using a FFS Plus model combined with pay for performance and shared savings, and each region practices a different payment methodology.

History:

In September 2007, the Pennsylvania (PA) Chronic Care Commission was formed to evaluate how chronic care should be handled in PA. The Commission determined that the Wagner Chronic Care model should be implemented statewide. This model incorporates the medical home, multi-payer support, and is implemented on a region by region roll-out. The program was implemented in 2008 starting in the Southeast of the State with 32 practices, and gradually spread throughout the state. This roll-out took approximately a year and a half and evolved over time. Initially, each insurer paid a portion of the provider fees proportional to representation in the practice. For example, if Blue Cross Blue Shield (BCBC) represented 27 percent of the practice's revenue, BCBS paid 27 percent of the practice's supplemental payments. However, BCBS knew that there could not be proportional payments, because Medicaid and SCHIP were not participating initially payers in the regional pilot.

Payment Methodology:

Pennsylvania uses the National Committee for Quality Assurance (NCQA) certification process for medical homes. In the pilot, bonus payments were given to medical homes that used NCQA

accreditation. Because many of the activities performed to achieve accreditation were non-billable, a pot of nearly $30 million was set aside – totaling approximately $20,000 per FTE on a quarterly basis. In the Southeast, physicians were paid on a per member per month (PMPM) basis, which was validated by averaging the number of FTEs and reporting patients. The lump sum payment is split into categories. If providers showed they hired or contracted for care management, they received $1.50 PMPM for the number of patients on a quarterly basis. If the medical home achieved level 3 in the NCQA accreditation process, they received a bump up of $1.50 PMPM. The level 3 of NCQA includes the incorporation of meaningful use and quality improvement indicators.

In subsequent regions, the pilot provided more specific incentives. Eventually the pilot evolved into a more sustainable model using shared savings. The shared savings model consisted of 14 measures, agreed upon by the participating health plans and providers. Health plans evaluated the practices' performance against a core set of measures and split the savings. Depending on the indicator, the practice received approximately 40-50 percent of savings. In the Northeast, the pilot provided lump sum payments money with payout at the end. On a quarterly basis, providers received a $1.50 PMPM fee; and if the practice hired a care manager they received another $1.50 PMPM in month 4.

Minnesota
Minnesota has developed a unique approach to paying for medical homes based on the presence of chronic disease in the population. This is combined with a pre-existing pay for performance system.

History and Payment Methodology:
Medical home legislation was initially passed in 2007 in Minnesota (MN), but was expanded in the 2008 health reform law. Chapter 358 is the comprehensive health reform law enacted in MN in 2008, and health care homes (medical homes) are a key component of the law. Chapter 358 establishes health care homes for all patients in Minnesota, but in particular focuses upon patients with chronic and complex conditions. The implicit idea is that providers can better manage patients with chronic diseases, such as diabetes, cardiovascular disease or asthma. Minnesota's health care home model puts patients and families at the center of their care in closer partnership with primary care providers. Minnesota uses two primary payment methodologies: an incentive-based reimbursement program focused on outcomes, where providers are rewarded for providing high quality, low cost care; and care coordination payments. The former predates the medical home and is a traditional pay for performance payment methodology. These performance incentives are administered separately from the payment system for federally qualified health centers (FQHCs) and rural health centers (RHCs). In other words, they got paid these incentive payments on top their encounter reimbursement. For the latter, the target population of this coordinated payment includes complex Medicaid fee-for-service (FFS) enrollees. Providers in certified medical homes receive a graduated payment based on the severity of the patients' chronic disease (risk-stratified). For example, providers receive approximately $487 per patient per year (PPPY) for patients with 5-6 conditions. This payment increases as the number of conditions increases. Providers in the health care home categorize patients into "complexity tiers" based on the patients' number of chronic conditions;

and payers can audit this tier assignment. There are also add-on payments if a patient has supplemental factors, including any mental health conditions and/or language barriers. The patient's complexity tier is revaluated on an annual basis. In August 2010, the Minnesota Department of Health established its own certification process for all medical homes, based upon the Medical Home Index.

