National Academy for State Health Policy
Value-Based Payment Reform Academy

Advancing Value-Based Payment Methodologies for Federally Qualified Health Centers and Rural Health Clinics
2016 – 2017

Request for Applications for Technical Assistance

Through a cooperative agreement with the Health Resources and Services Administration (HRSA), the National Academy for State Health Policy (NASHP) is pleased to announce a new technical assistance opportunity for states interested in advancing value-based approaches to Medicaid reimbursement for federally qualified health centers (FQHCs) and rural health clinics (RHCs).

States selected to participate in NASHP’s Value-Based Payment Reform Academy will receive 12 months of targeted technical assistance to support the development and/or implementation of value-based alternative payment methodologies (APMs). Technical assistance will include individual learning opportunities tailored to each state’s specific goals, group activities designed to promote state-to-state learning, as well as ongoing access to expert faculty, including state and federal officials, national leaders, and NASHP staff (for more information on expert faculty, please see both page 3 and Appendix A of this RFA).

This Academy will work with states to develop and/or implement value-based APMs for FQHCs and RHCs that support their goals for transforming how care is paid for and delivered. For the purposes of this Academy, NASHP defines value-based APMs as those that incentivize value over volume, promote the delivery of comprehensive, coordinated, and patient-centered care, are tied to quality and efficiency, and meet the requirements for FQHC and RHC reimbursement under current federal law.

Through this request for applications (RFA), NASHP will select up to six (6) states to join this Academy. Applicants will name a core team of four to six members, including a senior Medicaid official, a senior representative from the state’s primary care association, a FQHC or RHC provider representative, and others as identified by the state. NASHP is seeking applications from states with diverse geographies, political compositions, and Medicaid delivery systems. States may have an array of experiences with and readiness for payment reform for FQHCs and RHCs.

Key Value-Based Payment Reform Academy Dates in 2016:

**March 10:** RFA Informational Webinar

**April 1:** Application due to NASHP

**April 21:** Notification of selection to states

**Early May:** Technical assistance period begins

**June 14-15 or June 23-24:** Kick-Off Meeting, location TBD
and/or RHCs. Successful state applications will demonstrate how their work will be transformative and achievable within the 12-month technical assistance period. For some states this could be designing and building consensus on a specific value-based APM; for others it could be developing a state plan amendment or managed care contract language; for others it could be bringing a pilot to scale. This work may also be part of states’ larger delivery system and payment reform efforts.

**A Time of Opportunity**

Medicaid agencies are charged with the responsibility of increasing system capacity and efficiency to provide and pay for the services for more than 66 million enrollees plus, an additional 16 million enrollees by 2016. Delivery system reform is widespread across states’ Medicaid and CHIP programs: 23 states are actively making Medicaid payments to medical homes and 20 states are actively making Medicaid payments to health homes; 18 are advancing ‘accountable care’ models. Additionally, 35 states plus the District of Columbia have been awarded State Innovation Models (SIM) Initiative testing or design grants to develop and test new delivery system models designed to improve care quality and decrease costs. With these innovative care delivery models, states are advancing a range of payment models that are often specific to provider type or beneficiary and are outcome driven. It is important for FQHCs and RHCs to not be left out of states’ payment innovations because safety net providers are an important provider of care for Medicaid beneficiaries.

Under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, state Medicaid programs reimburse FQHCs and RHCs through the prospective payment system (PPS), which sets minimum per visit payment rates for individual clinics, or through an APM. APMs are allowable as long as they are agreed to by individual clinics and each clinic’s total payments are equivalent to or higher than the total payments they would receive through PPS.

As long as states meet the above requirements for APMs, they have the opportunity to design reimbursement models that incentivize value-based, quality care rather than volume-based care. For instance, in 2013 Oregon implemented a value-based APM for a small pilot of FQHCs after health centers expressed their desire to be reimbursed through a methodology that better aligned with the patient-centered medical home model of care delivery. The pilot paid health centers per-member per month (PMPM) payments, which allowed them to fund ancillary services not typically paid for through claims such as care coordination. At the end of each year, each health center’s PMPM payments are reconciled against the total payments it would have received through PPS and if the PMPM total payments are lower, then Medicaid pays each health center the difference. Since health centers are paid rates equivalent to PPS, the initiative is budget neutral for Medicaid. Participating health centers are also required to report on a set of performance metrics. Early results from an evaluation of the Oregon pilot has shown that participating health centers have seen aggregate decreases in emergency department utilization and inpatient hospital utilization, as well as improved childhood immunization rates and weight control for children.
What’s in it for States?

