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

Options and Gaps Report

Submitted by:
JSI Research & Training Institute, Inc.

February 22nd, 2011

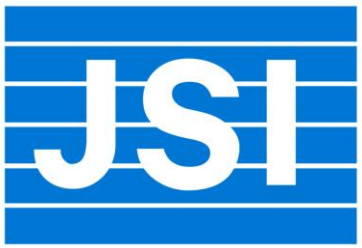

Table of Contents

INTRODUCTION

The purpose of this report is to present the Department of Health Care Policy and Financing with an initial set of options for implementing a new reimbursement methodology, PPS Plus, for Federally Qualified Health Centers and Rural Health Clinics under Colorado's Children's Health Insurance Program and Medicaid. This report, through its analysis and discussion of an initial set of potential options and the related gaps and challenges, will facilitate the selection of a smaller set of options for more in-depth analysis to include rate development, impact, and cost estimation.

The Department of Health Care Policy and Financing's (the Department's) mission is to improve access to cost-effective, quality health care services for Coloradans. Over the past several years, the Department has laid the foundation for linking 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 (PPS) 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 Children's Health Insurance 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 value-based domains identified by the Department are health outcomes, patient access to and satisfaction with care, and cost containment. To be acceptable under Federal regulations, PPS Plus must meet federal requirements for FQHC/RHC payment methodologies and be agreed upon by FQHCs and RHCs in the state. In order to meet the Department's objectives it must also include a value-based payment system that is methodologically sound and fiscally sustainable.

In order to inform the state's approach to CHIPRA PPS implementation, JSI conducted research on PPS requirements, 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, state Medicaid/CHIP programs, and key Department staff to identify pertinent national trends and understand the experience of other states with PPS implementation in CHIP and value-based purchasing strategies and methodologies.

Based on this research, JSI is has developed four PPS Plus methodology options for moving from the existing PPS payment model to value-based purchasing. The models are not an exhaustive representation of options, but represent prototypes on a continuum of low program

impact to high impact. Each option is described in terms of its scope, payment model, quality and efficiency indicators, incentive structures, and financing.

This report first describes the various considerations in methodology design, detailing the range of choices for each aspect of the model. We then present the four prototype options and summarize the rationale for each. Following the description of the options is a discussion of the gaps between current systems and the proposed options, and a discussion of next steps for selecting a sub-set of options for further exploration and analysis.

OPTIONS

Four prototype options are presented below for consideration by the Department**.** These are intended as initial options that inform the Department's selection of a smaller set of options for more in-depth consideration and analysis. One of most important considerations in this decision making process is deciding which option will help the Department achieve its goals relative to PPS Plus. It may be helpful to re-affirm the objective of PPS Plus within the Department and with stakeholders at this stage. Of particular importance is clarification of whether PPS Plus is intended to drive toward FQHC/RHC payment reform, or whether it is intended to serve as a support for other payment reform efforts involving FQHCs/RHCs.

We refer to the options as "prototypes" because they do not represent the entire spectrum of possible options. Rather, they represent distinct approaches, individual components of which could be modified, so long as such modification does not change effectiveness of the approach. Based on its review of the options the Department could choose to:

- Implement one of the options as described, in its entirety,
- Begin with one option, and shift to another over time,
- Give clinics a choice of two options, allowing clinics with necessary care infrastructure to move forward to a more advanced payment model, or
- Implement portions of one option, and phase in the option's other components over time.

If choosing a phased approach, it will be important to ensure that the components implemented at any given time both hold together and also provide impetus for the implementation of the other components over time.

In this section the elements of the design are described, followed by a description of the four prototype options (hereafter referred to simply as "options").

Options Elements and Design

Building on information from national experts, other states, and Colorado stakeholders, JSI has developed an initial range of options that meet the following criteria:

- Inclusion of a value-based purchasing component,
- Applicability for both Medicaid and CHP+ (with the exception of one option),
- Feasible implementation in relationship to the PPS requirements for FQHCs/RHCs,

- Alignment of indicators and approach with other Department initiatives related to payment reform, including the Accountable Care Collaborative and Medical Home Initiative,
- Consideration of stakeholder perspectives and preferences, and
- Efficiency of design (e.g. the least complexity possible to achieve the desired results).

All of the options presented begin with the assumption that FQHCs/RHCs will be paid at least their BIPA PPS encounter rate,[1] and that it is desirable to employ value-based purchasing strategies that will increase value both to Medicaid/CHIP enrollees and to the Department as a purchaser. All options provide the opportunity for FHQCs/RHCs to attain reimbursement levels that are equal to or greater than those available under Colorado's Alternative Payment Methodology (APM). However, models differ in regard to some of the characteristics described below.

