Washington State Health Care Authority

Report to the Legislature

Alternative Payment Model 4 (APM4) Program Evaluation

Evaluating cost effectiveness and impacts on patient outcomes with the APM4 FQHC value-based purchasing model

Engrossed Substitute Senate Bill 5693; Section 211(44)(a); Chapter 297; Laws of 2022

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Acronym Glossary

AMM-Acute	Antidepressant Medication Management – effective acute phase
AMM-CONT	Antidepressant Medication Management – continuation phase
APM	Alternative Payment Model, Alternative Payment Methodology
CBP	Controlling High Blood Pressure
CDC-BP	Comprehensive Diabetes Care – Blood Pressure Control
CDC-HbA1c	Comprehensive Diabetes Care – poor Hba1c control
CDPS	Chronic illness and Disability Payment System
CIS	Change In Scope
CIS	Childhood Immunization Status – Combo 10
CMMI	Center for Medicare and Medicaid Innovation
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
ED	Emergency Department
EQRO	External Quality Review Organization
FFS	Fee-For-Service
FFSE	Fee-For-Service Equivalency
FQHC	Federally Qualified Health Center
HB	House Bill
HbA1c	Hemoglobin A1c
HCA	Health Care Authority
IS	Improvement Score
LSDV	Least-Squares Dummy Variable
MCO	Managed Care Organization
MEI	Medicare Economic Index
MLD	Member-Level Data
MMA	Medication Management for people with Asthma
MOU	Memorandum of Understanding
NCQA	National Committee for Quality Assurance
OFM	Office of Financial Management
PCP	Primary Care Provider
PHE	Public Health Emergency

PM2	Payment Test Model 2
PMPM	Per Member Per Month
PPS	Prospective Payment System
QIS	Quality Improvement Score
QS	Quality Score
RHC	Rural Health Center
SB	Senate Bill
SIM	State Innovation Model
SPA	State Plan Amendment
VBP	Value-Based Purchasing
VSSL	Value and Systems Science Lab
WAC	Washington Administrative Code
WACH	Washington Association of Community Health
WCV	Well-Child Visits in the 3rd-6th years of life

Executive summary

This report provides an evaluation of the federally qualified health center (FQHC) value-based purchasing (VBP) model titled Alternative Payment Model 4 (APM4). The evaluation for APM4 is from July 1, 2017–December 31, 2020, as required by Senate Bill (SB) 5693 (2022), Section 211(44)(a), Chapter 297, Laws of 2022 (full proviso is in Appendix A):

> The authority in collaboration with the office of financial management and representatives from fiscal committees of the legislature shall conduct an evaluation of the APM4 model to determine its cost effectiveness and impact on patient outcomes and report its findings and recommendations to the appropriate committees of the legislature by November 15, 2022.

This report includes:

- An overview of the APM4 program, including background, goals, and details of the payment model.
- A fiscal analysis of the APM4 payment model for each available reconciliation year (2017-2020).
- An evaluation of the APM4 program, including the impact on total cost of care and total expenditures, quality of care performance, and utilization of care from July 1, 2017–December 31, 2020.
- Next steps and recommendations for future development of FQHC VBP models.

FQHCs are safety net providers who deliver outpatient services to a medically underserved area or population. FQHCs are a critical component of the primary care infrastructure in Washington, serving 37 percent of Medicaid enrollees in the state.

FQHCs receive cost-based reimbursement for face-to-face or telehealth patient visits, known as encounters. The payment method incentivizes providers to increase patient encounters, regardless of the clinical need for those encounters.

The Health Care Authority (HCA) and state FQHCs wanted to pilot a model that would purchase value (e.g., more health and quality outcomes) rather than volume. The goals of the model were to expand access to care, incentivize alternatives to traditional face-to-face visits, stabilize growth of costs, and potentially generate savings from reduced utilization.

FQHCs that chose to participate in APM4 were paid for volume of assigned Medicaid enrollees rather than volume of services. Consistent with federal law, participating FQHCs could never be paid less than the APM3 entitlement (FQHC encounters multiplied by the encounter rate). FQHCs could be eligible for payments beyond the APM3 entitlement if they achieved certain quality thresholds.

The thresholds, agreed upon by HCA and FQHCs, were essentially equivalent to maintaining prior performance. Participants met the threshold in 2017-2019, and only four FQHCs missed the threshold in 2020 (during nationwide declines in quality performance due to COVID-19). FQHCs that chose not to participate in APM4 remained in the APM3 construct (encounter-based payment).

