



Affordable, high-quality health care -
The Washington way

July 16, 2012

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Summary

Overview

Washington state intends to submit a request to establish an Alternative Payment Methodology (APM) that enables the state to make prospective per-member, per-month (PMPM) payments to federally qualified health centers (FQHCs) and rural health clinics (RHCs), using a reimbursement methodology that complies with the intent of Section 1902(bb) of the Social Security Act. This request envisions new flexibility that may be achieved through a traditional state plan amendment process and/or waiver authority, as needed.

Clinics that choose to be reimbursed pursuant to the APM would be reimbursed at amounts at least equal to the amount they would have received under the encounter-based Prospective Payment System (PPS). Per-member, per-month payment rates under the APM would be constructed in an actuarially sound manner that achieves this requirement. PMPM rates would include the supplemental payment referenced in 1902(bb)(5)(A) of the Social Security Act and would account for unique clinic and client characteristics; provide risk corridors that account for unusual events that affect demand for health services; accommodate the impacts of changes in the type, intensity, duration, or amount of services; and provide incentives to encourage investments in efficient primary care delivery models that reduce systemic costs while maintaining or improving outcomes.

If CMS decides that the desired changes cannot be accommodated through a State Plan Amendment, Washington state requests specific guidance as to the elements of Section 1902(bb) of the Social Security Act or other federal rules that must be waived to implement such a system.

This document presents a clear rationale for the request that is supported by executive and legislative branches of state government and by the FQHC/RHC community. The need to develop and implement a payment approach that ensures the long term viability of Washington's FQHCs and RHCs is especially critical as we prepare for a major expansion of Medicaid beginning in 2014¹ and simultaneously endeavor to manage the program under continuous, compounding budget constraints. To this end, the request targets a January 1, 2013, implementation date through adoption of five key elements.

1. A reformed, prospective alternative payment methodology that focuses on patient-centered outcomes rather than encounters;
2. Maintaining the Prospective Payment System for those clinics that do not choose the alternative methodology;
3. Elimination of costly and burdensome reconciliation going forward;
4. Establishment of a five -year per capita expenditure plan that bends the health care cost curve for FQHC and RHC services; and
5. Leveraging of future savings to build primary care capacity essential for addressing the looming Medicaid coverage expansion that begins in 2014.

Shared Payment Reform Goals

Since 2008, Washington State and our FQHC/RHC partners have been engaged in conversations over significant issues with payment methods. During recent discussions, a shared view of goals has been developed to guide development of a reformed payment methodology. These goals include:

1. *Move away from volume-based purchasing that rewards more face-to-face encounters.*

The current alternative payment methodology for FQHCs and RHCs rewards volume of per person encounters instead of care coordination. A revised alternative payment methodology based on a per capita budget that is appropriately adjusted for health risk and each clinic's scope of services will encourage patient-centered care with a focus on high-quality care instead of numbers of billable visits.

2. *Build a payment system that aligns with Washington's goals for an integrated care delivery system.*

Washington has set a health policy path based on integrated care solutions with intensive care management provided through community-based entities including FQHCs and RHCs. Payment that focuses solely on the number and intensity of encounters seriously undermines these efforts and encourages inefficient investments that will continue to drive up the cost of care.

3. *End the burden of reconciliation.*

Certain federal guidance requires reconciling payments for any alternative payment methodology to amounts that would be paid under the encounter-based PPS. The annual reconciliation process required under Washington's current alternative payment methodology creates significant uncertainty for FQHCs and RHCs, and adds a costly administrative burden for everyone involved. If clinics can be reimbursed appropriately on a prospective, per-capita and actuarially sound basis, continuation of a cumbersome and costly reconciliation process becomes unnecessary.

4. *Encourage innovative payment practices that reward outcomes and provide opportunities for shared risk/savings.*

The current reimbursement methodology discourages innovation by forcing a payment-per-service mindset. A new prospective, per capita rate structure must encourage investments in efficient delivery models and help inspire shared savings opportunities as better primary care reduces systemic costs while improving outcomes.

5. *Expand the primary care workforce and optimize team-based care opportunities.*

Federal law limits the services and provider types that can generate a face-to-face, billable encounter. An unintended consequence is the constricting of primary care capacity. Payment flexibility can increase the capacity of FQHCs and RHCs to provide appropriate care to Medicaid recipients through the availability of a broader range of primary care team members operating within their training and scope of practice. Maximizing Washington's primary care workforce capacity will be critical in supporting access to care once access to coverage increases for low-income populations beginning in 2014.

6. *Move away from full reliance on face-to-face visits and encourage alternative patient-provider connections.*

The current encounter-driven payment methodology creates full reliance on face-to-face visits as a means of producing clinic revenue. Resource commitments to providing virtual medicine touches that keep patients away from the office (e.g., through phone or email connections) are now discouraged. A new per-capita, prospective payment model that links to the patient will encourage an emphasis on health outcomes, beyond the boundaries of the four walls of a clinic.

7. *Provide sufficient funding for the FQHC and RHC delivery system that helps build capacity for the 2014 expansion.*

Any new payment methodology must ensure that FQHCs and RHCs remain financially viable and well prepared for the looming Medicaid coverage expansion. In making this request to CMS, it is our intent to make PMPM payments that equal or exceed those that would have been made under the prospective payment system, and to preserve other protections for these clinics established under federal law.

8. *Flexibility to experiment with variable incentive structures that recognize varying capacity to bear risk.*

Clinics that help reduce unnecessary utilization across the whole system of care should be able to share a portion of the savings. FQHCs and RHCs have very different capacity and ability to accept risk which should be accommodated in the reimbursement system design. A flexible payment structure supports real opportunities for investments in the primary care delivery system that will increase care coordination, reduce unnecessary (costly) service utilization and improve health.

Impact of the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) will radically change the coverage continuum in Washington state as of January 1, 2014. Based on an Urban Institute simulation for Washington state,ⁱⁱ more than 500,000 adults will be newly eligible for Medicaid, with nearly 330,000 individuals likely to enroll in Medicaid by 2019. This poses new challenges for the primary care delivery system in particular if the newly eligible population arrives with significant pent-up demand for health care.

FQHCs and RHCs will play an integral role in meeting the needs of newly insured individuals, some of whom will become Medicaid beneficiaries with comprehensive coverage for the first time. Although estimates of their health status and needs suggest a population generally "less sick" than current Medicaid enrollees, FQHCs and RHCs will likely see the higher cost and higher need portions of this expansion population. Clinics have been providing care for much of this population for a long time as uninsured patients and as enrollees of the Basic Health and Medical Care Services programs. These two programs were fully state-funded until January 1, 2011ⁱⁱⁱ.

The ACA affords states with ample additional opportunities for payment and delivery system reforms geared to controlling health costs and improving the value of health care delivered. Washington State is pursuing many of these opportunities. For example, the state is eagerly pursuing opportunities under Section 2703 related to the provision of health home services as well as new coordination and integration opportunities for individuals dually eligible for Medicare and Medicaid. However, we remain convinced that expanding our Medicaid program by up to 40 percent over a few short years without fundamental changes to a predominantly fee-for-service payment system will greatly undermine the success of our Medicaid expansion. We will have also missed a unique opportunity to reduce costs and radically improve care for our clients.

This state is firmly committed to further care coordination and performance evaluation with our managed care partners yet it is clear that fundamental payment reform cannot happen independent of the FQHC and RHC delivery system.

A rigid, encounter-based payment system for safety net providers encourages increased utilization and waste and threatens the future viability of Washington's primary care delivery system. Newly insured clients will need right-sized treatment aimed at better health outcomes. The current encounter-based payment methodology will fall far short of achieving that goal. The critical safety-net mission of FQHCs and RHCs is unique, with cost-based reimbursement an imperative element. There is, however, growing agreement that creating new primary care capacity and innovative incentive structures cannot coexist with an encounter-based system that constrains flexibility. The ACA provides a renewed vision for methods of payment that improve the functioning of the health care system over the long term. For FQHCs and RHCs, this exists in parallel with assurances that critical protections for FQHC and RHC providers are maintained as intended in section 1902(bb) of the Social Security Act.

Unified Executive-Legislative Intent

The 2011 Washington State Legislature, through enactment of E2SSB 5596^{iv}, indicated support for a revised safety-net payment system. The Health Care Authority was directed to:

... submit a request to the centers for medicare and medicaid services' innovation center and, if necessary, a request under section 1115 of the social security act, to implement a medicaid ... demonstration project. The demonstration project shall be designed to achieve the broadest federal financial participation and, to the extent permitted under federal law, shall authorize the development of an alternative payment methodology for federally qualified health centers and rural health clinics that enables capitated or global payment of enhanced payments.