- Access to expert consultation (mostly distance but some in-person)
- In-person site visit to your state from NASHP staff
- Small group state-to-state learning opportunities
- Travel support for four team members to June in-person Kick-Off Meeting
- Ongoing access to NASHP staff

Each of the six states selected through this RFA will receive both group and individual technical assistance designed to help them develop and implement their initiatives. The technical assistance provided as part of this Academy will provide your state with access to national, federal, and state experts, as well as NASHP staff to identify strategies and best practices as you plan and implement your initiative.

Individual Technical Assistance
NASHP has assembled a group of on-call faculty that will be available to support states in initiative planning, development, and implementation. States selected through this RFA will have the opportunity to work with these experts, either remotely, such as through conference calls or video meetings, or in-person. NASHP will continue to add experts to our faculty list, as appropriate, throughout the Academy and encourage selected states to identify and suggest additional experts. Please see Appendix A for a list of confirmed on-call faculty.

Additionally, a NASHP team will visit each selected state during the Academy. Site visits are intended to support states to further their initiatives. Previous site visits have included helping to identify state needs, including identifying project barriers, facilitating stakeholder meetings, and providing targeted state-specific technical assistance. We anticipate these visits will occur in the fall of 2016 or winter of 2017. Site visits may coincide with additional in-person expert consultation from one or more members of the Academy’s on-call faculty.

States will also have ongoing access to NASHP staff who will be available by telephone and e-mail. NASHP staff will provide a timely and actionable response to all inquiries, including referrals to external experts when necessary. Monthly individual state team calls will be held with each state to discuss its progress and barriers. States will have the opportunity during these calls to identify and address emerging technical assistance needs.

Group Technical Assistance
Group technical assistance activities will include an in-person Kick-Off Meeting in June 2016 and three state-to-state virtual learning opportunities. These learning opportunities will allow states to hear about work going on in other states, identify areas of shared need, discuss emerging challenges, and receive expert technical assistance. Topics for each group learning opportunity will be developed collaboratively to meet priority technical assistance needs identified by participating states.

NASHP will fund meeting and travel expenses for four-members of each state team selected through this RFA to attend the Kick-Off Meeting. States may bring additional team members to the Kick-Off Meeting at their own expense.
Expected Outcomes for Value-Based Payment Reform Academy States

Over the next 12 months, selected teams will advance the development and/or implementation of value-based APMs in their states. While NASHP acknowledges that state-specific goals and priorities will vary, we have identified seven common key accomplishments for participating states:

1. Agreement on a project plan that outlines shared team goals, including the project’s purpose and the intended process for developing and implementing the project. Selected states will begin collaboration on a project plan one month before the Kick-Off Meeting that details the necessary steps to reach their goals. States will have the opportunity to share and get feedback on their project plan during the Kick-Off Meeting. Subsequently, the state teams will be responsible for developing and updating the project plan over the course of the Academy. The project plan will reflect necessary steps for developing value-based APMs that align with states’ goals for transforming the delivery of care.

2. Promotion of collaboration across agencies, organizations, and other key stakeholders. Each state will work across multiple agencies and form partnerships with other key stakeholders, such as FQHC and/or RHC leadership, providers, billing staff, data analytics experts, and other payers, including Medicaid managed care organizations where applicable, to secure buy-in and inform the development of value-based APMs.

3. Identification of project scope. Stakeholders will reach agreement on whether the project will be statewide, regional, or a pilot, the number and type of providers included, and whether the APM will be implemented for a clinic’s entire assigned Medicaid population or a specific target population.

4. Development and agreement upon a value-based APM that supports states’ goals for transforming the way care is delivered to patients. State teams will need to collaborate as they develop and build consensus on value-based APMs. In states where Medicaid managed care is prevalent, state teams are encouraged to include managed care organizations in their planning. By the end of the Academy, NASHP expects that state teams will have at least coalesced around a value-based APM and have begun making any necessary policy or programmatic changes needed to implement the new payment model.

5. Establishment of new criteria or expectations for providers. Successfully implementing new payment models requires changes on both the part of Medicaid and providers. Transitioning from volume-based to value-based payment requires shifts in the way care is delivered, the necessary workforce, and an increased use of data analytics to guide quality improvement efforts. NASHP expects that by the end of the Academy states will have engaged providers in the development and refinement of a value-based APM, created new expectations or standards for providers, identified provider needs, and begun developing resources and training opportunities to support providers in the transition to a new APM.

6. Identification of capacity for both the Medicaid agency and FQHCs/RHCs to share cost, quality, utilization, and patient experience data. The capacity to share data is critical for the successful implementation of value-based APMs. Understanding the Medicaid
agency and providers’ capacity to share data and produce and utilize data analytics, respectively, is an important consideration when developing value-based APMs. NASHP expects that by the end of the Academy state teams will have assessed and identified their capacity for data exchange and utilization and factored those considerations into the development of their models.