Scope. The Department desires to implement a payment model that will apply to both Medicaid and CHP+. The impetus for developing a PPS Plus model is the required implementation of a PPS model in CHP+. Implementation of PPS Plus will, for most FQHCs/RHCs, represent an increase in payment over current CHP+ fee-for-service (FFS) rates, and stakeholders are open to exploring how that increase can be used to support value-based purchasing. The addition of new dollars provides a ready opportunity for a new approach within CHP+. However, within Medicaid, no parallel "increase" is available, and subjecting a portion of the current FQHC/RHC encounter methodology to a value-based model would represent a significant shift by putting current cost-based reimbursements "at risk." Thus, only one option applicable to CHP+ is included.

It is important to note that the scope of the value-based purchasing model is of critical importance to its impact. CHP+ represents a very small portion of both patients and revenues for both FQHCs and RHCs. Approximately 4% of FQHC patients and less than 2% of RHC patients are enrolled in CHP+. Conversely, Medicaid is the largest insurance category (after uninsured) for FQHCs and one of the largest for RHCs. A PPS Plus approach limited to CHP+ may lack the impact needed to motivate change, and may cost providers more in terms of resources than is seen in terms of benefits. Including Medicaid in the new rate methodology allows for greater impact, but may require more effort to garner stakeholder acceptance.

Payment Model. As described in the Review and Research Report, there are three major payment models used in value-based purchasing: pay for performance,[2] shared savings,[3] and

[1] 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 is inflated annually by the Medicare Economic Index but the inflated amount has generally 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. 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.

[2] In pay for performance systems, individual providers or provider groups are paid for meeting quality metrics over a specified time period. The most common approach to pay for performance is to pay providers a bonus payment for meeting quality metrics or thresholds. Although pay for performance programs have historically used quality metrics, they have begun to incorporate measures of

global payments.[4] Because PPS Plus will apply to FQHC/RHC services only, and because of the potential downside risk to providers, global payments are not included in any of the options. The presented options use a combination of the established encounter rate with pay for performance and/or shared savings, referred to as 'blended payment.'

Incentive Design. The incentive design describes how the payment model will be paid to FQHCs/RHCs in relationship to the selected indicators. All of the model incentives, made through bonus payments for achieving the selected indicators, are above and beyond the agreed upon base payment.

A range of rate/payment methodologies could be used to deliver the bonus payments. Mechanisms for making the payments could include:

- Lump sum payments made from the available dollars on a quarterly or annual basis, based on attainment of indicator targets (either a fixed amount or a per-member amount),
- Per-member-per-month payments made once a FQHC/RHC has attained a certain benchmark or certification,
- Incentive dollars distributed based on attainment of indicator targets. These could be assessed and applied retrospectively or, to allow for more budgeting consistency, applied prospectively (i.e., applied in the upcoming fiscal year for targets attained in the current year),
- Payment for a specific service provided either on a per-visit basis, as an in increase to the encounter rate, or in an annual lump-sum payment. Examples might include a per-visit incentive payment each time an e-visit or otherwise uncovered service (i.e., nutritional counseling) is provided. Other examples include increasing the encounter rate for medical home certification or achievement of benchmarks related to certification.

Another consideration in the incentive methodology is whether each FQHC/RHC will be compensated proportionally to its stake in the progress, or whether all incentive dollars available will be pooled and distributed based on some other criteria (i.e., percent of total patients). This is an important consideration for options financed by the difference between the BIPA PPS minimum and the APM (or some portion of it), because this differential varies significantly across FQHCs and RHCs. Pooling allows for the practices with the highest quality to be more highly rewarded, and additionally allows equal opportunities for providers to earn comparable incentives for meeting a given target. However, pooling also could have significant negative

physician practice efficiency. Several limitations of existing of pay for performance programs have been widely discussed including, among others, inaccurate quality metrics and incentives levels of payment that are too low to change provider behavior.

[3] Under a shared savings system, a 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. Shared savings approaches are designed to give provider groups incentives for efficiency improvements, without assumption of risk. Some experts believe that shared savings approaches must institute access and quality incentives to prevent the risks of under treatment.

[4] 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 savings 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. 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 and require achievement of quality measures.

implications for those providers with the greatest difference between the BIPA PPS minimum and their APM, should they not be able to achieve the targets required to earn the incentives.