A little over a year ago Governor Chris Gregoire transmitted a proposal to the Department of Health and Human Services outlining actions she intended for transformation of Washington state's health care system. Included was Washington's desire for flexibility to incorporate payment innovations that would sustain FQHCs and RHCs while incentivizing quality and efficiency improvements in their delivery of health care services. In response, Health Care Authority (HCA) staff engaged in a series of discussions through the fall 2011 with a Medicaid State Technical Assistance Team (MSTAT) from CMS. This request summarizes the expectations of the Legislature and the executive branch in pursuing payment flexibility, and clarifies elements questioned during the MSTAT discussions.

Background

Current Managed Care Delivery System

The HCA is Washington state's "single state agency" responsible for administration and supervision of the Medicaid program. The HCA is also responsible for purchasing state employee benefits and oversees the Transitional Bridge waiver programs, including Basic Health.

For coverage that will begin July 2012 through December 2013, the HCA recently concluded a competitive joint procurement process with contracts being awarded to five managed care organizations^v (MCOs). These MCOs will cover about 700,000 enrollees in the Medicaid, CHIP and current Basic Health programs, establishing the infrastructure that will support a successful coverage expansion in 2014. Details of the entire competitive procurement process are available at <http://www.hca.wa.gov/procurement.html>. Through this process, the Medicaid program has advanced its path toward comprehensive coverage delivered by managed care. The full phase-in of Supplemental Security Income recipients (SSI) will culminate in more than 70 percent of current Medicaid, CHIP and Basic Health enrollees being enrolled in managed care before several hundred thousand more enrollees are added through the Medicaid expansion beginning in 2014.

The HCA makes monthly managed care enhancements to FQHCs and RHCs for each client enrolled in an MCO and served through the clinic system. The Community Health Plan of Washington (CHPW) is based on a network of community health centers, with about 68 percent of its enrollees served by the clinic system. Other MCOs also contract with FQHCs and RHCs, but reliance on that infrastructure is on a much smaller scale. FQHCs and RHCs receive enhancements in addition to the negotiated payments they receive from the MCOs for services provided to enrollees. Federal law established in Section 1902(bb) of the Social Security Act, included as Appendix B, requires managed care visits to be reimbursed at amounts equal to that of fee-for-service (FFS) encounter visits. To achieve this, the aggregate of enhancement and MCO payments ensures that FQHCs/RHCs receive total managed care reimbursement equal to their FFS encounter rate for each billable visit.

FQHC/RHC Characteristics

FQHCs and RHCs are community-based clinics that provide comprehensive primary and preventive care to individuals of all ages, regardless of their ability to pay. FQHCs meet federal health center grant requirements and are required to report administrative, clinical and other information to the federal Bureau of Primary Health Care. The most current data available cover the 2010 reporting year^{vi}. Selected data for 25 FQHCs are included in Table 1. Limited comparable data are currently available on the RHC system; however, details have been requested from the RHCs.

Additional FQHC details are included in Appendix D, which provides a snapshot of the FQHCs operating in the state in 2011, developed by the Washington Association of Community and Migrant Health Centers in collaboration with Community Health Network of Washington.

Table 1: 2009 Washington FQHC Data from the HRSA Primary Care Online Reporting Tool

Characteristic	FQHCs	RHCs
Number of facilities	25 (2010)	124 (2012)
Patients		
Number of patients served	753,269	n/a
Number of patients who used medical services	588,667	n/a
Number of patients who used mental health services	35,469	n/a
Number of patients who used substance abuse services	3,889	n/a
Number of patients who used dental services	249,755	n/a
Source of Coverage		
Percentage of patients with Medicaid coverage	43.8%	n/a
Percentage of patients uninsured	35.4%	n/a
Percentage of patients with income up to 200% of the federal poverty level	93.4%	n/a
Visits		
Total visits	3,066,033	n/a
Total medical visits	2,019,689	n/a
Total mental health visits	156,510	n/a
Total substance abuse visits	41,090	n/a
Total dental visits	656,912	n/a
Expenditures		
Total Medicaid expenditures	\$310,134,242	n/a
Total Medicaid expenditures – managed care	\$138,157,790	n/a
Total Medicaid expenditures – fee-for-service	\$171,976,452	n/a
Average Medicaid cost per encounter	n/a	n/a
Percentage of total expenditures for Medicaid managed care	31.8%	n/a
Percentage of total expenditures for Medicaid fee-for-service	39.6%	n/a

Evolution of Current Alternative Payment Methodology

Applicable Federal Statute

Payment for FQHCs and RHCs is guided by Section 1902 of the Social Security Act, which defines parameters for a prospective payment system (PPS) and includes the option of an alternative payment methodology. The original purpose of the PPS system was to prepare a forward-looking payment model that would cap the rate of growth in costs per encounter to certain inflation factors and to accommodate changes in the scope of services, and that would allow FQHC/RHCs to know their payment for care with certainty that would enable them to develop the infrastructure necessary to better manage patient care.

Prospective Payment System

The calculation and methodology used to make FQHC and RHC enhancement payments began in the mid-1990s. Through collaboration among Washington's Medicaid agency, MCOs, the Washington Association of Community and Migrant Health Centers, and the FQHCs and RHCs, a cost-ratio analysis was developed to calculate enhancement rates. Using surveys and cost reports, a cost ratio was established for each FQHC and RHC to approximate additional funding requirements. The cost ratio was expressed as the additional percentage of dollars required to meet full FQHC/RHC costs. These additional dollars were then distributed among the total number of Medicaid managed care enrollees and paid on a per-member, per-month basis.

For example, if a FQHC/RHC's total allowable costs were \$1 million per year and they received \$720,000 per year in plan premiums, they would have been owed an additional \$280,000 in enhancements. The applicable cost ratio would have been approximately 39 percent.

Until 2009, Washington did not reconcile enhancement payments. Similar to encounter rates, enhancement rates were increased annually by the Medicare Economic Index, and payments to the FQHCs/RHCs were made on a monthly basis. This methodology remained in place through calendar year 2008.

Alternative Payment Methodology 1 (APM1)

In 2006, a CMS audit found insufficient evidence that Washington's PPS methodology for making enhancement payments met the federal requirements of Section 1902(bb), included for reference in Appendix B. Specifically, we were unable to demonstrate that enhanced payments were sufficient to make each FQHC/RHC's total reimbursement for each managed care visit at least equivalent to its encounter rate.

As a result of the CMS audit finding, actuarial consultants (Milliman) were contracted in 2009 to conduct an analysis of enhancement rates. Enhancement rates were subsequently adjusted and Milliman designed a tool to update yearly enhancement rates. The tool used each FQHC/RHC's actual managed care utilization and fee-for-service encounter rate, along with appropriate trend factors, to derive a clinic-specific enhancement rate.

At the same time, in collaboration with representatives from the Governor's office, FQHCs, RHCs, and their association representatives, the Medicaid program developed an Alternative Payment Methodology (APM), as allowed under federal Section 1902(bb)(6) of the Social Security Act. During the negotiation, FQHC/RHC representatives advised that the new reconciliation methodology would introduce incentives to increase billable visits.

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

calendar year 2009. The reconciliation requires MCOs to work with the FQHC/RHCs to validate the MCO claims data to be used by the HCA and its actuarial consultant Milliman. That process is under way and the subject of the litigation (See Neighborcare Health, et al v. Porter). For FQHCs and RHCs that subsequently participated in voluntary rebase derived from actual, allowable costs from 2008, encounter rates were reset, and their enhancement rates were adjusted accordingly. The rebased rates were applied by the state on January 1, 2010.

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

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

Alternative Payment Methodology 2 (APM2)

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

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

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

Alternative Payment Methodology 3 (APM3)

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

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

Ongoing Issues

As Washington's history shows, we have experimented with three alternative payment methodologies in the past three years in response to the 2006 CMS audit findings and state budget balancing directives. None of the approaches has addressed the inherent incentives to increase billable visits rather than quality improvements. Furthermore, none has reduced the burden and complexity of reconciliation.

Proposed Alternative Payment Methodology

Revised Payment Methodology (APM4) for Managed Care Enrollees

The imperative for Washington to implement a better FQHC/RHC payment approach is evident in the rocky history just described. It is our intent to implement a new alternative payment methodology, APM4, effective January 2013, using the current APM3 payment methodology to establish the baseline at the point of implementation. Any new methodology will intentionally be predicated on preserving reimbursement that surpasses the floor established by PPS. A brief technical description of the key components and imbedded assumptions in the APM4 approach follows.