7. **Development of a plan for using metrics for quality improvement and project evaluation.** We expect states to reach consensus on key measures for assessing practice performance and promoting quality improvement as well as a set of core measures for evaluation of the value-based APM. States may wish to consider taking advantage of the Uniform Data System\textsuperscript{13} data already collected from many FQHCs participating in the federal Health Center Program overseen by HRSA.

**The National Academy for State Health Policy**

NASHP is uniquely positioned to support states in developing and/or implementing value-based payment models for FQHCs and RHCs because of its strength in coalescing state agencies, organizations, and other stakeholders with a broad range of perspectives to focus on strategies to address specific issues.

NASHP also has a long track record of providing technical assistance to states to create concrete and sustainable health system reform. NASHP has extensive experience working with states on Medicaid delivery system and payment reform initiatives. It convened four learning collaboratives between 2008 and 2015 that assisted and accelerated state efforts to improve the delivery of primary care through advancing the medical home model for Medicaid, CHIP, and commercial populations. In 2014 and 2015, NASHP convened a learning community of eight states to support their efforts to advance delivery system and payment reforms that promote integrated care. Since 2015, NASHP has convened a learning collaborative that supports states to develop integrated models of care that incorporate primary care, behavioral health, and social services for patients with mild-to-moderate behavioral health needs. NASHP also has an in-depth understanding of the safety net health system. Between 2012 and 2014, NASHP convened a learning collaborative that supported six states in promoting collaboration between Medicaid and safety net providers to advance Medicaid policies impacting vulnerable populations. Participating states developed and implemented a host of initiatives, including a patient-centered medical home pilot and a community care team pilot.

**Expectations of Participation**

With support of the Health Resources and Services Administration, NASHP plans to commit time and resources to each selected state team. In return, we expect each state team to commit to furthering its own initiative and helping us to advance the field more broadly. Specifically, each state team will be expected to:

- **Maintain a core team of at least four members:** participants from the state’s Medicaid agency and Primary Care Association should have decision-making authority.
- **Draft a project plan** that identifies your goals and actionable steps to achieve these goals. States will have the opportunity to share and receive feedback on their project plan during the Kick-Off Meeting.
• Respond to a needs assessment survey describing the infrastructure and capacity in your state for implementing a value-based APM for FQHCs and RHCs, as well as any perceived or realized barriers or challenges that could impede the development of your work. Surveys will be used by NASHP to develop the most effective and efficient technical assistance that targets state needs.
• Participate in monthly individual team technical assistance calls with NASHP staff to identify progress and barriers as well as identify any emerging technical assistance needs.
• Revise project plan as necessary to improve your state’s initiative during the 12-month technical assistance period.
• Participate in all group and individual technical assistance activities as planned, including the June 2016 in-person Kick-Off Meeting, three state-to-state learning opportunities, monthly state team calls, and consultation with experts.
• Achieve goals stated in your project plan. NASHP will check in with each state team regarding progress toward these goals as well as challenges during the monthly individual state team calls.
• Organize a site visit with NASHP staff for fall 2016 or winter 2017.

Application Guidelines

Team Composition
Applicant states must identify four to six team members to participate in this Academy. Teams must include:

1. Senior Medicaid leadership
2. Senior Primary Care Association leadership
3. FQHC or RHC provider representation
4. Other based on state’s project focus (e.g., other payers, Medicaid managed care organizations, state data analytics staff, legislators, public health officials, health policy advisors)
5. Other (Optional)
6. Other (Optional)

Letters of Support
In some cases it may not be feasible for the Medicaid Director and/or Primary Care Association Executive Director to be involved in monthly team meetings for this project. In these cases, a letter indicating their support is encouraged.

States interested in implementing APMs through managed care organizations are strongly encouraged to have managed care representation on their team or, at a minimum, to submit a letter of support along with their application.

Kick-Off Meeting
All core team members are expected to attend the June 2016 Kick-Off Meeting. We are planning to hold the Kick-Off Meeting on either June 14-15, 2016 or June 23-24, 2016 (the location is to be determined). The application asks core team members to list their individual availability for these two potential dates in June. We kindly ask that you hold these dates on your calendar and we will make every attempt to meet state team members’ availability. Funding is available to
cover the travel and meeting expenses of up to four members of the core team. State teams may bring additional members at their own expense.

*Application Evaluation Criteria*

NASHP staff and an advisory group will review all state applications. Applications will be evaluated on the extent to which they demonstrate the following four criteria. Please note all four criteria will be weighted equally.