Financing. There are no "new" state dollars that can be allocated to finance PPS Plus at this time. However, Colorado has recognized the importance in the long-term of supporting primary care as a mechanism for saving overall health care costs. Thus, the financing that can be leveraged includes:

- The difference (or some portion of the difference) between the BIPA PPS minimum and the APM for each FQHC/RHC, aggregated.
- Shared savings as a result of providing better more comprehensive care. One example is the medical home model; while savings are not realized within the primary care setting, states using this model have accepted the argument that systems savings will accrue. This is the basis under which the ambulatory care visit payments are made under the Colorado Medical Home Initiative (MHI), and for funding the per-member-per-month (PMPM) in the Accountable Care Collaborative (ACC). While the same rationale can be applied for PPS Plus, it is important to note that many of the same providers are or will be involved in the ACC. It is also important to understand whether the full savings are already being allocated to support ACC or whether the savings are available to support PPS Plus.
- Discrete savings that are redistributed. For example, this could include reduced savings due to generic drug use (over brand name), or reduced Emergency Department and hospital admissions compared to a benchmark.
- Federal dollars such as increased Federal match for Chronic Care Medical Home implementation, or other HRSA grant funds anticipated to be made available through the Affordable Care Act implementation.

It is important to note that where a portion of existing funds is used to create the incentive (as in a pooling of the difference between the BIPA PPS minimum and APM amounts), both winners and losers could be created. This effect could be reduced by drawing from only a portion of the difference between the BIPA PPS minimum and APM for the incentive pool, up to a specified dollar limit.

The financing mechanism used will impact the overall pool of dollars available, and will in turn make some of the options more attractive and feasible. It would not be reasonable for FQHCs, RHCs or the Department to invest considerable resources into measuring indicators or administering payment methodologies if the total number of dollars available is not sufficient to justify the effort. The models that include financing from shared system savings or efficiencies provide an opportunity to expand the available dollars. However, the amount of additional funding available depends on the specific indicators agreed upon and the degree to which savings or efficiencies are realized.

Indicators. For simplification of presentation, the indicators presented in the prototype options are the same, except where the model itself requires a different indicator. For example, the options with shared savings components include cost indicators that support the identification of savings. Each option includes suggested indicators that are related to the scope of the model and support the payment methodology. The indicators included in the models are:

- Successfully in use by other states with value-based payment models,
- Most related to value (that address cost but also have a quality impact or component), and are
- Currently being collected and/or reported either by the Department or by the relevant stakeholders (MCOs, FQHCs/RHCs).

At least one indicator in each of the four quality/value areas identified by the Department (health outcomes, patient access, patient satisfaction, and cost containment) is identified for each option. However, it is important to indicate that the employment of too many indicators can result in a lack of focus. Similarly, some indicators may be very complex to measure, and the real/opportunity cost of incorporating multiple measures may end up acting as a disincentive to provider participation.

For these reasons, and because of the increased focus nationally on the medical home model, JSI has included medical home certification in several models as an alternative to a combination of individual outcomes, patient access and patient satisfaction measures. Medical home certification (both through NCQA and the Colorado Medical Home Initiative) requires that providers have certain systems in place, including systems to track and provide quality care to patients with chronic conditions, and systems that ensure patient-centeredness and access. Thus medical home certification can be considered a proxy for health outcomes, access and satisfaction, and is included in the models for use instead of, or potentially in combination with, individual indictors for those areas.

Health Outcomes. Because there are a limited number of health outcome indicators currently vetted for the primary care arena, process measures have been substituted for some health outcome measures.

Patient Satisfaction and Access. Minnesota has adopted two social or access indicators that fit well with the mission of FQHCs, RHCs, and Colorado's health care reform objectives: provision of services in foreign languages and provision of behavioral health services. In Minnesota's model, additional dollars are included in the per member per year medical home payment rates for demonstrated provision of those services. Foreign language service provision and ambulatory care visits are included as access indicators. Because no metric for patient satisfaction is used consistently across FHQCs/RHCs, and measuring patient satisfaction consistently across provider practices requires substantial resources, patient satisfaction with care is included only in one model.

Cost Containment. In our interviews with other states and stakeholders in Colorado, four targets for efficiency have been identified that have a high return on investment: generic drug substitution, greater adherence rates for chronic disease medications, lower rates of emergency

department visits, and lower hospital re-admission rates. The Accountable Care Collaborative is also including lower rates of certain procedures (such as imaging) as an efficiency target.

While JSI has provided specific indicators in the models based upon our research findings, the indicators included in the models are intended to be examples. The final identification of indicators will require additional discussion within the Department and with stakeholders. Before finalizing the indicators, it is important to clearly define the clinical and financial objectives the Department is pursuing and identify measures that support those objectives, and then determining what the benchmark for the measure will be (i.e., improvement against baseline, comparison to state or national averages, etc.)