The state of Minnesota has agreed upon a multi-payer health care model; because it was agreed upon from stakeholder input that no one payer could realign incentives alone. The multi-payer model is designed to decrease administrative burden by creating common definitions for billing and coding. The multi-payer system is also working with Medicare and various private providers to maximize initiatives set forth in the Affordable Care Act.
The most unique feature of Minnesota's program is that it targets incentives to providers based upon the preexisting chronic condition(s) of patients. Minnesota believes that those with chronic conditions need the most comprehensive and coordinated of care. One of the inherent challenges in the care coordination payment methodology, however, is in the definition of complex chronic conditions. It is not always certain how much time and work are required for patients of varying complexity in a primary care setting. More research will be needed to evaluate and adapt the model over time. ,

Vermont
Vermont has a multi-payer payment system to encourage the implementation of medical homes. Vermont is combining this system with shared savings and community health teams (a provision also set forth in the Patient Protection and Affordable Care Act)

History:
The Blueprint for Health, administered by the Vermont Department of Health, originated from 2006 legislation (Act 191). This legislation established six original Blueprint Communities charged with improving health care and prevention for the most prevalent chronic conditions – the Wagner Model. In 2007, Act 71 called for a multi-payer approach, which included a mandate for commercial insurers to participate. It also included a mandate to focus on three Blueprint communities targeting all chronic conditions in adults as well as health management for general population, disease prevention, and wellness. A key component of the mandate is the incorporation of meaningful use and an evaluation infrastructure, including NCQA accreditation.

Payment Methodology:
The payment methodology is similar to Pennsylvania's in which providers are paid on a PMPM basis based upon quality improvement and the completion of NCQA accreditation. Providers receive anywhere from $1.20 to $2.49 PMPM; and these payments are scaled based on the NCQA score active case load. Medical homes in Vermont work with "community health teams" consisting of a nurse coordinator, social worker, nutrition specialist, community health worker, and public health specialist to provide the most coordinated care possible.

North Carolina
North Carolina has developed payment models to support the medical home and its community care networks. The State provides primary care practices and community care networks with per

member per month (PMPM) fees as well as other services, such as care managers and health information technology (HIT).

History:
North Carolina has one of the oldest and most successful of medical home projects in the country. North Carolina first implemented its medical home initiative in 1991 through a traditional primary care case management (PCCM) program (Carolina Access) for Medicaid beneficiaries. In 1998, an enhanced primary care case management program (Community Care of North Carolina) began as a pilot based on the Carolina Access program. Under this program, providers were required to form non-profit networks that include primary care, safety net, and specialty care providers in collaboration with the local health departments, departments of social services, and hospitals. Both primary care providers and the networks receive a per member per month (PMPM) fee to implement population management strategies (such as disease and care management and preventive services), as well as support in implementing practice improvements from Community Care of North Carolina (CCNC). Program data confirms both cost savings and quality improvement and NC is expanding the program to people who qualify for both Medicaid and Medicare (dually-eligible).

Initially CCNC paid networks the same as providers, but starting in 2006-2007, the network PMPM increased to $3 because they wanted networks to have a local pharmacist. The PMPM also later increased because they wanted to bring in psychiatrists and palliative care coordinators. The increase on PMPM was contingent on having these professionals added to the networks.

Payment Methodology:
The PMPM payments are tied to outcomes. While some quality measures are in place, the program mainly has implemented utilizations measures (e.g. readmission rates, hospitalization rates, etc.) One centralized informatics center collects information and provides reports to providers and medical homes. The Medicaid agency does its own benchmarking and data collection, which it shares with the Department of Human Services. Medicaid claims data is provided to the informatics center two times a week. A staff of twenty-four works full time to build the web based systems, case manager information systems, provider portals, etc. at the informatics center. Finally, the informatics center works closely with providers to identify the type of information they need to better manage patient care.

North Carolina also has the infrastructure in place to support ACOs. They have a pilot that will most likely be an ACO as of this summer. The demonstration will address long-term care support services, home health, personal care support, and how to integrate mental health with physical care. The program is very committed to a population management approach – stratifying the population and providing management on the highest risk and highest cost patients. Patient management happens at the network level and practice level. Clinics work closely with the networks and receive real time data from all hospitals and emergency rooms.

