Multi-payer alignment

ALTERNATIVE PAYMENT METHODOLOGY 4

SYNOPSIS

Engaging federally qualified health centers (FQHCs) in an alternative payment methodology that transitions reimbursement from an encounter-based system to a value-based system for services provided to Medicaid managed care enrollees.

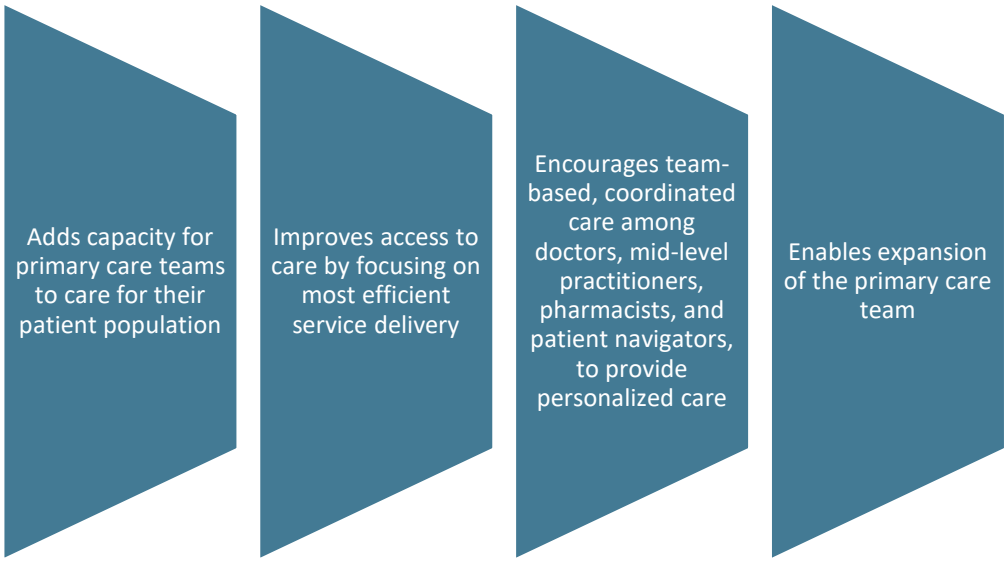
GOAL

Alternative Payment Methodology 4 provides additional flexibility in delivering primary care services, expands primary care capacity, and creates financial incentives for improved health care outcomes while meeting federal requirements. This methodology allows participating providers to enhance their capacity for managing population health.

DESIRED OUTCOMES

- Improve and maintain access to care by focusing on efficient service delivery
- Enhance team-based care coordination among doctors, mid-level practitioners, pharmacists, and patient navigators
- Expand primary care teams and improve quality

HOW IT WORKS



THE CHALLENGE

Primary care providers offer some of the most innovative and integrated delivery models in the state, yet their reimbursement structure stifles further innovation. Face-to-face, encounter-based payments currently drive reimbursement for FQHCs, resulting in a system that creates an incentive to deliver care based on volume over value. While statutory and regulatory requirements help to maintain access, these regulatory requirements make changes to payment especially difficult.

DESCRIPTION

With strong support from these clinics and hospitals, the state has introduced a value-based alternative payment methodology in Medicaid for FQHCs and rural health centers (RHCs). The model tests how increased financial flexibility can support promising models that expand care delivery. On July 1, 2017, 16 clinics began using a new alternative payment methodology for Medicaid managed care enrollees. The new model provides flexibility in delivering primary care services, expands primary care capacity, and creates financial incentives for improved health care outcomes while meeting federal requirements.

HOW WE GET THERE

APM4 applies only to Medicaid managed care enrollees and does not include current MCO contractual arrangements or flow of payments. APM4 converts the entire encounter-based rate into a baseline per member per month (PMPM) rate, which is adjusted prospectively according to quality performance. Financial conversion is based on calendar year 2015 reconciliation. Within this basic framework, clinics will continue to perform annual reconciliation to ensure that federal reimbursement requirements are met. However, instead of resolving underpayments or overpayments through a settlement process, APM4 will prospectively adjust payments based on a clinic's performance on quality measures. Given its experimental nature, APM4 is not mandated for all clinics and maintains an opt-in/opt-out approach.

RESULTS

APM4 will allow clinics to improve access to care by focusing on improvement against specific quality measures and allowing clinicians to work at the top of their license. This payment methodology provides flexibility for primary care providers to have a larger member panel without the burden of increasing the number of face-to-face patient encounters, thus expanding primary care capacity in medically underserved areas. APM4 also incentivizes alternatives to face-to-face visits and allows clinics to offer convenient access to primary care services.