Initial Options

Based upon on an extensive literature review, interviews with other states, and stakeholders in Colorado, we have developed four prototype models for moving from the existing PPS/APM payment model to value-based purchasing. Each option is detailed in terms of its scope, payment model, quality/cost indicators, incentive design, and financing. The models represent a continuum from low program impact to high impact. In other words, Option 1 represents the smallest departure from existing payment systems, while Option 4 is the most ambitious and contributes most significantly to meeting the Department's long-term goals for payment reform.

Each option has been designed with consideration for the interrelationship of its various components to ensure they function together to maximize the benefits of the option. However, the described options are intended to be prototypes, and the substitution of one or two elements from another option is also feasible so long as the incentives, measures, payment and financing models used are supportive of each other. Similarly, not all components of each option need to be implemented simultaneously. While the impact for the option will be greatest when fully implemented, phased implementation is also possible. This is recommended for options which include indicators, incentive strategies, or financing mechanisms that are not already established or agreed upon between the Department and its stakeholders. For sake of simplicity only elements of the model that are critical to the design are varied between models.

The four options are presented in Table 1 and described more fully in the following section:

- Option 1: Pay for performance in CHP+ only, financed by the difference in BIPA PPS and APM for CHP+ patients. No explicit cost/efficiency component.
- Option 2: Pay for performance in Medicaid and CHP+, with additional financing from system level efficiencies.
- Option 3: Pay for performance in Medicaid and CHP+, with additional financing from system level savings attributable to FQHCs/RHCs.
- Option 4: Option 3, layered with a shared savings model whereby FQHCs/RHCs keep any efficiency savings at their FQHC/RHC.

Table 1. Initial PPS Plus Model Options

Option	Scope	Payment Model	Possible Indicators for Incentive Payment	Incentives	Financing
1	CHP+ only	Encounter Plus	• Certification as children's medical home (with NCQA or MHI standards) as a way of patient access, satisfaction and outcomes. or • Specific indicators for children: - Health process: obesity screening - Access: ambulatory care visits	• Per-member-per-month (PMPM) paid for medical home (MH) certification or for attainment of thresholds for other indicators	• Difference between PPS and current APM for CHP+ Encounters
2	CHP+ and Medicaid	Encounter Plus	• Quality related to adult medical home (with NCQA or MHI standards) or • Specific indicators: - Health process: hypertension or diabetes control; obesity screening for children and adults - Access: ambulatory care visits for adults and children; language access • Cost/Efficiency: generic drug substitution	• PMPM paid for MH certification or bonus payment for achieving targets • Bonus payment for a portion of total efficiency or costs reduction	• Difference between PPS and current APM for CHP+ encounters • Percent of difference between PPS and APM, up to a specific dollar amount • Systems savings attributable to FQHCs/ RHCs
3	CHP+ and Medicaid	Encounter Plus	• Quality related to adult medical home (with NCQA or MHI standards) or • Specific indicators - Health process: hypertension or diabetes control; obesity screening for children and adults - Access: ambulatory care visits for adults and children; language access • Cost/Efficiency areas defined by Department: - Generic drug substitution; adherence to medications; ER utilization; reduced hospitalizations	• PMPM for achieving MH or bonus payment for achieving targets • Bonus payment for portion of system savings	• Percent of difference between PPS and APM up to specific dollar amount • Systems savings attributable to FQHCs/ RHCs
4	CHIP and Medicaid	Encounter Plus **and** shared savings	• Quality related to adult medical home (with NCQA or MHI standards) and/or • Specific indicators - Health process: hypertension or diabetes control; obesity screening for children and adults - Access: ambulatory care visits for adults and children; language access - Satisfaction: patient satisfaction with care • Cost/Efficiency areas defined by Department: - Generic drug substitution; adherence to medications; ER utilization; reduced hospitalizations • Cost/Efficiency achieved at the FQHC/RHC level for projected vs. actual costs	• PMPM for achieving MH or bonus payment for quality targets • Bonus payment for portion of system savings • Shared savings for internal efficiency improvements	• Percent of difference between PPS and APM up to specific dollar amount • System savings attributable to FQHCs/RHCs • Internal efficiency savings

Option 1. The first model would affect CHP+ enrollees only and would apply financial incentives on top of the PPS minimum. As CHP+ payments represent only a small percentage of revenues for clinics, any payment reform would have only small effects on FQHC and RHC revenues. This would not provide a strong incentive to either improve quality or the efficiency of care delivery. Rather, the primary strength of this model is as a starting point in engaging FQHCs/RHCs in a value-based payment model, from which the systems and reporting experience needed to engage in a model of broader scope could build upon. Option 1 would also allow the Department to meet requirements for implementing CHIPRA on a timelier basis, while maintaining its goal of implementing value-based purchasing across CHP+ and Medicaid. This option could be part of a phased implementation approach and is offered primarily because it could take considerably more time to implement a model that includes both CHP+ and Medicaid.

