Idaho Develops a Medicaid Value-Based Payment Model for its FQHCs, Based on Cost and Quality

by Neva Kaye

Starting in early 2020, Idaho will launch a new value-based payment model that will compensate federally qualified health centers (FQHCs) and other providers based on how much they improve the cost and quality of care delivered to Medicaid enrollees. The agency plans to sign contracts to implement the model in January, with implementation beginning July 1, 2020.

Both FQHCs and other types of providers have expressed interest in participating in this value-based model.

Background

Idaho has operated a Medicaid Primary Care Case Management (PCCM) program since 1993 and has worked to advance patient-centered medical homes (PCMHs) since 2008, when the Governor's Select Committee on Health Care recommended PCMH implementation as a priority. In 2016, Idaho Medicaid launched its Healthy Connections program, which blended the two initiatives. In 2017, the Medicaid agency began working to incorporate value-based payment into Healthy Connections. The agency submitted a State Plan Amendment (SPA) in October 2019 to secure Centers for Medicare & Medicaid Services (CMS) approval of its new payment model, which awards payment to FQHCs and other providers based on how much they improve costs and quality of care provided to Medicaid enrollees.

How Healthy Connections Value Care Operates

In the Healthy Connections program, primary care providers (PCPs) are paid on a fee-for-service basis, plus a per member per month (PMPM) care management fee. Care management fees range from $2.50 to $10 and vary based on the characteristics of the PCP's practice and the patients attributed to the PCP. Specifically, PCPs qualify for one of four reimbursement tiers based on their capabilities – those who qualify for higher tiers receive higher care management fees. The types of capabilities considered in tier assignment include being able to both send and receive data from the state health data exchange or offering extended hours of service to patients. Also, the PMPM care management fee is higher for beneficiaries with disabilities or special needs.

The Healthy Connections Value Care (HCVC) program will operate under Section 1905(t) of the Social Security Act and builds on the structure of the Healthy Connections program. Participating PCPs will continue to receive both fee-for-service payments and care management fees. Participating PCPs, including FQHCs and rural health centers (RHCs), will participate as one of two types of organizations:

- **Accountable primary care organizations** are primary care clinics (or groups of clinics) that serve at least 1,000 Medicaid enrollees. Clinics that wish to participate as a group must create a legal entity and sign a joint operating agreement. (Hospitals may not participate in this type of organization.)
- **Accountable hospital care organizations** are integrated networks of providers that include an acute care hospital and serve at least 10,000 Medicaid enrollees.

Both types of organizations (referred to collectively as value care organizations or VCOs) are expected to contain Medicaid's total cost of care (TCOC) and improve quality for their Medicaid patients. Both types of VCOs will share in any savings or losses they generate. The specific amounts will be determined through an annual settlement process. Each VCO's share of savings will depend on the VCO's performance. A VCO's share of losses will not be adjusted for performance. However, an accountable primary care organization's liability for losses is limited to the total amount paid to the organization in care management fees. Importantly, because the model builds on the fee-for-service payment structure and limits accountable primary care organizations' risk to the amount paid in care management fees, the model enables FQHCs to participate without placing their federally-mandated per visit payments at risk.

How Performance Determines Savings

Shared savings will be distributed to VCOs based on their performance on reducing growth in total cost of care and achieving specified quality measures goals. Idaho Medicaid chooses the measure set in conjunction with VCOs and updates the set each year. For the first year of the program, the set will include hospital re-admissions, emergency department visits, breast cancer screening, diabetes HbA1c test, well-child visits during the first 15 months, well-child visits during ages 3 to 6 years, and well-care visits for adolescents. Idaho publishes the measure specifications in its Healthy Connections website. If a measure does not apply to a practice, that measure is excluded from consideration when calculating share of savings (e.g., pediatric measures are only considered if the practice serves children). However, hospital-related measures apply to all VCOs as PCP performance affects those outcomes.