From 2017-2020, Washington paid APM4 participants $112.4 million beyond APM3 payments (roughly $7.91 more per member per month (PMPM) than APM3 clinics). **The goal of a sustainable, budget-neutral program was not achieved.** The overpayments were driven by two key factors:

- As managed care membership growth exceeded projections from 2017-2020, APM4 entitlements exceeded APM3 entitlements. This disparity was particularly pronounced in 2020 during the COVID-19 pandemic, which caused notable declines in utilization (drawing down the APM3 entitlement) and notable increases in Medicaid enrollment (increasing the APM4 entitlement).
- The memorandum of understanding (MOU) between HCA and the FQHCs did not include any guardrails to limit overpayments or to enforce budget neutrality.

In 2021, HCA and the participating FQHCs signed an amended APM4 agreement that revised the calculation of the PMPM rate and slightly increased the quality threshold required to retain payments above the APM3 entitlement. The financial impact of this amendment will not be available until the end of 2022. Due to the deadline mandated by the Legislature in SB 5693 (2022), a fiscal review of the 2021-2022 contract periods is outside the scope of this legislative report.

HCA's evaluation of the APM4 program identified the following impacts:

- **Quality:** compared to non-participating FQHCs, patients assigned to APM4 FQHCs showed no statistical improvement on seven of nine quality measures in the original contract. There were statistically significant improvements in two diabetes outcomes measures (blood pressure and hemoglobin A1c control).
- **Cost:** there is evidence that FQHCs that did not participate in the APM4 program had higher costs per member month than did APM4 participants prior to implementation of the payment model. Our findings suggest this gap may have slightly widened following implementation. From 2015-2020, the total cost of care for members assigned to APM4 participants was $8 lower PMPM relative to non-participating FQHCs, though this finding had minimal statistical significance for such a large data set. The $8 PMPM in lower cost was largely canceled out by payments that exceeded the APM3 entitlement ($7.92 PMPM).
- **Utilization:** APM4 participants and non-participants experienced similar decreases in the probability of an assigned member having an emergency department visit, a primary care visit, and in the total number of claims.

Next Steps and Recommendations

The APM4 model concluded on December 31, 2022, in accordance with the MOU and the legislative directive in SB 5693 (See Appendix A). At the conclusion of the APM4 model, participating FQHCs will revert to the APM3 encounter-based payment model.

HCA is committed to continuing sustainable and meaningful value-based purchasing arrangements with FQHCs and has begun preliminary concept development of future FQHC VBP models. HCA recommends the development of a future FQHC VBP model that:

- Holds FQHCs financially accountable to evidence-based practice transformation activities and to meaningful cost and quality targets.
- Incentivizes meaningful and tangible annual improvements in quality of care and patient outcomes, and reduced disparities in health outcomes.
- Ensures that FQHCs never receive less than their federally mandated entitlement.
- Sustainably maintains transparent and predictable spending, including setting a budgetary maximum on any payments beyond the federally mandated entitlement.
- Is mutually agreed upon by FQHCs, HCA, the Legislature, OFM, and CMS.

Background

FQHC overview

FQHCs are "safety net" providers, such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. FQHCs treat a predominantly Medicaid population in underserved urban and rural communities. They offer access to primary and comprehensive care regardless of a patient's ability to pay for services. Cost-based payment requirements for FQHCs under Medicare (and subsequently Medicaid) were established by Congress under section 4161 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 and were effective beginning on October 1, 1991. FQHC services are typically provided in an outpatient setting.

There are currently 31 FQHCs with a combined total of 433 locations serving Apple Health enrollees. (Apple Health is Medicaid in Washington State.) These FQHCs provide services to approximately 37 percent of Washington's Medicaid managed care population, and approximately 61 percent of all Medicaid adult dental services. FQHCs in Washington provide a wide range of primary and comprehensive care, including outpatient medical services, mental health, dental, maternity support and infant case management services, substance use disorder services, and pharmacy.

FQHC payment structure

FQHCs receive cost-based reimbursement in return for serving medically underserved areas and/or populations. The basic premise behind FQHC cost-based encounter rates can be captured by the following formula: Allowable Costs ÷ Visits (as reported in each FQHCs Medicaid cost report) = Encounter Rate.