Within this prototype model there are different possible metrics that be used for incenting improvements in quality and cost. As we learned in our interviews, many states are using the medical home as a proxy for quality and access measures. Rather than incenting individual quality metrics, the state can encourage medical home initiatives and overall systems transformation in the process. Specific quality, access and patient satisfaction indicators could be combined with or used as an alternative to medical home certification.

The individual quality metrics need to be scientifically valid and already in use so they may be deployed rapidly in the reformed payment model. In this model, bonus payments would be made to clinics for meeting quality and access targets, or for evidence of medical home certification. This model's primary method of financing utilizes the difference between the BIPA PPS minimum and the APM on an individual clinic basis in order to make added payments on top of the BIPA PPS minimum.

Option 2. The second prototype model is very similar to Option 1; however, it would apply to both Medicaid and CHP+, and not to CHP+ alone. Because Medicaid is the payer for a high percent of Colorado FQHC (approximately 35%) and RHC patients (approximately 30%), this model will have the potential to promote far greater changes in quality and efficiency. As outlined in Table 1, many of the same quality targets could be used in Option 2 as well as Option 1. One exception is that specific quality targets would need to focus on adults and children, and not just children alone (as in Option 1). This option also includes efficiencies from system savings (i.e., substitution of generic for brand-name drugs). The same general financing arrangements are used as in Option 1. Given that FQHCs/RHCs may resist subjecting the difference between the BIPA PPS and APM to attainment of benchmark, only a percentage of the difference, capped at an agreed-upon dollar amount, is made available as a funding source for incentives.

Projected savings from efficiency improvements could be estimated and incorporated into a pool for funding the bonus payments. This would help offset differences between clinics by reducing the amount of the APM that is set aside for incentive-based payments.

Option 3. The third prototype model is similar to Option 2 in that it applies to Medicaid and CHP+ and could incorporate many of the same features. The major difference between Option 3 and Option 2 is in the method used to calculate the incentive payment. In Option 2, a predetermined incentive amount is paid when the related target is achieved, while Option 3 uses a shared savings approach for efficiency and value improvements. The Integrated Healthcare Association in California, which has pioneered many techniques for pay for performance, is utilizing this method. In this limited shared savings approach, clinics can receive payments for all or a portion of savings that result from meeting specific efficiency improvements. In this model additional cost/efficiency indicators are included (i.e., adherence to medications, emergency room utilization, and avoidable hospitalizations) because incorporation of multiple metrics will increase the potential impact of the systems savings.

Option 4. The fourth prototype option represents the most significant departure from existing payment methods for FQHCs and RHCs. It is an important step in moving to a global payment system. In this option, shared savings of clinic efficiencies is a central component of the payment model. FQHCs/RHCs would agree upon a budget of risk-adjusted expected expenditures for the Medicaid/CHP+ population, and actual costs would be tracked. Any savings between actual and expected spending would be distributed between the Department and the individual FQHC/RHC, so long as access and quality standards are maintained. The individual clinic can choose its own targets for improvement, which have the highest value in terms of improving quality and reducing costs. Unlike global payment, there would be no financial risk for the clinic; only an opportunity for added revenues. The Department and/or MCO would continue to assume risk as they do currently. This model would introduce complexity to the process of establishing FQHC/RHC payments to ensure that they are equivalent or greater than the BIPA minimum PPS.

Shared savings approaches can be combined with traditional pay for performance related to quality and access. For example, if Colorado believes that medical homes should be available to all Medicaid recipients in the state, it could add additional per-member-per-month payments to encourage the development and spread of medical homes. Many health policy analysts believe that shared savings approaches should be combined with access and quality standards to ensure that clinics are not cutting costs by reducing services.

ANALYSIS OF CHALLENGES AND GAPS

This section discusses the gaps and challenges between current systems, operations, systems and financing that would be required under the four options above. The gaps and challenges include those for the Department, as well as those related to stakeholder systems and acceptability. These issues should be considered in the context of the Department's objectives related to PPS Plus, and the role of PPS Plus within other Department initiatives and priorities.

Interviews with Department personnel and FQHC, RHC and MCO stakeholders, described in the *Stakeholder Summary and Analysis Report*, provide the foundation for JSI's understanding of current systems and stakeholder perspectives in Colorado. Our understanding of system needs and processes for the proposed options is based on key informant interviews with national experts and with Medicaid/CHIP department staff in other states regarding value-based purchasing and prospective payment system (PPS) implementation.

