Developing a Federally Qualified Health Center Alternative Payment Methodology in New York State

Updated October 2020

Background

Federal law mandates that state Medicaid programs reimburse FQHCs using a visit-based bundled payment methodology, known as the prospective payment system (PPS), regardless of contractual agreements between FQHCs and Medicaid managed care plans. However, Federal law also permits an FQHC to be paid under an Alternative Payment Methodology (APM), as long as a) the APM reimbursement is not less than what the FQHC would have received under a “traditional” visit-based PPS methodology **and** b) each health center individually agrees to participate in the APM.

The traditional PPS incentivizes volume over value, as the payment methodology itself is visit-based. However, an FQHC APM allows State Medicaid programs to adopt a different methodology that can support integrated care, incentivize high-quality comprehensive primary care services, allow flexibility to address patients’ social determinants of health, and promote increased access to care. Some states with health center APMs, i.e. Oregon and Washington, have shown that the model ultimately improves health outcomes among health center patients.

Developing a FQHC APM in New York State

CHCANYS is exploring the development of a capitated APM. In a capitated APM, health centers would receive a per member per month payment for attributed patients. By transitioning from visit-based reimbursement to a capitated APM, health centers would be provided the flexibility to support services outside of the traditional “billable” visit; for example, by enabling care team members to communicate and interact with patients as needed, connecting them to services that are not traditionally billable under the PPS model. The APM can support the alignment of health center practices with the drive towards value-based payment.

Capitated APM payments are not contingent on visit volume or visit type. Participating health centers report quality measures to the State under an accountability plan. The process and outcome measures in the accountability plan demonstrate the value of care provided under a capitated payment system as traditional billable visit volume decreases. Accountability measures may change over time as the APM model matures, data collection improves and the community health center model of care evolves.

Accountability Plan

Accountability plan measures align with existing health center reporting requirements and support ongoing statewide practice transformation priorities such as New York State Patient-Centered Medical Home (NYS PCMH). Measure categories include clinical quality as well as cost, access, innovation, and patient and provider satisfaction. As new measures require participating centers to develop infrastructure to capture and report this data, pilot centers will report quality, cost, and experience measures, with access and innovation measures to be developmental priorities. As stakeholder priorities and best practice care models evolve, so too will the accountability plan be updated to reflect new needs.

APMs in Other States – Highlighting Oregon's Capitated APM

Nationwide, FQHCs are increasingly participating in new payment and delivery system models. As of 2019, 27 states have adopted some form of APM. Notably, Oregon successfully phased in a capitated APM beginning in 2013 to align their payment model with their care transformation goals.

Oregon's APM model is a capitated per-member per-month payment based on each health center's historical PPS payments. Participating health centers use payment and patient data for applicable services from its most recent reconciliation period that has been finalized by the state. Each health center establishes a "Wrap Cap" rate paid for managed care patients, which approximates the health center's wrap around payments. In addition, a full FQHC APM rate is calculated and paid for the few remaining Fee-for-Service patients each clinic serves.

Oregon's capitated APM has been successfully adopted by FQHCs and has resulted in these key outcomes:

- Robust, team-based, comprehensive care with reported improvement in quality outcomes;
- Increased flexibility to provide alternative access to care, such as telehealth;
- Increased flexibility to address social determinants of health;
- Better FQHC-reported financial health under the APM model (e.g., more predictable payments, less variability with provider turnover, prospective payments); and
- Accountability plan encouraged FQHCs to build VBP capabilities.

CHCANYS contact:
Bethany Wolfe, Director of Health Center Reimbursement
bwolfe@chcanys.org