Allowable costs must be reasonable and necessary, and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of FQHC services. Visits reported in the FQHC Medicaid Cost Report include all face-to-face or telehealth visits between a qualifying practitioner and a patient, regardless of insurance coverage or payer type (e.g., commercial, Medicare, Medicaid.). FQHC encounter rates are cost-based and unique to each organization. FQHCs are entitled to receive the full encounter rate for each qualifying Medicaid visit.[1]

FQHC reimbursement in Medicaid managed care

CMS and HCA recognize that FQHCs do not receive their full encounter rate throughout the year from their contracted Medicaid managed care organizations (MCOs). MCOs pay for services only. It is HCA's

[1] Qualifying FQHC visits are defined as a face-to-face or telemedicine visit between a qualifying Medicaid client and an FQHC provider who exercises independent judgment when providing services that qualify for encounter rate reimbursement. Qualifying FQHC visits can only be performed by independent health care professionals, such as physicians, dentists, and physician assistants. See WAC 182-548-1300. Services provided by non-encounter-eligible FQHC staff, such as those performed by registered nurses, care coordinators, and community health care workers, are not eligible for encounter reimbursement. The costs for providing non-encounter-eligible services are included in the calculation of the encounter rate and are therefore indirectly reimbursed each time an encounter is billed.

responsibility to ensure that FQHCs are paid as close to their encounter rate as possible for each qualifying visit. Therefore, HCA calculates and pays monthly enhancement payments to FQHCs based on total clients assigned to the FQHCs by MCOs.

HCA performs an annual reconciliation of the total payments received by FQHCs (i.e., MCO payments and enhancement payments) to ensure they received their full encounter-based reimbursement. After the determination has been made, HCA either recoups from (in the case of overpayments) or makes an additional payment to (in the case of underpayments) each FQHC.

FQHC payment structure and legal framework

Overview of federal and state regulation

FQHC cost-based encounter payments and alternate payment methodologies (APMs), including APM4, are derived from the following federal and state authority:

Federal statute 42 U.S.C 1396a (bb)(6):

> (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.

Washington APM history

From January 1, 2001, through December 31, 2008, FQHCs were reimbursed on a prospective payment system (PPS). As described in WAC 182-548-1400, effective January 1, 2009, FQHCs were provided the option to participate in an APM as authorized in Section 1902 [42 U.S.C. 1396] (bb)(6) of the Social Security Act. FQHCs that did not choose the APM are paid under the PPS methodology.[2]

All FQHC APMs must be approved in a State Plan Amendment (SPA). Additionally, payments under APMs must be at least equal to payments that would have been made under the PPS. Prior to APM4, HCA and FQHCs went through three APMs as described below:

- APM1: January 1, 2009–April 6, 2011
  - Based on FQHC cost reports and calculated based on an average of 1999 and 2000 PPS rates.
  - Encounter rates inflated by a Washington-specific health care index.
- APM 2: April 7, 2011–June 30, 2011

[2] One FQHC in the state of Washington operates under the PPS methodology. All other FQHCs are on paid under an APM.

- PPS rate inflated by five percent.

- APM 3: July 1, 2011–present
  - Calendar year 2008 FQHC encounter rates as calculated under APM1 inflated by Medicare Economic Index (MEI)[3] from 2009-2010
  - FQHCs that have chosen not to participate in APM4 remain on APM3.

[3] MEI is defined as "An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule." https://www.aapc.com/medicalcodingglossary/medicare-economic.aspx. FQHC encounter rates, enhancement rates, and APM4 PMPM rates are adjusted by the MEI each year on January 1.

APM4 program development and overview

State Innovation Model (SIM) overview

SB 5034 (2014) directed HCA to develop a report that identified options for a new payment methodology that rewarded for outcomes over the volume of services. Concurrently, in 2014, the Washington State Legislature passed House Bill (HB) 2572, which established a state health care innovation plan that would "advance value-based purchasing across the community" and directed HCA to be "responsible for coordination, implementation, and administration of interagency efforts and local collaborations of public and private organizations to implement the state health care innovation plan."

This plan formed the foundation upon which Washington launched the design of several health care reform efforts, including a new VBP model for FQHCs, using grant funding from the Center for Medicare & Medicaid Innovation (CMMI).

On February 1, 2015, Washington State received a four-year, $64.9 million Round 2 State Innovation Model (SIM) Test grant from CMMI to implement a broad range of health and health care reforms in Washington. Those reforms were intended to:

- Improve population health
- Improve quality of care, especially for persons with physical and behavioral health comorbidities
- Reduce growth in per capita health care payments.

One program within SIM was the introduction of a voluntary VBP model for FQHCs. The specific VBP model was termed "Payment Test Model 2 (PM2)." PM2 encapsulated two different models and pilots, one focused on reforming payments for FQHCs and rural health clinics (RHCs), and another pilot focused on the creation of a rural multi-payer model.