The identified gaps and challenges exist at a variety of levels, including within the systems or capacity of individual FQHCs/RHCs, with managed care organizations, at the program level (Medicaid or CHP+), and at the broader systems level. The gaps fall into several broad categories: overall readiness or acceptability, financing challenges, stakeholder considerations, payment and claims systems, and indicators.

Readiness and Acceptability

A fundamental challenge is ensuring that there is a shared understanding of the objectives and scope of PPS Plus, both within the Department and between the Department and stakeholders. FQHCs, RHCs and, to a certain degree, MCOs consider the FQHC/RHC prospective payment system as a methodology for ensuring a reasonable portion of their costs for caring for Medicaid patients are covered. The prominent role of Medicaid within the FQHC/RHC payer mix results in the FQHC/RHC encounter rate being one of the only stable assumptions upon which FQHCs/RHCs can make budgetary projections and decisions. Therefore, a shift in the FQHC/RHC methodology to include a value-based payment methodology is significant. In pursuing such a shift, it is critical that the Department be able to articulate clearly what it is hoping to achieve with PPS Plus, the ultimate objective of moving to a value-based methodology, as well as the scope and timing of that effort.

Financing Challenges

There are limited new dollars available to support PPS Plus. From the FQHC/RHC perspective, payment even at the PPS rate of the BIPA minimum for CHP+ will result in additional revenues. However, only a portion of those additional revenues can be made dependent on an incentive methodology. Any alternative payment methodology put in place by the Department must ensure that FQHCs and RHCs are paid at least the equivalent of what they would be paid at the BIPA PPS minimum rate. Should the Department apply the same APM to CHP+ as is used in Medicaid, the difference between the BIPA PPS minimum and the APM could be used as an incentive. However there are several challenges with this approach:

1) *Low volume of CHP+ Patients.* The low volume of CHP+ patients within FQHCs and RHCs limits the total number of dollars at stake, and the ability of those funds to

motivate participation within a value-based purchasing mode. This is especially true if any aspect of the model requires additional administrative or clinical resources to be employed that would offset the amount available as an incentive.

2) *Variation across providers and provider types.* The current Medicaid PPS reimbursement methodology varies across provider types, and the difference between the BIPA PPS minimum and the APM varies greatly by individual providers, both within and across provider types.[5] Thus, a methodology that uses that difference to fund incentives will impact both provider types and individual providers very differently. If the methodology is designed so that each provider has the opportunity to earn that difference with the described incentives, some providers will have much greater dollars at stake than others. An alternative approach could be to pool the available amount across all provider types and distribute the pool according to each FQHC/RHC's performance. It is not clear, however, that such an approach could be implemented in a way that would be equitable. There would be very little incentive for FQHCs/RHCs that have a substantive difference between the PPS Minimum and their PPS rate to participate in such a methodology and risk loosing dollars that are needed to cover costs.
3) *Stakeholder acceptability.* The APM rate for Medicaid is lower than actual costs for most providers, so that stakeholders (namely, FQHCs) may resist putting this amount at risk as part of incentive payments.

As discussed in the Options above, there are two avenues for increasing the amount available to support a value-based purchasing model:

1) Applying the model to Medicaid as well as CHP+, and leveraging savings to support value-based purchasing. Including Medicaid in the PPS Plus model would allow the inclusion of a much greater proportion of health center patients and revenues, effectively increasing the importance of PPS Plus to providers. If the difference between PPS and the APM is used for incentives, it substantially increases the dollars available. This is also true for RHCs, although to a lesser extent, as their biggest payers are private insurers (and in some cases, Medicare). However, the same equity and stakeholder acceptability concerns listed above would still apply, and to a greater degree given, the relative importance of Medicaid as a payer for FHQCs/RHCs.
2) Leveraging additional dollars to support the incentive methodology. Other states have done this by redirecting savings from system improvements to support incentive payments, as in Option 3 where systems savings related to reduced emergency room visits are used. In Option 4, FQHCs/RHCs would retain savings they generate through their own internal efficiencies, providing a financial incentive for increased efficiency. An important consideration for Colorado in regard to using shared savings is the degree to which the savings that FQHCs/RHCs would achieve in PPS Plus are already being counted on to support the Medical Home Initiative payments for ambulatory care visits or the Accountable Care Collaborative per-member-per-month payments.

[5] For some providers, including at least one FQHC and a substantive number of RHCs, the BIPA minimum rate is typically higher than the APM. See the *Review and Research Report* for a full discussion of this issue.