1. *Reimbursement mechanism*

a. How Payments Flow to Providers

The first component is the reimbursement mechanism, which will take the form of a monthly capitated payment for each client whose assigned primary care provider is located within an FQHC/RHC. The capitation payment will combine both the Medicaid primary care capitation or fee-for-service payment and the FQHC/RHC supplemental payment defined by §1902(bb)(5)(A), and will flow through the managed care organizations (MCOs) to the FQHCs and RHCs. MCO contracts will be amended to assure these funds pass through to the FQHCs/RHCs on a timely basis free of any withholding not otherwise authorized in the MCO-provider contract. We request technical assistance on whether further flexibility under §1902(bb)(5)(A) is necessary to achieve this purpose.

b. Rate Setting Mechanisms

Capitation rates will be actuarially sound and risk adjusted by clinic to reflect patient demographics (e.g., age and sex), geography and scope of services. This risk adjusted payment is intended to assure that a clinic receives, at a minimum, the equivalent of its full PPS encounter rate for managed care patient visits. It is applicable strictly to *medical* service encounters, given that other encounter types such as dental, some mental health and maternity support services are outside the scope of the Medicaid managed care contracts. Mid-year changes in the type, intensity, duration, or amount of services would be reflected in the annual rate setting process and until that time, would be addressed through supplemental fee-for-service payments.

c. Other Factors to Minimize Underpayment Risk Under Consideration

- There are risk corridors that provide for outlier years/circumstances;
- Utilization trend factors will be established on valid, cost-effective changes in care patterns;
- Clinics that enter into APM 4 with very low historical utilization levels (i.e., PMPY encounters under 2.0) will have incentives to optimize appropriate access to care rather than decreased utilization;
- We account for factors specific to FQHCs and RHCs demonstrated to cause cost inflation exceeding MEI; and
- Clinics will have flexibility to opt out of the APM on an annual basis and revert to the PPS reimbursement methodology.

2. *Expenditure base*

The second component is the expenditure base at the point of implementation of the new APM4 methodology. This establishes the level from which we can begin to simulate alternative payment

methodologies. The base is calculated by multiplying estimated encounters for Medicaid clients enrolled in managed care plans by the expected encounter rate where:

- Estimates of the encounters are based on actual FQHC/RHC medical encounter experience in the managed care setting using historical data from calendar year 2009; and
- The encounter rate is a composite, weighted average rate based on the current APM3 rate structure.

3. *Growth over time*

The third and final component is the set of critical assumptions and estimates of growth over time. Otherwise known as trend factors, these will be applied to encounters and encounter rates as follows:

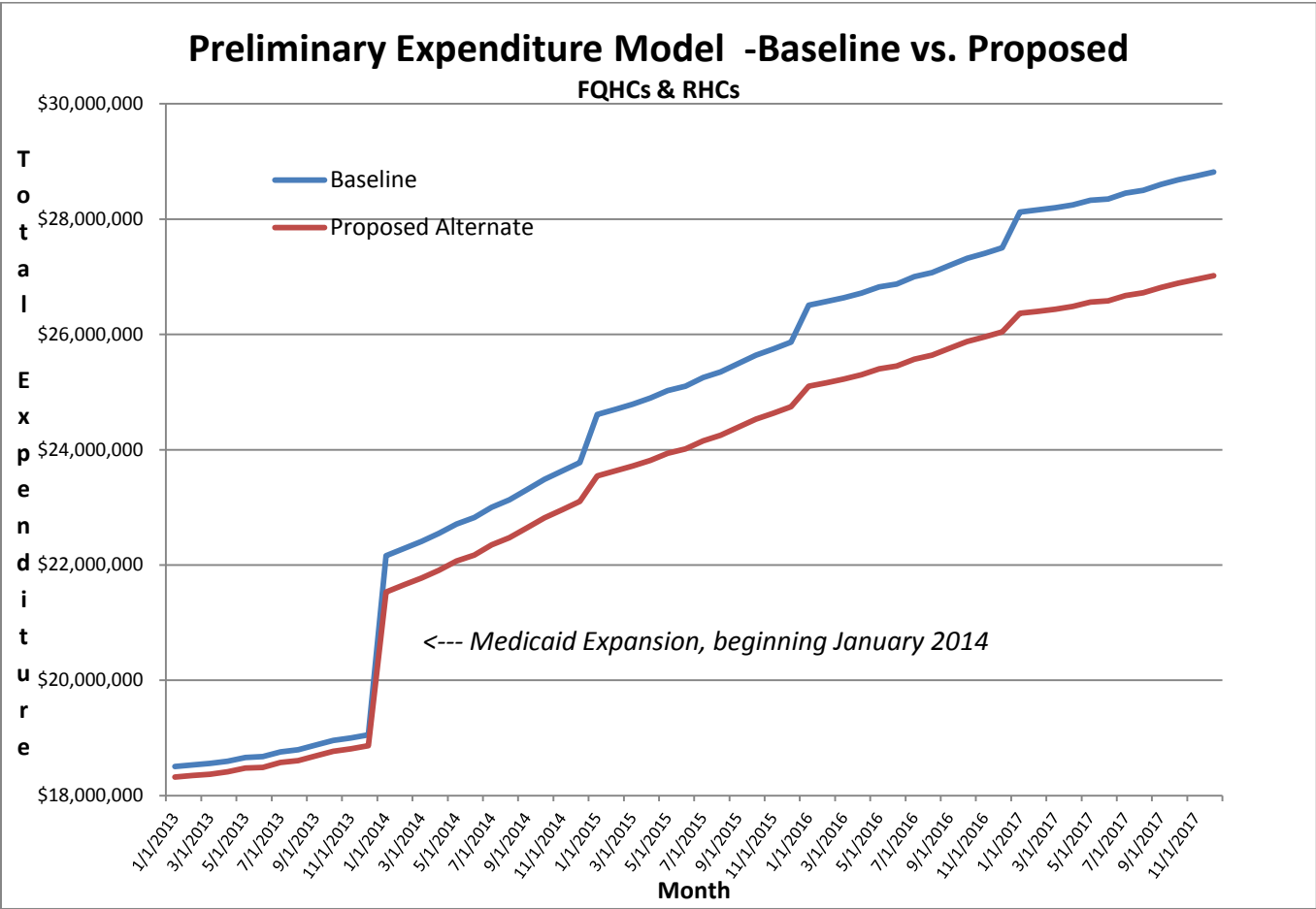
- The trend factor for encounters will be tied to caseload growth trends, the unique characteristics of different populations becoming enrolled in Medicaid managed care plans, and to the assumed future distribution of new client assignments to FQHC/RHCs; and
- The trend factor for the encounter rates will be tied to the medical cost inflation assumptions embedded in APM3, plus any assumed growth in encounters per person (i.e., utilization).

These components collectively allow us to construct a baseline scenario of the “status quo” going into January 2013, and project that scenario forward five years. The baseline scenario is fairly straightforward to model as it simply uses historical data to estimate prospective trend factors. Trend assumptions for medical inflation are known and provided by external entities (e.g., CMS and Global Insights). Trend factors for baseline utilization are based on an independent actuarial analysis for FQHC/RHC encounters in the managed care delivery system. The analysis included extensive participation from the HCA, FQHCs, RHCs and the Medicaid managed care plans.

Baseline trend factors for encounters are based on extended unofficial caseload forecasts provided by Washington State’s Caseload Forecast Council (CFC) based on its just released June 2012 forecasts^{vii}. These forecasts extend to December 2017, and include forecasts of the Medicaid expansion populations in 2014. The caseload forecasts are then used to calculate the subpopulations that are assigned to Medicaid managed care –by specific MCOs–based upon historical patterns through July 2011. Finally, the managed care population is further winnowed down to those that are assigned to a PCP in an FQHC or RHC, again based on recent historical patterns. Assignments of future clients to specific plans are based upon the assignment algorithms used by HCA.

Once the baseline is established, we can estimate a fixed calendar year per-member-per-month (PMPM) capitated payment in which all baseline trend factors are embedded. Any savings estimated off baseline will require creation of an alternate scenario with different growth assumptions. The alternate scenario proposed here is to reduce the year-to-year growth rate in the encounters per person relative to the growth assumed in baseline. The result is a lower PMPM growth rate over the time period of interest (2013-17). We assume that (a) the PMPM percentage reduction will be fully achieved through utilization reductions relative to baseline, and (b) the medical inflation rate will remain the same as assumed in the baseline.

Once the alternate rate structure is estimated, it is a straightforward task to multiply the estimated FQHC /RHC client count by the differential between baseline and alternate PMPMs. Appendix F includes charts that graphically represent a sizing exercise to model potential APM4 results for FQHCs and RHCs separately. Aggregated results of that same model are included below.



Impact of APM4

The move to a risk-adjusted, full-encounter payment for primary care in a clinic setting will establish certainty of payment for FQHCs and RHCs, which is missing in today’s retrospective reconciliation environment. Clinics have limited capacity to prepare for reform when the uncertainty of recoupment for prior and future years hangs over their critical planning efforts.

With certainty also comes flexibility to consider performance incentive arrangements and shared savings opportunities that are hard to entertain in an encounter payment and reconciliation environment. Clinics that can demonstrate their contribution to a reduction of systemic costs should be able to share in those savings. With proper level of oversight and accountability, contractual arrangements between managed care plans and safety net clinics can take many different forms. It will be important to facilitate broad flexibility to allow clinics in different regions, with different patient mix and risk tolerance, to engage in meaningful shared savings arrangements that equally benefit the payer and provider.