The Medicaid agency will retain 20 percent of savings produced by a VCO for administration. The VCO can earn the remaining 80 percent. The VCO will earn half of the available savings (40 percent of total savings) if it maintains quality of care, which is defined as maintaining baseline performance – the individual clinic's performance on the measure in the previous year – on at least half of the measures in the quality measure set. This half is referred to as the efficiency pool. The other half of the available savings, referred to as the quality pool, can be earned by showing acceptable improvement on the measures in the set — improvement on more measures secures a greater share of savings. Acceptable improvements are either:

- Performing at 90 percent of the state or national benchmark established for the measure (aspirational goal); or
- Producing a 3 percent reduction in the gap between the VCO's performance and the aspirational goal (individualized annual improvement target).

Supporting Participating Providers

Healthy Connections staff provide support to practices seeking to qualify for a higher tier. Idaho Medicaid plans to continue this support and to offer new types of support to help VCOs succeed. The state has structured other features of the program to encourage provider engagement:

Enrollment policies: On July 1, 2019, Idaho Medicaid implemented an annual fixed enrollment policy (enrollment lock-in). Previously Medicaid enrollees could change their PCCM provider at any time. Under the new policy, enrollee will have 90 days from enrollment with a PCCM provider to change providers. If an enrollee does not change providers within the 90 days, the individual will not be able to do so until that next annual enrollment period, which occurs from May 1 to June 30 of each year. Enrollees can request a change outside of the enrollment period due to special circumstances, such as moving out of the provider's service area or poor quality of care. This new enrollment policy supports VCOs by creating a more defined and stable panel of patients for the VCOs to manage.

Information on provider performance: Once an FQHC indicates an interest in participating in the HCVC program, Idaho Medicaid generates a cost/quality dashboard showing the clinic's current performance on both cost and quality. Idaho Medicaid also plans to establish an automated claims data portal for VCOs that will enable them to view their performance on selected qualify measures on an ongoing basis.

Community-level investments in patient health, including addressing the social determinants of health (SDOH). Idaho Medicaid plans to form and support two regional advisory groups to support the work of the VCOs in the region. Regional care collaboratives will consist of physicians who participate in the HCVC program and are responsible for identifying the

health care needs in the region and seeking collaborations to improve cost and quality by addressing those needs. Community health outcomes improvement councils will be composed of community stakeholders and are responsible for identifying opportunities to improve health and wellness, including addressing SDOH in their communities.

A Medicaid Perspective

The Idaho Medicaid agency pursued VBP because it wanted to foster cost control, but not at the expense of quality. After reviewing their options, the agency chose to pursue the HCVC model because it allowed it to "begin where they are" by building on the existing PCCM payment structure. The existing Healthy Connections payment model is also well known to – and has the strong support of – PCPs. The agency developed the HCVC model with the input of both hospitals and PCPs, including FQHCs. As the agency sought feedback on successive iterations of the model, the model evolved. Early versions of the model proposed that accountable hospital care organizations would share both savings and losses, but accountable primary care organizations would share only savings. In early 2019, the agency added shared loss for the accountable primary care organizations at the suggestion of hospitals and after consultation with primary care providers.

Agency representatives report they have encountered two major challenges. The first was determining which federal authority to use to implement the model. It could have been implemented as managed care under Section 1932(a) of the act or as fee-for-service under 1905(t).* Idaho ultimately decided that 1905(t) would better support the HCVC model for a number of reasons. Implementing the model under 1905(t) enabled Idaho to avoid the need to require primary care organizations to secure agreements with the hospitals, specialists and other providers whose costs are included in calculations of savings/losses when using a TCOC approach. Idaho found the State Medicaid Director Letter on *Policy Considerations for Integrated Care Models,* as well as consultation with CMS staff, to be very helpful in guiding the decision. Reflecting on their experience, agency staff advise other states to consult with CMS early in the development of new VBP models. The agency also found it valuable to engage outside experts to help staff evaluate policy options and determine how each option would affect operation.