Oregon
Oregon is the only state combining the alternative payment methodology (APM) for FQHCs with financial incentives for the medical home. The State plans to submit a Medicaid state plan

amendment (SPA) for health centers to receive a capitated payment rate under the APM methodology.

History:
In 2008, Oregon (OR) passed comprehensive health reform legislation, with medical homes as a central provision. In 2009, this legislation was strengthened through the collaboration of the Oregon Health Policy and Research Board and the Oregon Health Authority. Under this 2009 legislation, Oregon was required to provide every resident with an integrated health care home.

Payment Methodology
Oregon has been using incentives to encourage medical homes through its Medicaid managed care organization (MCO), with its largest being Care Oregon. The Medicaid managed care plans are using FFS with PMPM payments for uncovered services related to medical homes (i.e. care management and health information technology). Health centers submit the costs of various medical home functions and can get approved for doing so under its APM. Oregon is moving towards a system where it combines capitated payment system with the APM. The State pays health centers a capitated rate/fee equivalent to the health center's current costs; while the health centers submit data to the state on the number of "touches" – or any type of patient interaction other than just visits. In addition to this, health centers provide quality metrics data to the state on access, quality, and actual costs. Health centers will be allowed to voluntarily join the new integrated model, but will not be required to. Oregon is proposing perhaps the most ambitious payment model for FQHCs in the country, by moving to a capitated system.

APPENDIX I: Stakeholder Summary Report

INTRODUCTION

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires state Children's Health Insurance Programs (CHIPs) to adopt a prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) participating in CHIP. CHIPRA requires that states pay FQHCs and RHC the BIPA (Benefits Improvement and Protection Act of 2000) PPS minimum or a rate developed under an alternative payment methodology. The Colorado Department of Health Care Policy and Financing (the Department) is interested in using this opportunity to develop a rate methodology for FQHCs and RHCs, beyond the PPS minimum that will provide incentives in the state CHIP and Medicaid programs to improve enrollee health outcomes, satisfaction with and access to care and to contain costs. This alternative payment methodology is tentatively called referred to as "PPS Plus".

BIPA establishes a payment floor, which hereafter referred to as the BIPA PPS. However, an Alternative Payment Methodology (APM) is also permitted for FQHC and RHC services**.** For example, states may opt to continue the reasonable cost reimbursement system if it does not pay less than what the FQHCs/RHCs would be receiving under BIPA PPS. Whichever methodology the state chooses, individual FQHC/RHC rates cannot be below their calculated BIPA PPS rate for that fiscal year. In addition, all affected FQHCs and RHCs have to agree to the APM for the APM to be used statewide. If all of the FQHCs/RHCs do not agree to the APM, the APM can then only be applied to the FQHCs/RHCs that have agreed to the methodology, and the BIPA PPS must be applied to those that do not agree to the APM. The Department received a grant from the Centers for Medicare and Medicaid Services (CMS) to assist with implementing the PPS requirement in Colorado's CHIP program (called CHP+) as described above, and has engaged JSI Research and Training Institute, Inc. (JSI) to assist with the process. The Department's approach to development of PPS Plus includes soliciting and incorporating stakeholder feedback in all stages of the process.

This report summarizes the feedback provided by stakeholders during the identification of national and state models for PPS implementation under CHIPRA and for Value Based Purchasing strategies that can inform the value-based component of PPS Plus. The groups identified as stakeholders for the PPS Plus project include Federally Qualified Health Centers and Rural Health Clinics, their State associations (The Colorado Community Health Network and Colorado Rural Health Center, respectively), and managed care organizations (MCOs), particularly those with both Medicaid and CHP+ lines of business, and with substantial FQHC/RHC presence in their provider networks.

Approach for Soliciting Stakeholder Feedback

JSI gathered stakeholder input through discussions at regularly scheduled meetings of stakeholders, and in additional meetings scheduled specifically to discuss relevant aspects of PPS Plus. In initial meetings with Colorado Community Health Network (CCHN), Colorado Rural Health Center (CRHC) and CHP+ HMOs in December of 2010 and early January of 2011, JSI presented the overall scope of the project and solicited input on our approach and on which

additional stakeholders to include in stakeholder interviews. Subsequent meetings provided an opportunity to delve more deeply into the relevant aspects of the proposed PPS Plus project, and to solicit stakeholder ideas and the acceptability of various options. A list of the stakeholder meetings is included in Appendix F.