Stakeholder Considerations

*Support for Value-Based Purchasing***.** While there is conceptual support for a shift to a value-based payment methodology, there is also very strong concern among FQHCs/RHCs that such a shift will result in payment that is less than the current payment, or that undermines their financial stability. There is a wide range in the degree of readiness and interest among FQHCs/RHCs to engage in value-based purchasing. Continued engagement of FQHCs/RHCs in the design of the PPS Plus model, including especially the payment mechanism and indicators involved, is critical to securing their agreement to the new APM.

*Agreement to Indicators***.** In order to move forward with PPS Plus, the Department will need to gain agreement from both FQHCs and RHCs on the quality and costs measures for the selected option(s). The following gaps should be considered:

- *Capacity:* There is a wide range of capacity within FQHCs/RHCs currently to collect and report on the potential measures identified. While all FQHCs have or are adopting electronic health records that can facilitate capture and reporting of the data, very few RHCs have adopted them. Because of their relatively small size and limited staffing, RHCs are less ready to capture and report data. Any measure that requires chart reviews to assess will require additional resources from FQHCs/RHCs.
- *Readiness:* Some FQHCs/RHCs have already invested considerable resources in clinical information systems (such as electronic medical records and data warehouses), while other have not. Thus, it is very possible that some providers will agree to an APM for the above options, while others will not. Efforts by FQHC/RHC associations to develop data warehouses that support efforts such as this are underway, but are at varying levels of development.
- *Patient Assignment:* While Medicaid and CHP+ enrollees can be assigned to specific providers, they are not necessarily restricted to that provider for their care. Thus, providers may be hesitant to agree to measures that hold them responsible for patient outcomes when the patients are not limited to using them exclusively for primary care.

Gaps in Payment and Claims Systems

Determining and Paying on Encounters. The CHP+ system is not currently designed to pay FQHCs/RHCs on an encounter basis, and the Department has not developed encounter rates for FQHCs and RHCs. All of the parties involved (the Department, MCOs and FQCs/RHCs) will need to make some changes to their systems to ensure appropriate payments and tracking. In order to comply with CHIPRA, the Department must ensure:

- Establishment of FQHC/RHC encounter rates for CHP+ that are equal to at least the BIPA PPS minimum.
- A clear definition of an FQHC/RHC CHP+ encounter that can be operationalized by the Department, MCOs and FQHCs/RHCs within billing and payment systems, and that makes clear how services that are outside of the encounter definition must be paid.
- A billing system and payment process that ensures FQHCs/RHCs are paid at least the equivalent of their BIPA PPS minimum in CHP+ by either:
    - Paying encounter rates at the time of service, or

- Establishing that payments made through other mechanisms (capitation, fee for service) equal at least what would have been paid with the BIPA PPS per-encounter minimum.

In either case, the State must have data on CHP+ encounters provided by each FQHC/RHC. This data could be generated by the Department or MCOs by analyzing visit data and converting visits to encounters, or by FQHCs/RHCs themselves by billing on an encounter basis. These systems do not currently exist for CHP+, although they have been developed within the Medicaid program and could be applied to CHP+.

Systems for making performance/bonus payments. Given the pay-for-performance component in each of the options outlined above, the Department will need to develop a methodology for making such payments in conjunction with encounter payments, or through an alternative mechanism. Because CHP+ is delivered primarily through MCOs, and Medicaid as fee-for-service, the mechanism may be different for each program.

*System for Shared Savings in Context of Encounters***.** To implement a shared savings component in PPS Plus, the Department will need to develop with stakeholders a methodology for determining the scope of services and the risk adjustment that will be used to determine the cost benchmark against which savings will be measured, and the methodology for distributing those savings. In addition, a process will need to be established to ensure that total payments to a given FQHC/RHC meet the Federal requirements for PPS, as well as the degree to which any shared savings should be considered in that calculation.

*Alternative Payment Methodology***.** For any of the options to be linked formally with the FHQC/RHC PPS methodology, the methodology will need to be described as an Alternative Payment Methodology and approval secured from the Centers for Medicare and Medicaid Services. One important consideration should be the degree to which the current APM, which relates only to costs, should be maintained in the new APM, or whether it can be phased out with the implementation of a new option. A further consideration is the degree to which CMS will accept a phased-in methodology, or whether the Department will need to establish a new APM corresponding to every stage of a phased-in approach. Initial research indicates that the APM methodology allows for multiple choices as long as it is agreed upon by the FQHCs/RHCs.

*Resources for Implementation***.** In addition to financing for the APM methodology itself, implementation of the methodologies will require dedication of staff resources at the Department, MCO, and FQHC/provider levels which, depending on the model chosen, may require additional funding.

Indicator Gaps

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 and beneficial for the clients served, reasonable, and amenable to impact through factors that are under the control of the FQHCs/RHCs.