In this preliminary expenditure model, we have demonstrated a five-year savings target of more than \$60 million by controlling trend and reducing utilization while ensuring greater capacity and a renewed focus on better patient outcomes. If we can demonstrate significant, projected savings over the 5-year demonstration, Washington is requesting an early investment of future savings for the purpose of building clinic capacity to achieve the delivery system reform objectives set out earlier. These upfront savings will be specifically targeted at immediate delivery system enhancements for the medical home model of care, with quality incentive payments tied to measurable performance targets and investments in more efficient models of delivering care outside the traditional encounter-oriented system. Efficient

practices such as telemedicine, and primary care teams operating within their training and scope of practice are anticipated to help achieve savings but will require significant upfront investments to fully realize.

Voluntary Participation

Any FQHC/RHC not wishing to participate in APM4 will retain the option provided in Section 1902(bb) of the Social Security Act to receive the Prospective Payment System payment under the methodology prescribed in the Benefits Improvement and Protection Act of 2000.

Impact on Tribal Facilities

Two tribal facilities have contracted with Indian Health Services to provide care to urban Indians. In addition, they receive federal funding as FQHCs and are therefore subject to the revised payment methodology option. Further consultation would be anticipated to comply with public notice requirements disseminated by CMS in April 2012.

Stakeholdering Process

Stakeholdering has been constant for many years as the Medicaid agency, Governor’s Policy and Budget Offices, Legislature and FQHC/RHC representatives have sought to revise and refine Washington’s payment approach. At the heart of these discussions has been an intent to ensure that payment for services delivered by the clinic FQHC/RHC system is adequate and complies with federal law while encouraging attention to improving the quality of health care and the appropriate utilization of services. We recognize that specific additional public notice requirements would be necessary if the flexibility we request necessitates full submission of a Section 1115 Demonstration Waiver Application. However, to confirm that this has been a collaborative and long-term conversation, Table 2 provides notable stakeholder engagement since early 2009. (Additional engagement with legislative staff and legislators is not detailed in Table 2.)

Table 2: Stakeholder Activities 2009-2012

2009 Interactions	
1. February 4, 2009 FQHC/RHC Discussion	Meet with Mary Looker and clinic representatives
2. April 3, 2009 FQHC/RHC Alternative Payment Methodology Discussion	Meet with clinic representatives and OFM/Gov Office
3. May 15, 2009 Follow up FQHC/RHC Alternative Payment Methodology Discussion	Meet with clinic representatives and OFM/Gov Office
4. May 22, 2009 Follow up FQHC/RHC Alternative Payment Methodology Discussion	Meet with clinic representatives and OFM/Gov Office
5. June 5, 2009 Follow up FQHC/RHC Alternative Payment Methodology Discussion	Meet with clinic representatives and OFM/Gov Office
6. June 12, 2009 FQHC/RHC Reimbursement System – SPA/RAI	Meet with clinic representatives
7. July 14, 2009 FQHC/RHC Reimbursement Redesign	Meet with clinic representatives
8. October 30, 2009 Reconciliation Discussion	Meet with clinic representatives
2010 Interactions	
9. April 26, 2010 FQHC/RHC Reconciliation Methodology Workgroup Purpose: Strategize 2009 MC Reconciliation, timeline.	Clinics, WACMHC, RHCAW, Milliman, Regence, Molina, CHPW, Group Health, HCA
10. April 27, 2010 RHC Conference	
11. May 13, 2010 FQHC Reconciliation Process Overview	Meet with staff from Columbia Basin FQHC to explain process
12. September 1, 2010 FQHC/RHC Status Meeting Purpose: Data requirements of plans for MC reconciliation	Meet with MCOs, Milliman, HCA
13. September 13, 2010 FQHC/RHC Reconciliation Purpose: Data requirements of plans for MC reconciliation	Plans, Milliman, Keith, HCA
14. September 23, 2010 Reconciliation Questions Purpose: Outstanding reconciliation questions	Clinics, Mary, Milliman, Keith, HCA
15. September 30, 2010 Purpose: Outstanding reconciliation issues	Meeting with Keith, HCA
16. October 15, 2010 FQHC/RHC Reconciliation Meeting Purpose: Data requirements of plans for MC reconciliation	Plans, Keith, Milliman, HCA
17. October 21, 2010 FQHC/RHC Reconciliation Meeting Purpose: Data requirements of plans for MC reconciliation	Plans, Keith, Milliman, HCA
18. November 3, 2010 FQHC/RHC Reconciliation Meeting Purpose: Data requirements of plans for MC reconciliation	Plans, Milliman, HCA
19. December 13, 2010 FQHC/RHC Policy Meeting Purpose: Discuss policy questions of reconciliation	Clinics, Mary, Barb, Keith, Mike Bell, HCA

2011 Interactions	
20. April 5, 2011 FQHC/RHC Managed Care Reconciliation Purpose: Discuss additional data requirements of reconciliation	Keith, Milliman, Plans, HCA
21. April 11, 2011 FQHC/RHC Data Review Purpose: Weekly meetings to discuss ongoing issues with reconciliation	Keith, Milliman, Barb, Mary, HCA
April 19, 2011	May 3, 2011
May 10, 2011	May 17, 2011
September 27, 2011	October 11, 2011
October 18, 2011	October 25, 2011
November 1, 2011	November 8, 2011
November 15, 2011	November 29, 2011
December 6, 2011	December 13, 2011
December 20, 2011	
22. October 4, 2011 Reconciliation and Next Steps Purpose: Discussed ongoing reconciliation issues and requested clinics provide ideas for alternative to reconciliation to HCA.	Mary Looker, Barb Malich, Peter Toop, Keith (?), HCA
23. January 23, 2012 Meeting with RHCs Purpose: RHCs issues regarding reconciliation and cash flow challenges	Cindy Robertson, DJ Wilson, Nathan Johnson, Thuy Hua-Ly, Jean Bui
2012 Interactions	
24. March 9, 2012 Meeting with DOH Purpose: RHCs had contacted DOH regarding issues with reconciliation, DOH staff requested information regarding RHC reimbursement	Kris Sparks, John Hanson, Melissa Usitalo, Jean Bui
25. April 3, 2012 RHC Reimbursement Policy Purpose: RHC had requested meeting to seek information from CMS on whether reconciliation and recoupment were required by CMS	RHCAW Board, DJ Wilson, CMS, DOH, Thuy Hua-Ly, Nathan Johnson, Jean Bui
26. April 25, 2012 RHC Conference	
27. June 6, 2012 Rural Health Systems Meeting Purpose: Payment methodologies for rural providers	
28. June 6, 2012 Meeting with RHCs Purpose: Discuss plan for HCA to pursue waiver	RHCAW Board, DJ Wilson, Andy Cherullo, Thuy Hua-Ly, Nathan Johnson, Jean Bui
29. June 11, 2012 FQHC Steering committee call to discuss waiver concept	WACMHC FQHC Steering Committee, Nathan Johnson, Andy Cherullo
30. June 14, 2012 Meeting with FQHCs Purpose: Discuss plan for HCA to pursue waiver	WACMHC Board members, Len McComb, Kate White Tudor, Andy Cherullo, Nathan Johnson, Thuy Hua-Ly, Jean Bui, Kevin Collins
31. June 18, 2012 Rural Health Reconciliation Methodology Purpose: Discuss plan for HCA to pursue waiver	Bob Perna, RHCAW Board, DJ Wilson, Doug Porter, Jason McGill, Thuy Hua-Ly, Andy Cherullo, Nathan Johnson, Jean Bui
32. June 22, 2012 FQHC Conference Call Purpose: Discuss plan for HCA to pursue waiver	WACMHC Board members, Andy Cherullo, Andy Glenn, Nathan Johnson, Jean Bui
33. June 25, 2012 FQHC Meeting Purpose: Discuss outline of waiver proposal	WACMHC Board members, Len McComb, Kate White Tudor, Andy Cherullo, Nathan Johnson, Thuy Hua-Ly, Andy Glenn, Jenny Hamilton, Rebecca Burch, Jean Bui
34. June 28, 2012 Phone call with consultant Keith Hearle to discuss expenditure model for waiver proposal	Keith Hearle, Thuy Hua-Ly, Jean Bui, Andy Cherullo, Andy Glenn, Nathan Johnson

35. July 9, 2012 FQHC conference call to discuss details of waiver proposal	WACMHC Board members, Andy Cherullo, Thuy Hua-Ly, Nathan Johnson
36. July 10, 2012 FQHC Conference Call to discuss details of waiver proposal	WACMHC Board members, Andy Cherullo, Thuy Hua-Ly, Jean Bui, Andy Glenn, Nathan Johnson
37. July 11, 2012 RHC Follow-up (2 calls) Purpose: Discuss outline of proposed request and RHCAW response letter	RHCAW Board, DJ Wilson, Andy Cherullo, Thuy Hua-Ly, Nathan Johnson, Jean Bui, Jenny Hamilton
38. July 12, 2012 FQHC Meeting Purpose: Discuss changes requested to draft of proposed request	WACMHC Board, Len McComb, Kate White-Tudor, Andy Cherullo, Nathan Johnson, Thuy Hua-Ly, Andy Glenn, Jean Bui

Appendix A: Letters of Support



July 16, 2012

Cindy Mann, Deputy Administrator
Center for Medicare & Medicaid Services
Director
Center for Medicaid, CHIP, and Survey and Certification
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, MD 21244

The Washington Association of Community and Migrant Health Centers (WACMHC) has engaged with the Washington State Health Care Authority Medicaid Program to develop a broad, conceptual model of Federally Qualified Health Center (FQHC) payment reform for Washington state. The FQHCs in Washington are pleased to be involved in these discussions, with the goal of developing a capitated, per member per month, risk-adjusted payment system that will further the triple aim: better care for individuals, better health for populations, and lower per capita costs. Primary care is critical to this equation. In the spirit of working with our state partners to realize our common vision of payment and practice reforms, WACMHC commits to working with the Health Care Authority over the next several months as the details of this payment reform model are further developed and refined.