The main objectives of the stakeholder meetings held to date were to:

- Understand the operational aspects of the current PPS methodologies, and the implications of changes on stakeholder systems and processes.
- Obtain input on possible quality measures/indicators that could be used for PPS, and develop a comprehensive list of value or quality measures/incentives that currently apply to FQHC and RHC providers, exploring the:
    - Degree to which stakeholders find the measures to be reliable in their construct and relevant/beneficial for the patients they served;
    - Degree to which the associated incentives are effective;
    - System/processes in place at providers and HMOs that support these measures/incentives; and
    - Relevance for PPS rate methodology.
- Understand stakeholder views about various value based purchasing approaches and challenges in implementing them.
- Understand the support stakeholders would need for implementation of a new payment methodology.

JSI developed tailored interview guides for each of the stakeholder groups to ensure the exploration of the topics listed above. The JSI Project Director attended the meetings in person whenever possible, as did the Department Project Officer. In most meetings additional JSI project team members and some stakeholders joined the conversations via conference call.

This report summarizes the findings of the Stakeholder conversations held to date, and will be used to inform the development of PPS Plus options and the implementation model for the selected options. While extensive stakeholder interviews have been conducted, it is important that stakeholder input continue to shape the development and selection of a PPS Plus methodology and implementation plan. Specific methodology options had not yet been proposed when the stakeholder meetings summarized here were held. Thus, the summarized meetings focused primarily on a discussion of possible methodologies, measures and implementation approaches, and solicited stakeholder perspectives regarding their design. Once an initial set of options is developed, it will be critical to solicit further feedback on those, including on the design of the incentive payment, and on the value-based measures for each option.

FINDINGS

Overall Observations from Stakeholders about PPS Plus Implementation in CHP+
All stakeholders commented on the fact that a very small percentage of FQHC and RHC patients are CHP+ enrollees, which creates challenges for building a quality incentive program around CHP+.

Among RHCs, CHP+ patients represent only approximately 1.4% of their unduplicated patient population. RHCs may be opting out of the program because the administrative burden of submitting and tracking such a small number of claims. CRHC noted that overall, Medicare and Medicaid combined account for between 40%-50% of RHC's total payer mix, while commercial insurance accounts for about 30%. CRHC noted, however, that an increase in reimbursement for services provided to CHP+ enrollees may result in greater interest on the part of RHCs in CHP+ participation. Currently only 9 RHCs are CHP+ providers, which could be due in part to the current low reimbursement rates; CHP+ rates are currently around half that of RHCs' PPS rates..

Preferred Approach for Implementation
There was general agreement that services in Colorado Medicaid and CHP+ are similar enough to support using the Medicaid rate in CHP+. Both FQHCs/RHCS expressed the need to bring CHP+ payments closer to their costs for providing CHP+ services, and felt that implementing the PPS rate would be very helpful in that regard

Stakeholders voiced a preference for having the same encounter rate apply for both Medicaid and CHP+. Both providers and MCOs felt that it is administratively easier to implement and budget for one rate.

- Providers preferred one payment system for Medicaid and CHP+.
- While the Department initially considered an enhanced FFS under CHP+, FQHCs preferred one payment rate across all CHP+ payers.

In contrast to the agreement that the same rate should apply to both Medicaid and CHP+, FQHCs expressed a strong preference that any value-based payment methodology should apply only to CHP+, and for amounts above the BIPA PPS. FQHCs as a group are not in favor of implementing a value-based payment component within the existing Medicaid PPS methodology at this time.

In terms of provider receipt of payment through MCOs:

- FQHCs prefer that the Department establish the encounter rate which is paid to FQHCs by the MCOs on a prospective basis, and that the Department makes the MCOs whole on the back end through reconciliation. Stakeholders felt that the selected process should minimize any payment delays, and therefore should not include a reconciliation process between FQHCs and HMOs/State.
- CRHC advocates minimizing any administrative burden related to encounter identification and payment on RHCs.