There are three data gaps that will impact the options identified above: limitations in the current system capacity to consistently capture visit-level detail on encounter claim forms, limited indictors available, and variations in capacity to track and report indicators across provider types.

- *MMIS Encounter level limitations*. Technical issues related to payment of encounters through the Medicaid MMIS system limits the availability of administrative data for quality indicators. Any payment option that uses administrative data for incentive payments would need to address this gap. 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.
- *Indicator Availability*. There are a limited number of standardized indicators for each of the PPS Plus domains that are currently collected by the Department. The table below summarized the availability of standardized indicators for the domains and measure types within them. The table includes indicators collected/reported on by the Department, as well as those that are part of national data sets such as CHIPRA, Meaningful Use, the FQHC UDS data set, as these national requirements will drive data collection and focus at the provider level. It is important to note that while multiple data sets may include a measure for a specific indicator, the definitions and specifications of those measures are likely to vary to some degree.

Table 2. Availability of Standardized Measures for PPS Plus Indicator Domains

	Department Measures (ACC, CDOT, HEDIS, CAHPS)	**CHIPRA**	**Meaningful Use**	**UDS**
Health (Process or Outcomes)				
Birth outcomes		X		X
Timely Prenatal Care	X	X		X
Obesity (BMI Assessed)	X	X	X	X
Depression Screening	X			X
Childhood Immunizations	X	X		X
Patient Access				
Ambulatory Care	X	X	X	
Patient Access	X			
Patient Satisfaction	X			
Cost Containment				
Reduced ER Utilization	X			
Avoidable hospitalization	X			
Generic drug substitution	X			
Service Utilization	X			

- *Challenges with medical home certification as an indicator.* NCQA and Colorado Medical Home Initiative indicators are already in place, and could readily be demonstrated by clinics that have been certified. However, there are several related gap that must be considered.
    - Certification is at the clinic level, so that a decision would need to be made about whether the bonus payments are available for the FHQC/RHC's entire operation if a subset of clinic sites are certified.
    - The capacity of FQHCs/RHCs to engage in the certification process varies greatly.
    - The current Department certification process is supported by grant funds such that certification of many more sites in a short timeline may not be supported by existing Department resources.

- *Gaps in current data collection*. While the Department currently collects a number of indicators, there are gaps in terms of how the data can be used to implement an incentive specific to FQHCs/RHCs.
    - Health process and outcome measures are collected at the program (Medicaid or CHP+) level, and are 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 gathers additional quality, patient access and patient satisfaction data through HEDIS and CAHPS 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. Many of these indicators are based on claims data and face the same MMIS challenges noted above.
    - The Department 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 currently routinely analyzed at the FQHCs/RHCs provider level, and there are systems challenges to doing so.
    - 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.
    - Many FQHCs collect data on patient access and satisfaction, as do some RHCs. However, there is no consistent measure currently in use across all FQHCs or RHCs. Typically this data is collected across payer categories, and is not analyzed by patient insurance category.

CONCLUSION AND NEXT STEPS

This report has presented an initial set of potential options for a PPS Plus Methodology and the related implications, challenges and gaps.

The next step in the development of PPS Plus is for the Department to identify a more limited set of options for further analysis, either of the four presented or of a new option with a different configuration of the elements presented. This analysis will include rate modeling, incentive design, cost estimation, and financial impact analysis. In addition to the technical analysis of options, the next step should include additional stakeholder input and dialogue with the Department on the acceptability of the selected options and their elements to stakeholders.

The refining of options will be greatly facilitated by considering and coming to agreement on the answers to the following questions:

- What is the overall objective of PPS Plus? Is it to implement value-based payment within CHP+, to develop a value-based payment system that can be implemented across Medicaid and CHP+ over time, or to shift FQHCs/RHCs to a payment methodology that is primarily supported by value-base payments rather than encounter payments?
- Are any of the presented options immediately or obviously unacceptable?
- Is the desired result to end up with one option that FQHCs/RHCs can agree to participate in, or several options that FQHCs/RHCs might choose from?
- What is the most desirable implementation process? Is it a phased approach, or is another implementation approach acceptable? How closely should and can the indicators and incentives for PPS Plus be linked with those being used in other Department initiatives?
- How desirable and feasible is it to leverage cost efficiencies and shared savings to finance PPS Plus? What amounts would be available currently or in the foreseeable future for enhanced payments under the proposed models?

The Department's selection process for options to be explored more in-depth should take into account the Department's strategic goals and initiatives, as well as the identified gaps, challenges and stakeholder priorities.

This Report was funded by a Center for Medicare and Medicaid Services CHIPRA PPS for FQHCs and RHCs Transition Grant