There are several areas of critical importance that must be addressed in the payment reform request:

- We would strongly prefer to implement a new APM through a state plan amendment. We believe flexibility exists within the Medicaid statute for a state plan amendment that would achieve our goals. We will appreciate CMS support toward development of a SPA that accomplishes our objectives. In the unlikely event a waiver might be necessary, our preference would be tailoring it as narrowly as possible, with built-in protections adequate to ensure that FQHCs receive appropriate funding that is not less than PPS established under federal law. If a waiver appears necessary to accomplish our common goals, we reserve our right to revisit the potential benefits and apparent risks and decide at that point if we will weigh in support.
- Implementing patient centered medical homes in FQHCs will generate upfront investments as well as ongoing operating costs. The baseline model of savings and reimbursement methodology must account for the investment inherent in creating and maintaining this new practice infrastructure.

- o The model under development must address many technical issues to earn FQHC endorsement. Substantial details and issues are still under development: baseline, client and population-specific risk-adjustment factors, trend, change of scope process, handling of current fee for service programs, outcome measurement and incentives, supplemental payment pass-through, etc. We look forward to continued discussions with the state to resolve these issues to our mutual satisfaction.

As we face the challenge of serving Medicaid expansion patients in 2014, we must innovate and improve our practice model to fulfill the promise of primary care. Thank you for the opportunity to resolve more than a decade of ongoing payment discussions to bring Washington's FQHCs into health reform with a modern care delivery system. We look forward to working with our state partners to bring this vision to implementation in Washington. Specifically, we request an early opportunity for the FQHCs and representatives from the Washington Medicaid program to jointly meet with CMS to discuss this proposal.

Sincerely,



Mary C. Looker
Chief Executive Officer

Cc: Doug Porter
Director, Health Care Authority

Andrew Cherrullo
Chief Financial Officer, Health care Authority

Nathan Johnson
Medicaid Policy Manager, Health Care Authority



Rural Health Clinic Association of Washington

July 16, 2012

Cindy Mann, Deputy Administrator
Center for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop: 52-26-12
Baltimore, MD 21244

Dear Ms. Mann,

This letter is in response to the FQHC-RHC Flexibility Request from the HCA to CMS, which we understand is being submitted today.

The level of our engagement on this matter in the last six weeks with the HCA has been considerable. We have appreciated very much the level of transparency on the part of the HCA and the willingness to be available to answer questions as they have arisen.

It is our intent to remain in close dialog with the HCA as this process continues. It is an important process, addressing an important problem: that the current Medicaid reconciliation methodology threatens the very viability of as many as two-thirds of the RHC population in Washington State.

As you also know, our members have grave concerns about the direction the HCA is taking in addressing its statutory obligation to reconcile previous payments dating as far back as 2009.

The RHCAW board, which represents 95% of the RHCs in Washington State, has deliberated on the question of supporting or opposing this Flexibility Request extensively. The RHCAW position continues to be neutral, notwithstanding our major concerns.

In fact, while the board has not taken a position, we expect active engagement by individual RHCs during the comment period following the submission of this request. Some of their comments may be in opposition to the underlying proposal.

The board, however, remains committed to working with the HCA and CMS to address the fundamental problem facing access to care in rural Washington State: the reconciliation methodology under the Medicaid State Plan has amounted to major financial liabilities to RHCs, in the hundreds of thousands of dollars per clinic.

We look forward to a continued dialog with the hopes that a solution will arise that solves our mutual concerns of access to care without inadvertently making the challenges worse.

Sincerely,

<signed electronically>

Barbara Berg
President
Rural Health Clinic Association of Washington

Appendix B: Applicable Federal Statute

Section 1902(a)(15):

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

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

Section 1902(bb)

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

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

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

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

(A) increased by the percentage increase in the MEI (as defined in section [1842\(i\)\(3\)](#)) applicable to primary care services (as defined in section [1842\(i\)\(4\)](#)) for that fiscal year; and
(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) Establishment of initial year payment amount for new centers or clinics.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section [1905\(a\)\(2\)\(C\)](#) furnished by the center or services described in section [1905\(a\)\(2\)\(B\)](#) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) Administration in the case of managed care.—

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

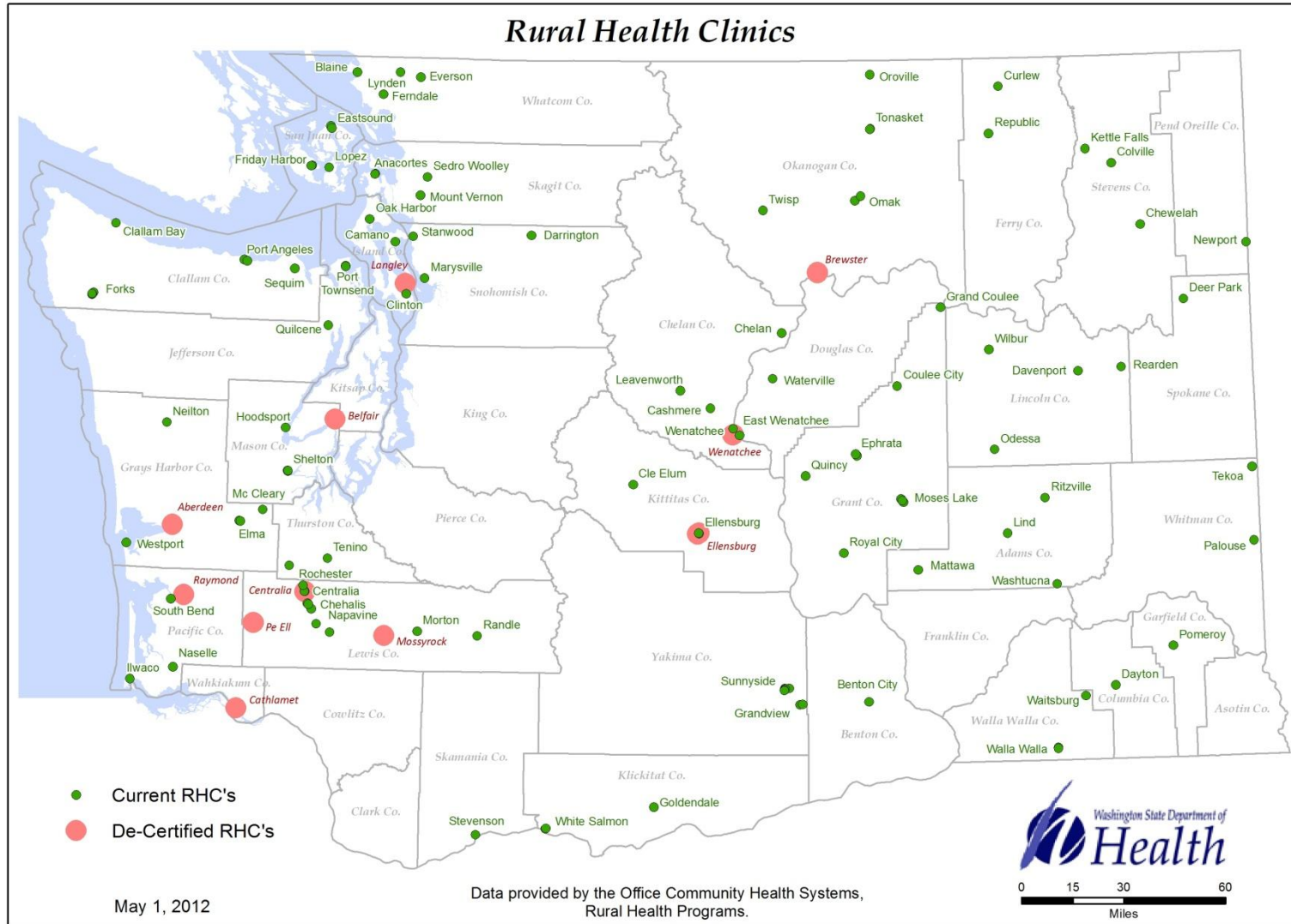
(B) Payment schedule.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

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

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

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

Appendix C: Maps of Washington State FQHC and RHC Distribution



2011 Snapshot: Washington’s Community Health Centers

26 Community Health Centers - Over 170 Service Delivery Sites
771,381 Total Patients

Washington’s Community Health Centers (CHCs) are local, non-profit, community-owned health care providers serving low-income and medically underserved communities. In 2011, CHCs were the health care home for 771,381 individuals in Washington-based community health centers:

- 36% of patients were uninsured (274,586 people)
- 43% of patients were on Medicaid (332,236 people)
- 37% of patients were under 19 (288,001 children)

Community Health Centers form a statewide network of thousands of staff exchanging information, ideas, and best practices. In this way, CHCs leverage their resources to expand health care access to more patients, creating Washington’s largest primary care safety net.