- At least one FQHC preferred receiving a flat encounter rate from MCOs, rather than attempting to layer a wrap-around payment on top of capitation payments currently received.

System Considerations

The selected PPS Plus methodology would most likely be implemented within the existing CHP+, Medicaid, and MCO claims processing and payment systems. Thus, it is important to understand the degree to which existing systems can support encounter-based and value-based payments, and capture indicators related to the proposed measure domains. Stakeholder input on system issues are as follow:

Observations on Current and Past PPS Systems:

Both FQHCs and RHCs perceive the current process for identifying rates, including the requirement to submit cost reports, to be straightforward and acceptable. However, stakeholders noted that the current PPS Methodology does not keep up with their actual costs and perceive there is not a process for a change in scope within the current PPS Methodology[4]. The three-year timeline for rebasing limits the ability of FQHCs to catch up costs with change in scope. While the lag time has insulated the Department from big rate increases, this is an issue the Department could consider addressing.

The MCOs interviewed have past experience with encounter-based payment, and stated that their systems could accommodate paying on an encounter basis for CHP+.

- Both MCOs interviewed (Colorado Access and Denver Health Medical Plan) indicated that they could capture the same level of claim detail for CHP+ as is currently being captured, even when switching to encounter-based payment. Further, Colorado Access indicated that it is able to process encounters regardless of whether they are reported through institutional (UB04) or professional (HCFA 1500) claim forms.
- However, one MCO preferred that FQHCs bill the State directly to receive their encounter rates.
- Denver Health Medical Plan and Colorado Access both noted that in the past they have faced challenges keeping up with changing FQHC/RHC encounter rates. Rates are not always distributed to MCOs in a timely fashion after updating, and in some cases the rate finalization can be delayed. Because the new rate applies back to the beginning of the FQHC fiscal year, or the calendar year for RHCs, MCOs face financial liability when rates changes are implemented late.

In order to accommodate encounter payments under CHP+, MCO systems would need to identify, from submitted claims, groups of services that constitute an encounter. MCOs noted that it would be necessary for the Department to provide clear definitions guidelines and procedures for implementing an encounter payment. Specific items mentioned include:

  - A clear, operationalized definition of an encounter.

[4] Colorado's current PPS methodology does provide a way for FQHCs/RHCs to request a modified rate based on a change in scope, but that provision has not been utilized.

- Clear guidelines/requirements of FQHCs/RHCS regarding how and on what form(s) they are required to submit claims.
- Clarity on what services would be paid outside of the encounter rate (in-office lab, for example).
- Timely notices of revised FQHC encounter rates.
- Guidance on how to handle services that are currently paid with bundled payments (for example, OB/Delivery).

MCOs and FQHC/RHCs alike noted that current systems, should they be used to make incentive payments, must capture related data fields correctly, and that providers must enter the data correctly. Several related challenges were identified:

- The Medicaid MMIS system does not uniformly allow providers to submit visit detail with encounter claim forms. Systems modifications may be needed to ensure the same problem does not occur when CHP+ claims are paid on an encounter basis.
- Because of MMIS system issues, providers do not always report comprehensive visit detail on claim forms, resulting in missing data.
- FQHCs and RCHS alike noted that enrollment delays impact participation in CHP+: for example, patients do not always receive timely notice that they are enrolled in Colorado Access CHP+, and may not receive their member cards until their eligibility span is almost expired.
- The eligibility web portal and the Colorado Access system for the state managed care plan often have conflicting eligibility and enrollment information, making it difficult to assume responsibility for patient care.
- Some providers, especially within RHCs, face challenges in coding and billing accurately. In many cases, their lack of knowledge may lead them to under-represent the services they are providing, and would thus be unreliable if used for a quality measure.
- Individual providers, and in particular RHCs, often do not have the systems or staff resources to report quality measures. CRHC noted that they are currently investigated the development and operation of a centralized data bank that could produce this information for individual RHCs and across all RHCs.
- In terms of limitations within the current CHP+ system, RHCs noted that CHP+ payments made through MCOs are often delayed. One RHC noted that Medicaid's reimbursement process would be a good mode for CHP+: Medicaid's reimbursement process is efficient, the turnaround timely, and the explanation of benefits system effective.