- **Collaborative:** Strong candidate states will include senior leadership from Medicaid and the state’s primary care association, as well as support and participation from a range of other relevant stakeholders, including FQHCs and/or RHCs, indicating an appropriate degree of policy “buy-in.” State applications should also reflect if there is history of collaboration across key stakeholders, if there is any complimentary work on which states can build, and a strategy to involve any necessary stakeholders not engaged at the time of application.

- **Transformative:** Strong candidate states will describe their goals for payment reform for FQHCs and/or RHCs and the reasons for changing payment. Additionally, candidates should describe how the development of value-based APMs would support providers in transforming the way care is delivered.

- **Quality and efficiency-oriented:** Strong candidate states will demonstrate how quality and efficiency will be incorporated into their value-based APMs.

- **Achievable:** Since this Academy is limited to 12 months, strong candidate states will demonstrate how their goals will be achievable within this time frame.

If you have questions about this application process, we are hosting an informational webinar on March 10, 2016 from 2:00-3:00pm EDT. NASHP staff will review this RFA and answer any participant questions. To register for the webinar, please visit: [https://cc.readytalk.com/r/y7ekmrz6tzrg&eom](https://cc.readytalk.com/r/y7ekmrz6tzrg&eom). If you are unable to attend the webinar, or have any other questions about the application process, please contact Rachel Yalowich (ryalowich@nashp.org).

To apply to participate in the Value-Based Payment Reform Academy, please complete the following application and provide accompanying letters of support, as necessary, electronically and email it to Hannah Dorr (hdorr@nashp.org) by 5pm EDT on Friday, April 1, 2016. Please answer the questions in no more than five to six double-spaced pages. We do not need extremely detailed answers to each question, but rather sufficient information to assess your initiative against the criteria listed above. **We will notify each candidate state of the status of its application no later than April 21, 2016.**
Appendix A – On-Call Faculty

The following lists on-call faculty that have committed to participate*:

State Medicaid
1. **Lindy Harrington**, Deputy Director, Health Care Financing, California Department of Health Care Services  
2. **Judy Mohr Peterson**, Med-QUEST Division Administrator, Hawaii Department of Human Services  
3. **Donald Ross**, Manager Policy and Planning, Office of Medical Assistance Programs, Oregon Health Authority  
4. **Ryan Witz**, Assistant Deputy Director, Health Care Financing, California Department of Health Care Services

State Primary Care Association
1. **Craig Hostetler**, Executive Director, Oregon Primary Care Association  
2. **Andrea Patterson**, Director of Government Affairs, California Primary Care Association

Federal
1. **Mary Cieslicki**, Technical Director, Division of Reimbursement and State Financing, Financial Management Group, Centers for Medicare and Medicaid Services  
2. **John Giles**, Policy Specialist, Division of Managed Care Plans, Centers for Medicare and Medicaid Services  
3. **Jennifer Joseph**, Director, Office of Policy and Program Development, Bureau of Primary Health Care, Health Resources and Services Administration  
4. **Suma Nair**, Director, Office of Quality Improvement, Bureau of Primary Health Care, Health Resources and Services Administration  
5. **CMS Regional Offices**

National
1. **Jana Eubank**, Associate Vice President, Public Policy and Research Division, National Association of Community Health Centers  
2. **Deidre Gifford**, Director of State Policy and Programs, National Association of Medicaid Directors  
3. **Dawn McKinney**, Director, State Affairs, Federal and State Affairs Department, National Association of Community Health Centers
Health Systems and Provider Groups
    1. Charlie Alfero, Executive Director, Hidalgo Medical Services
    2. David Labby, Health Strategy Advisor, Health Share of Oregon

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1 This work is supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services under grant number UD3OA22891. 
2 The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), requires FQHCs and RHCs to be reimbursed through the prospective payment system (PPS). Full text of the Act can be found here: https://www.govtrack.us/congress/bills/106/hr5661/text. 
7 The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), requires FQHCs and RHCs to be reimbursed through the prospective payment system (PPS). Full text of the Act can be found here: https://www.govtrack.us/congress/bills/106/hr5661/text. 
8 PPS rates vary by clinic because they are based on average cost per visit rates. For more information on PPS, please see http://www.nachc.com/IB69%20PPS%20Complete.pdf. 
12 Please note that this is a working list. NASHP is actively adding state, federal, andnational experts to this list in advance of the launch of this academy and will continue to add faculty throughout its duration. 
13 For more information on Uniform Data System data collected by HRSA about Health Center Program grantees, please visit: http://bphc.hrsa.gov/datareporting/reporting/index.html.