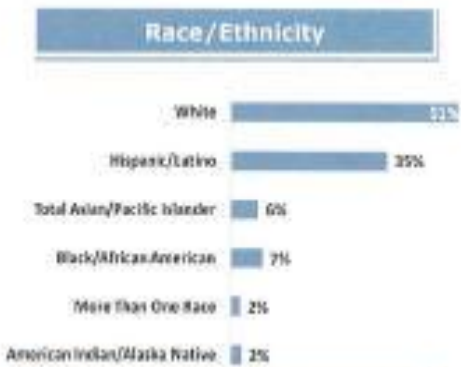
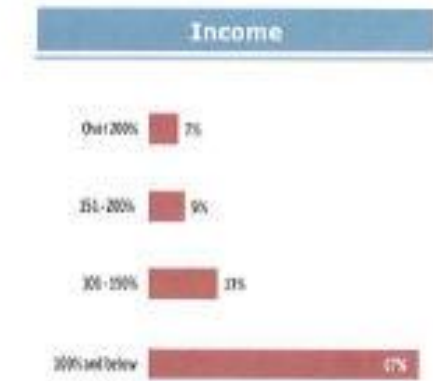
Essential – Washington’s health centers provide access to all patients who walk through the door, regardless of their ability to pay. The statewide network of CHCs:

- Serves the rising number of uninsured in Washington – the number of uninsured patients at health centers increased by 75% between 2000 and 2011.⁴
- Reduces health care disparities. The majority of patients (67%) live at, or below, the federal poverty level and nearly half of patients (49%) are people of color.
- Provides a health care home for nearly one-third of the state’s uninsured, including over half of the state’s uninsured children (43,573).¹

Experienced – Washington health centers have over 30 years of experience delivering quality primary care tailored to the needs of underserved populations in each community. Services include education, prevention and early intervention services that help patients lead full and productive lives. By investing in quality patient care on the front end, and encouraging a regular doctor/patient relationship, health centers prevent new health problems and minimize costs. CHCs continue to improve access to care by providing culturally sensitive care, health education, outreach, and case management in multiple languages.

In addition, the Community Health Centers fuel a positive and significant economic engine for Washington State. CHCs have an overall positive impact of \$1.16 billion on local economies and directly generate 5,797 full-time jobs.²

Efficient – CHCs are part of the health care solution. In 2006, the Washington State health care system wasted \$355 million in avoidable ER visits. These non-emergent visits could have been treated more cost effectively at a CHC.³ From chronic disease management to evidence-based clinical practice, CHCs deliver good health

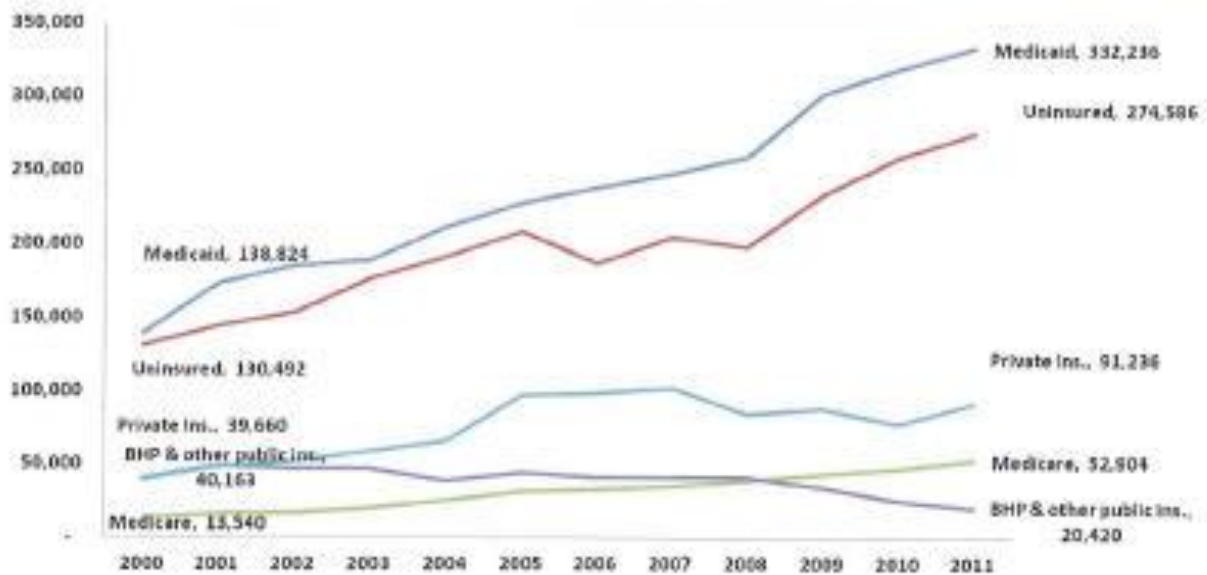


outcomes and are extremely efficient. By zeroing in on conditions that significantly drive up costs - such as asthma, diabetes, and hypertension - health centers simultaneously improve patient health and control unnecessary spending. This model reduces the need for more expensive hospital in-patient and specialty care and produces significant savings for the health care system.

Washington CHCs Provide a Wide Array of Services

Primary Care Services	Preventive Services	Wraparound Services
General primary medical care	Fap smear	Outreach
Prenatal care	Smoking cessation	Case management
Dental Care	HIV testing & counseling	Eligibility assistance
Mental health treatment/counseling	Glycosylated hemoglobin measurement, diabetes	Health education
Substance abuse treatment/counseling	Paternity Support Services	Interpretation/translation services
Hearing screening	Blood pressure monitoring	Transportation
Vision screening	Blood cholesterol screening	Outdated eligibility workers
Pharmacy	Weight reduction programs	

All Patients by Insurance Status Washington State CHCs, 2000-2011



1. WA State OFH 2010 Uninsured estimates: 319,199. Total patients 62,338 Children 0-19: <http://wa.state-ohs.us/GPSOnline/>
 2. "The Economic Impact of Washington's Community Health Care Centers", Capital Link, December 2011
 3. "Access to Community Health and Wasted Expenditures on Avoidable Emergency Room Visits: Gamblers of Evidence, 2006," HAOHC, Sept. 2006.
 * Source: Preliminary QDS data submitted by Washington state CHCs.
 * Methodology: data (QDS) is compiled and distributed by the federal Health Resources and Services Administration (HRSA)
 • Total patient, demographic, and insurance data: 2012 QDS is from all 26 of Washington's Community Health Centers.
 • Composition of Insurance Data: 2000-2011 data is from the 22 members required to report at that time.
 • All Patient Insurance Status data 2000-2011: Numbers include 27 original BHCRC members in 2000, expanded to all 26 current Community Health Centers in Washington.
 Developed by the Washington Association of Community & Minority Health Centers in collaboration with Community Health Network of Washington.
 3/19/2012

Appendix E: Excerpts from Washington's Current State Plan

REVISION

ATTACHMENT 4.19-B

Page 33

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

Federally Qualified Health Centers

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

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

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

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

R = Rate

E = Encounters

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

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

Effective January 1, 2009, and for services provided through April 6, 2011 APM rates will be increased by a Washington-specific health care index developed by IHS Global Insight. To ensure that the APM pays an amount at least equal to the PPS, the greater of the Washington-specific index or the MEI will be used. The greater of the Washington-specific index or the MEI will also be applied retroactively to the centers' base encounter rates.

For services provided on and after April 7, 2011, each center will have the choice of receiving either (1) its PPS rate, as determined under the method described above, or (2) a rate determined under a revised APM. The revised APM will be the center's PPS rate for calendar year 2011 inflated by 5%. Under the revised APM, each center's annual PPS rate will then be inflated by 5% on January 1, 2012, and each January 1 thereafter.

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

base year through calendar year 2008 and the cumulative increase in the MEI from 2009 through 2011. The rates will be inflated by MEI effective January 1, 2012 and each January 1 thereafter. The State will compare each year's APM rate to the rate that would have been paid under PPS to ensure the APM payments are at least equal to the payments that would have been made under PPS.