Stakeholder Input on Value-Based Purchasing Mechanisms

Overall, stakeholders' interest in and readiness to engage in value based purchasing varies considerably. There is general recognition that value-based purchasing is the emerging payment model. While individual FQHCs/RHCS may have embraced the move toward value-based purchasing, for both FQHCs and RHCS as group the move toward value based purchasing is a major cultural shift. Additionally, it requires infrastructure and practice models that exist at very different levels across FQHC/RHC providers.

Some FQHCs feel that strongly that the current PPS payment methodology allows for a full range of services (case management, translation, etc.) to be provided that already secure high quality outcomes. In effect, the State is currently paying for good clinical and business processes but the existing data systems don't allow for matching of investment with outcomes. They expressed concern that changes to the encounter rate upon which clinics rely heavily, could result in reduced services and quality of care. Nonetheless, FQHCs/RHCs were open to exploring a variety of approaches.

CRHC and RHCs expressed concern that many RHCs do not have the data systems needed to engage in value based purchasing. Many RHCs do not have electronic medical records systems, and some are barely functioning on an electronic billing system. Because of their size and the structure of their practices, many RHCs have not had the opportunity to engage in or leverage other resources or initiatives focused on health care quality. One example cited by RHCs is the Federal Meaningful Use rules, which have payment incentives built in. Many RHCs are not eligible to receive the incentive payments due to the current requirements in the rules on practice size and payer mix. There are concerns that most RHCs will not be able to make the investments needed to achieve meaningful use standards by the established deadlines.

Through CCHN, FQHCs have agreed to explore the incorporation of a value based component in CHP+ PPS, but there is not agreement to apply the same value-based component to Medicaid. Some FQHCs have invested heavily in redesigning their systems and are anxious to move away from a fee for services system toward a robust quality based payment methodology, and would like to see more aggressive goals from Department in this regard.

Representatives from CRHC strongly felt that the quality payment should be on top of the PPS, rather than integrated into the rate, and that the difference between the BIPA minimum and the APM should not be subject to a value-based payment methodology. They also emphasized that the administrative burden for any payment system should be kept at a minimum. A change to encounter-based billing is not a major concern, as most RHCs do have the capacity to bill on an encounter basis and are doing so under Medicaid. However, there is concern that the administrative resources needed to make any other required changes would be burdensome in relationship to the low volume of CHP+ patients and claims at RHCs.

Stakeholders made the following recommendations regarding the structure of value-based incentives:

- Overall, there was a consensus that the Department should focus on a few measures, and that these incentive parameters should be clearly defined up front to allow for providers to verify them against their own system.
- Providers should be incrementally rewarded for positive outcomes, over longer time periods. Representatives from Denver Health pointed out that improving overall health outcomes is a long process, and the timeframes for expected improvement in measures should reflect that.
- Several FQHCs urged the Department **not** to use less rigorous performance measures so that all FQHCs/RHCs could reach them or participate equally in the incentives. Rather, lagging centers should be encouraged to improve their health outcomes.