The second challenge was data. Idaho Medicaid is seeking to build a transparent model — one where participating providers can easily track their performance on cost and quality and have the information they need to improve on both. Idaho Medicaid has a small data team and has found it challenging to implement their data plans. For example, agency staff had hoped to have an automated claims data portal operating at program launch, but now anticipates that the portal will need to launch after January

2020. Similarly, the agency plans to give VCOs the information they need to make referral decisions on both quality and cost, but will not be able offer cost information at program launch.

FQHCs have already expressed interest in participating in the HCVC model as accountable primary care organizations. State officials believe the new model plays to FQHCs' strengths in panel management and the efforts they have already made to become effective, efficient PCMHs for their patients. Officials, note, however, that in order to produce savings, FQHCs may need to change some aspects of their practice. For example, FQHCs may need to identify which providers in a group (e.g., labs or specialists) produce equally good health outcomes, but at less cost to the Medicaid program and then shift their referral patterns to increase referrals to the less-costly providers within the group.

The FQHC Perspective

FQHC representatives report they believe the new model is a move in the right direction. They expressed concerns about some specific aspects of the model, but overall, believe it will be good for their patients and that FQHCs will succeed under the new model. Idaho's 16 FQHCs serve more than 50,000 Medicaid enrollees living in 54 communities throughout the state. In 2012, 14 FQHCs formed the Community Health Center Network of Idaho. This FQHC-owned network has engaged in VBP contracts with commercial payers since 2014 and also operates a Medicare accountable care organization. This experience and support give Idaho's FQHCs several advantages that should help them thrive under the HCVC model. Because the network is statewide and HCVC was originally conceived as a purely regional model, initial FQHC interest in participating as a statewide network presented some challenges. But the Medicaid agency adapted the approach and the FQHCs are now interested in joining the program as accountable primary care organizations when the final VCO contract and data are available.

FQHCs also see gaining access to the Medicaid data they need to manage cost and quality as one of the greatest advantages of participation — but they also identified data as a challenge. Although the dashboards the FQHCs received from Medicaid were helpful, they did not provide sufficient detail to enable FQHCs to manage their population as they will need to under the HCVC model. The network anticipates that the Medicaid agency will soon share claims level data, and the network plans to use the data to produce patient registries, identify gaps in patient care, and inform participation decisions.

The FQHCs also identify sharing losses from the program's inception as a challenge. They would prefer to have one to two years of shared savings-

only before they had to also share losses with the Medicaid agency. Officials are confident that their strategy of increasing primary care expenditures to reduce TCOC will produce savings. However, it has been the FQHCs' experience with other payers that it takes time to fully understand any VBP model and identify what they need to do to succeed under it. For example, because the individual FQHCs serve tend to be more high-risk than those served by other providers, FQHC representatives would prefer to test the Medicaid agency's approach to risk-adjustment in TCOC for a year or two before being asked to live with the results of the approach. Limiting accountable primary care organizations' risk just to the care management fee could make sharing in losses from the start of the program more palatable. However, FQHC officials remain concerned that any loss of the income from care management fees will endanger the care management programs that FQHCs have developed with that funding.

Conclusion

The HCVC payment model is Idaho's next step on its path to:

- Ensure that Medicaid enrollees are served by effective PCMHs; and
- Reward practices that produce savings while maintaining or improving quality with increased payments.

Some challenges, particularly in ensuring that primary care providers have the data they need to manage their patients' care, remain. However, stakeholders who were interviewed indicated that Idaho was on the right path and were optimistic about the new model's success.

*A July 2012 letter from CMS indicates that states can also operate integrated programs under other federal authorities, including waivers, but Idaho eliminated these options early in program development

Acknowledgements: The National Academy for State Health Policy wishes to thank Matt Wimmer and Meg Hall of Idaho's Division of Medicaid and Yvonne Ketchum-Ward of the Idaho Primary Care Association for their contributions. The author also wishes to thank Trish Riley and Kitty Purington of NASHP, as well as NASHP's Health Resources and Services Administration project officer, Lynnette Araki, and her colleagues for their review and guidance. Finally, the author thanks Kristina Long of NASHP for her assistance in the preparation of this case study.