[Back to TOC](#)

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

XVI. Federally Qualified Health Centers (continued)

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

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

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

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

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

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

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

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

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

XVI. Federally Qualified Health Centers (continued)

For clients enrolled with a managed care contractor, the State will pay the center a supplemental payment in addition to the amount paid by the managed care contractor. The supplemental payments, called enhancements, will be paid in amounts necessary to ensure compliance with Section 1902(bb)(5)(A) of the SSA. The State will pay the enhancements monthly on a per-member-per-month basis.

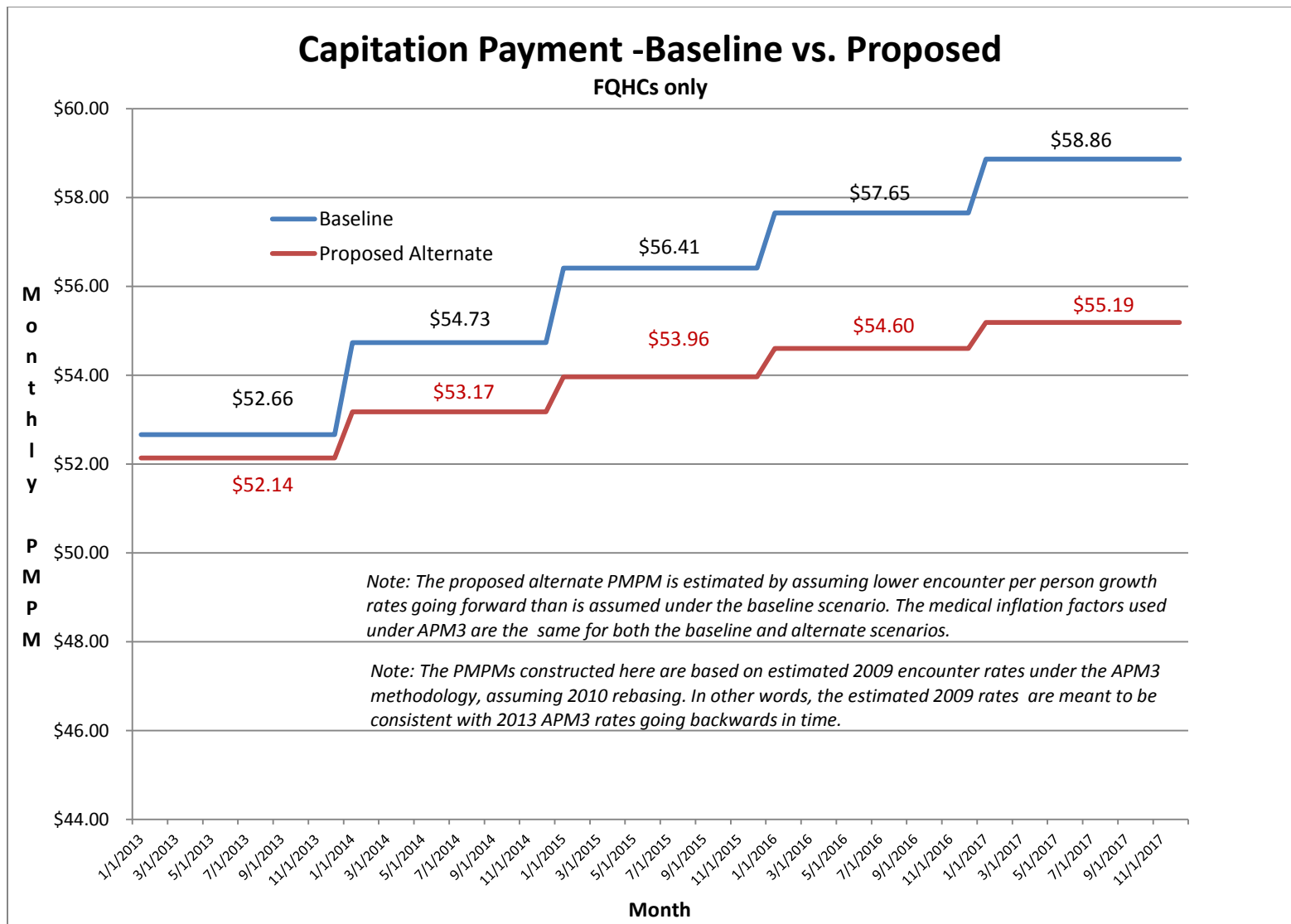
To ensure that the appropriate amounts are being paid to each center, the State will perform an annual reconciliation and verify that the enhancement payments made in the previous year were in compliance with Section 1902(bb)(5)(A). This process will apply to centers under the APM and to centers under the PPS. The annual reconciliation will be done as follows:

APM: (managed care encounters X APM encounter rate) less (fee-for-service equivalent) = State's payment amount

PPS: (managed care encounters X PPS encounter rate) less (fee-for-service equivalent) = State's payment amount

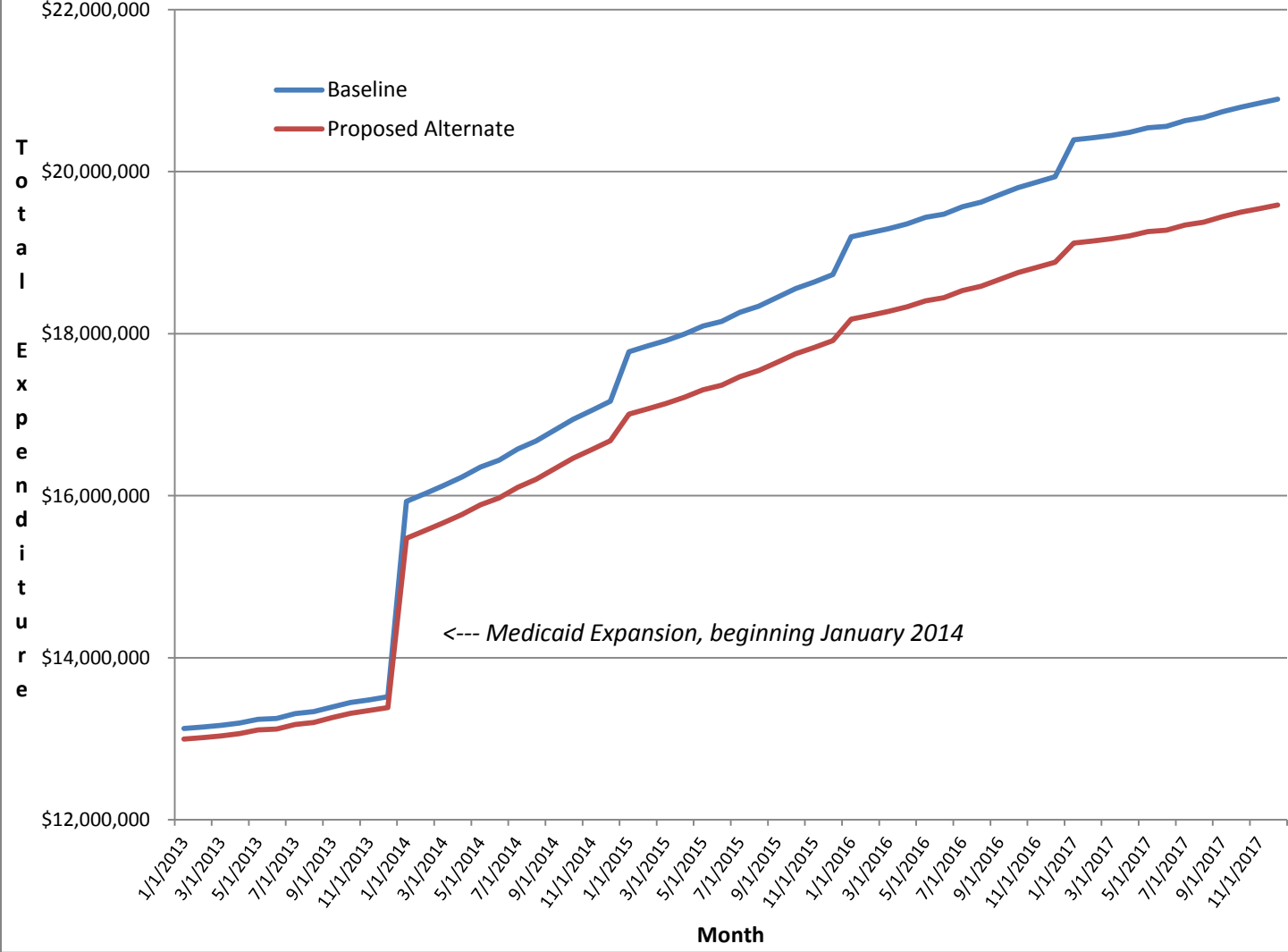
Covered services provided to Medicaid-Medicare patients are reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