- Representatives from Clinica Family Health Services suggested a phased approach, as many systems aren't yet able to support value-based purchasing strategies. This phased approach would first implement a fair reimbursement, then would subsequently incentivize performance measures, and would ultimately implement shared savings.
- Some stakeholders felt quality targets should facilitate transition to a model in which system savings can be shared. Such models allow for additional amounts to be paid to FQHCs/RHCs while maintaining budget neutrality.
    - If HCPF found there were cost savings resulting from capacity building or other incentives, a shared savings system should be created.
- The performance measures used should be good for both enrollees and the budget.
- National Quality Forum (NQF) quality measures were seen, by physicians in particular, as being generally acceptable measures because they are clearly defined and have been validated over time[5].
- Cost containment measures must be coupled with a patient lock-in that requires patients to see their assigned providers, so that the provider can effectively manage the patients' care.
- Primary care providers should not be held responsible for systems measures, like emergency room utilization, unless there are corresponding systems changes (e.g. disincentives for inappropriate utilization) that support primary care efforts to change utilization patterns.
- Colorado Community Managed Care Network (CCMCN, an FQHC association that has assisted its members with managed care participation and supports clinical quality improvement programs on their behalf) felt that, were cost savings agreements to be implemented as part of PPS Plus, long-term cost savings agreements should be separate negotiations between health centers and MCOs.
- All stakeholder groups expressed doubt over whether the volume of CHP+ patients is large enough for incentives to be effective in achieving changes in practice models. CRHC in particular felt that quality incentives would need to involve populations beyond just children in order to capture the attention of RHCs.
- Due to the relatively small number of CHP+ enrollees in individual practices, there should be some consideration given to the level at which incentives would be most effective. Specific stakeholder recommendations include the following.
    - In an MCO structure it is important to allow MCOs to maintain some control over performance measures and payment methodologies.
    - Increased passive or default enrollment can be an effective incentive at the MCO level.
    - Several stakeholders also felt it important for the Department to align any new performance measures with those being requested by other payers or initiatives within the Department/State.

[5] NQF recently retooled over 100 measures into "eMeasures" and is developing an authoring tool that can be used by measure developers and electronic medical record system vendors to report out measures from EMRs/data warehouses.

  - Representatives from CCHN felt it is not acceptable to have CHP+ MCOs working on different quality measures.
  - At the provider level, effective incentives could include a decrease in administrative burden, (for example, in the claims submission process) which make Medicaid more efficient and FFS providers more likely to participate in the program.
- When asked about the possibility of pooling the difference between the current PPS and APM and having health centers compete for the incentives, stakeholders felt such an approach would only work if the pool were big enough to potentially offset each provider's potential losses. This approach is less desirable because it would force providers to compete with each other just to get their costs covered.

Stakeholder Input on Domains and Measures for PPS Plus

One stakeholder noted that for children, 80% of whom are healthy, the issue is not reducing the inappropriate care or system use seen with adults, but rather incentivizing appropriate use of preventive care. Any effort focusing on children would, therefore, use different measures than for the adult population.

CCHN/FQHCs suggested looking at the intersections between the Medical Home Index, NCQA, Meaningful Use, and UDS measures to find measures that are already being implemented, and appropriate for PPS Plus. They noted that HEDIS measures are not emerging as the key measures for the future. Some potential measures for children that many health centers are measuring include:

- 2 year old immunizations;
- Asthma treatment and control;
- Obesity for children age 2-17;
- Dental caries and screening;
- Tobacco Use; and
- Access to and continuity of care.

Some of the above measures are operationalized differently across providers, including access to and continuity of care. Other measures that are being tracked, although with less consistency across clinics are:

- Provision of counseling for nutrition and exercise;
- Conduct of developmental screenings; and
- Conduct of mental health screenings (SBIRT) for children 12 and older.

MCOS are currently working on ways to measure and report on the Department's CDOT (dental caries, depression, obesity and tobacco) measures. MCOs noted that the ability to impact a particular measure depends on clear assignment of enrollees to a practice, and on their eligibility matching that assignment. This is especially true for newborn visits which cross the time span for switching from the State's managed care network to MCOs.

- Colorado Access noted that there have been challenges tracking cost containment measures within the CRICC program, (Colorado Regional Integrated Care Collaborative, in which Colorado Access serves as case manager for approximately 2000 Medicaid fee-

for-service patients with chronic conditions and high utilization), with matching MCO data with data in the State MMIS system.

Stakeholders reported tracking the following measures at the MCO level:

- For the CRICC program Colorado Access is tracking:
  - emergency room utilization'
  - hospital readmissions;
  - increased utilization of primary care physicians.
- For Medicaid Choice, Denver Health Medical Plan is tracking:
  - telephonic depression screening;
  - appropriate developmental screening for children;
  - preventative cancer screening;
  - well visits for children; and
  - screening for diabetes and hypertension.
- FQHCs participating in the (Colorado Associated Community Health Information Exchange) CACHIE initiative are tracking the following measures related to children:
  - Immunizations; and
  - Chronic disease management (i.e., asthma) that show adherence to a guideline-based metric.