Appendix F: Preliminary APM4 Modeling Results



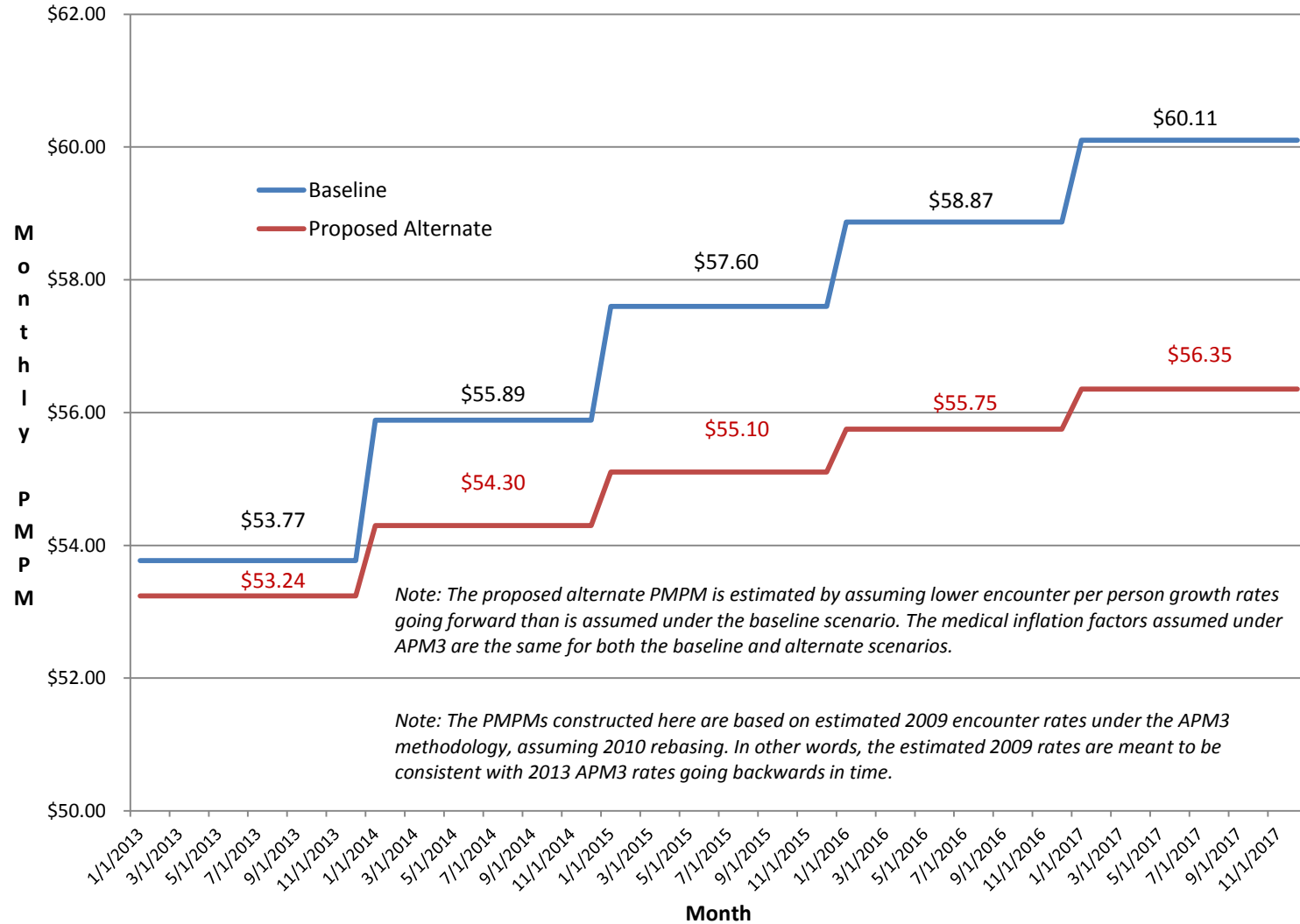
Preliminary Expenditure Model -Baseline vs. Proposed

FQHCs only



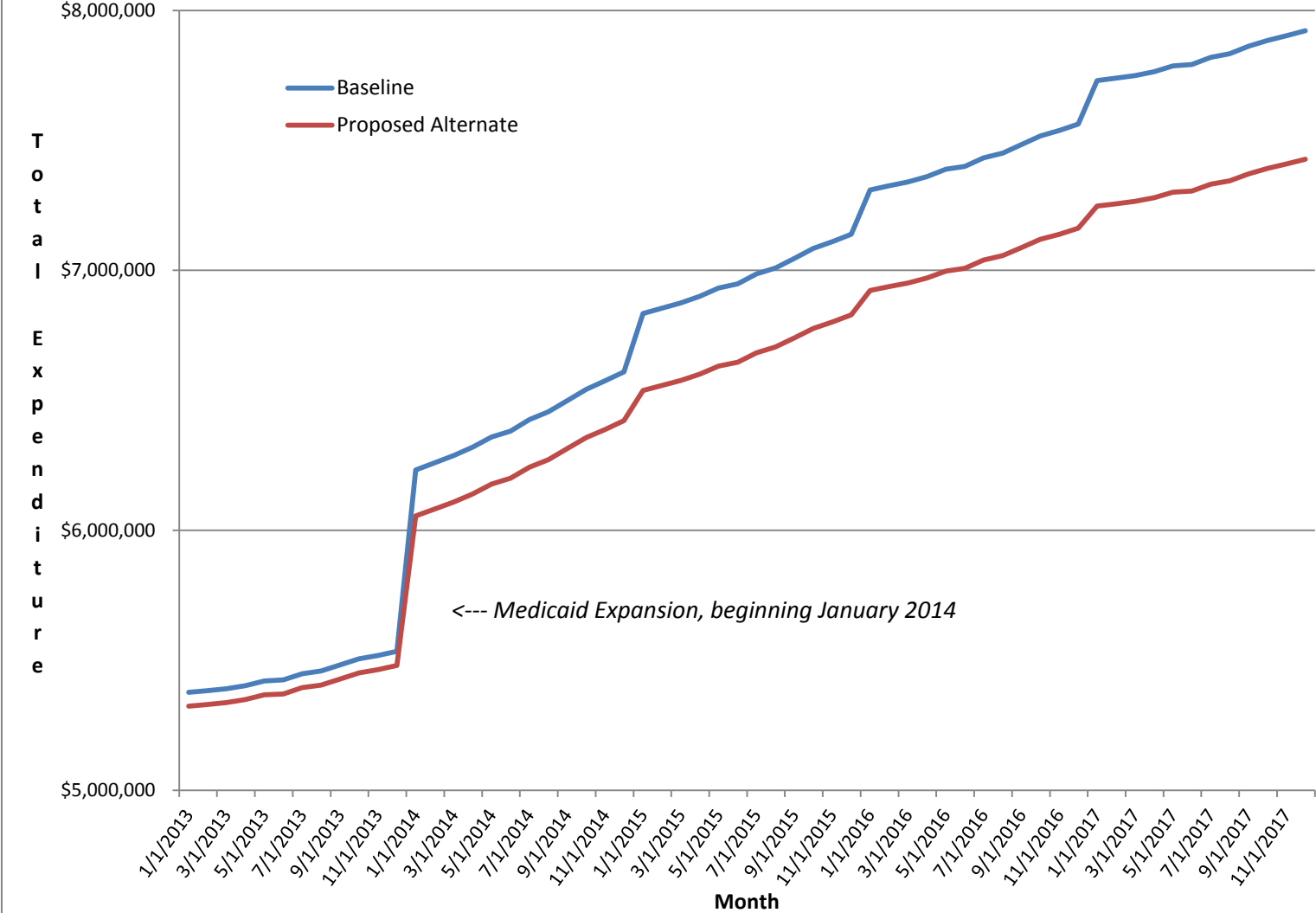
Capitation Payment -Baseline vs. Proposed

RHCs only



Preliminary Expenditure Model -Baseline vs. Proposed

RHCs only



Endnotes

ⁱ Estimates of numbers and characteristics of the Medicaid expansion populations are well documented in an Urban Institute analysis available at <http://www.hca.wa.gov/hcr/resources.html>.

ⁱⁱ See Urban Institute analysis above.

ⁱⁱⁱ As of 1/1/11 federal funding provided through the Section 1115 Transitional Bridge waiver has helped sustain coverage through the Medical Care Services and Basic Health programs. Transition eligible individuals are expected to transfer to Medicaid coverage beginning 1/1/14.

^{iv} <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2319&year=2011>

^v Successful MCOs include Amerigroup, Community Health Plan of Washington (CHPW), Coordinated Care Corporation, Molina Healthcare of Washington and UnitedHealthcare Community Plan.

^{vi} Data for the 2010 reporting period are available at: <http://bphc.hrsa.gov/uds/view.aspx?year=2010&state=WA>

^{vii} The Caseload Forecast Council is charged with forecasting the entitlement caseloads for the State of Washington. The Council meets several times a year to adopt official forecasts that are the basis of the Governor's budget document and utilized by the legislature in the development of the omnibus biennial appropriations act. Details are available at: <http://www.cfc.wa.gov/>