CCMCN suggested tracking capacity building measures for structural changes in practice, such as achieving certification as a medical home, as well as pay-per-performance measures for adherence to guidelines.

CRHC notes that because RHCs, unlike FQHCs, are not required to report a specific data set to the same funder, there is greater variability in what they are doing related to quality measurement and indicators. However, CRHC is providing technical assistance to twenty-two clinics in the Southeastern quadrant as part of a Colorado Health Foundation grant, and each of those clinics is conducting a quality improvement project. Eleven participating RHCs are collecting and measuring outcomes data.

Stakeholders were asked about their involvement and experience with current value-based efforts at the Department, and the potential of building off of them for the PPS Plus methodology.

- FQHCs noted that the payments received under CHP+ for the Colorado Medical Home Initiative do not produce a real incentive for practice change, because the payments are not linked to information about the reason for payment or how it was earned. Often individual providers are not made aware of the payments. Also, the payments are relatively small.
- FQHCs noted that most providers are pursuing NCQA certification for Medical Homes.
- Several FQHCs stated that the processes in place for the Colorado Medical Home Initiative (MHI) are cumbersome and duplicative. Barriers include the MHI's intensive process, including the requirement for a site by site certification and annual renewal, and the fact that payment incentives cannot be made to FQHCs for visits provided to Medicaid patients due to MMIS system limitations.

Capacity and System Considerations
Stakeholders shared the following perspectives regarding the capacity and system considerations at the Department, MCO and provider level that might impact the implementation of a PPS Plus methodology.

Measurement and Reporting of Indicators
- MCOs noted that conduct of chart reviews, such as those done for HEDIS measures, are very resource intensive.
- FQHCs expressed concerns about the data and systems available at the Department level to track process and outcome measures, and to make data available in real time to support quality improvement related to the indicators.
- Stakeholders are particularly concerned about the limitations within MMIS to accurately capture service level data for FQHCs and RHCs.
- MCOs noted that it has been challenging to map their data with MMIS data to identify system savings, and lags in claim processing can make calculation of measures difficult.
- FQHCs noted that it would be acceptable to have different reporting mechanisms for different payers, as long as the measures themselves are consistent and standardized.

FQHCs noted that the CACHIE initiative is developing capacity to capture and report on variety of indicators in real time, across payers, for all FQHCs and will eventually be well positioned to serve as a data source for measures such as those proposed in this project. Similarly, the CRHC is in the process of developing a centralized data center for Rural Health Centers, although its development is still in the planning stages.

Patient Assignment
Both MCOs and FQHCs expressed concern that the transition of CHP+ enrollees from initial enrollment in the CHP+ State Managed Care Network to final enrollment in one of the participating MCOs is not clearly represented in the system or communicated to plans/enrollees. Additionally, it appears that the transition does not transpire when it is supposed to, or is being reflected differently in Department and MCO systems. As a result, providers are less able to identify the population for which they are being held accountable for. These challenges would have to be addressed in any measurement methodology.

CONCLUSION AND NEXT STEPS

Overall, stakeholders expressed interest and commitment in working with the Department to develop a PPS Plus methodology. The primary issues raised during conversations with stakeholders that will need to be addressed in development of the PPS Plus Methodology include:

- Agreement upon a scope for the PPS Plus methodology, including whether it will apply to CHP+ and Medicaid, and whether the focus will be on children only or children and adults.
- Development of a payment methodology that can be implemented across the current range of provider capabilities and systems.
- Development of a payment methodology that is both financially beneficial to FQHCs/RHCs and supports the Department's strategic goals.
- Agreement on a set of indicators that can accurately measured and reported on a timely basis, despite existing system and measurement challenges, and that will be relevant for FQHC/RHC patients and practices.
- Identification of effective and administratively streamlined processes through which PPS Plus can be implemented, and incentives paid.

The stakeholder conversations summarized in this report provide a foundation for the development of PPS Plus methodology options, including the types of indicators that would be considered. All stakeholders expressed interested in and commitment to providing additional input on the design of the methodology and identification of specific indicators during the next phases of the project.

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