APM4 program: intended outcomes

HCA engaged with FQHC and RHC stakeholders in 2016 to develop the framework for APM4 as part of the SIM grant. HCA, FQHCs, and the Legislature agreed that a revised FQHC payment model should replace the volume-based payment system, which incented centers and clinics to schedule billable, but potentially avoidable, visits. Because of the strict definition of an "encounter," health centers could not bill for all critical services, such as patient education and case management for chronic disease support or non-clinical services (e.g., transportation or housing assistance) to address social determinants of health . The goal behind the switch from volume-based to value-based care was to create financial incentives for FQHCs to innovate and provide integrated, whole-person services.

HCA, participating FQHCs, and the Legislature further envisioned several intended outcomes for the model, including improved access to care, improved health outcomes, and slower cost growth. These outcomes were outlined as follows:

- FQHCs would manage their Medicaid clients without the burden of increasing the total number of encounters they provided.
    - Expand access to primary care in medically underserved areas.
- Incentivize alternatives to traditional face-to-face encounters, providing patients with more patient centered care.

- Stabilization of growth of health care costs on a long-term basis.
    - Yield savings from reduced emergency department (ED) use, inpatient stays, and other visits.
- Guarantee that FQHCs would receive their APM3/PPS rates through the annual reconciliation of qualifying encounters.

APM4 program overview

With these intended outcomes in mind, APM4 was designed to incentivize practice transformation and improved population outcomes via quality measures, while maintaining participating FQHCs' encounter-based entitlement under APM3.

The APM4 model was intended to remain budget neutral, meaning that annual state and federal spending on FQHC enhancements within the APM4 model should not be greater than annual spending would have been in absence of the model (e.g., payments under APM3). The model converted the volume-based payment of FFS plus enhancement payments, to a PMPM payment. FQHCs receive the PMPM for each client assigned to them through an MCO, regardless of whether the client generates a billable encounter. The precise calculation of the PMPM payments is detailed in the section of this report titled "Payment under the APM4 MOU and Amendments".

In addition to converting payment to a more flexible per member model, the APM4 model tied prospective payment incentives to quality performance on a subset of quality measures on the Washington State Common Measure Set. HCA used these metrics to calculate a Quality Improvement Score (QIS) on an annual basis for each participating FQHC.

The weights, targets, and means used to calculate the QIS were set by HCA's chief medical officer (CMO), along with FQHCs. Participating FQHCs were compared against two baselines (their own quality performance in the prior year, and the national 50th percentile benchmark from 2015), and a target (the national 90th percentile benchmark from 2015). A point value was awarded for each of these comparisons and converted to a composite quality score.

If the composite QIS did not meet an established minimum threshold, the FQHC's PMPM for the next year could be adjusted downward proportional to the QIS (though this downward adjustment could never result in a PMPM less than the APM3 entitlement). From 2017 through 2019, all participating FQHCs reached the minimum QIS threshold, and no payments were adjusted downward. The precise calculation of the QIS is detailed later in this report.

Washington Administrative Code (WAC) 182-548-1400(8) describes the methodology HCA used to pay APM4 participants from July 1, 2017, through December 31, 2022:

> (8) This subsection describes the payment methodology that the agency uses to pay participating FQHCs for services provided beginning July 1, 2017.
>
> (a) Each FQHC may receive payments under the APM described in subsection (7) of this section, or receive payments under the revised APM described in this subsection.
>
> (b) The revised APM is as follows:

(i) The revised APM establishes a budget-neutral, baseline per member per month (PMPM) rate for each FQHC. The PMPM rate accounts for enhancement payments in accordance with the definition of enhancements in WAC 182-548-1100. For the purposes of this section, "budget-neutral" means the cost of the revised APM to the agency will not exceed what would have otherwise been spent not including the revised APM on a per member per year basis.

(ii) The agency pays the FQHC a PMPM payment each month for each managed care client assigned to them by an MCO.

(iii) The agency pays the FQHC a PMPM rate in addition to the amounts the MCO pays the FQHC. The agency may prospectively adjust the FQHC's PMPM rate for any of the following reasons:

(A) Quality and access metrics performance.

(B) FQHC encounter rate changes.

(iv) In accordance with 42 U.S.C. 1396a (bb)(5)(A), the agency performs an annual reconciliation.

(A) If the FQHC was underpaid, the agency pays the difference, and the PMPM rate may be subject to prospective adjustment under (b)(iii) of this subsection.

(B) If the FQHC was overpaid, the PMPM rate may be subject to prospective adjustment under (b)(iii) of this subsection.

Payment and fiscal impact under the APM4 MOU and amended MOU

HCA engaged with FQHC and RHC stakeholders in 2016 to develop the framework for APM4 as part of the SIM grant. HCA and FQHCs initially codified the APM4 model in an MOU with an effective contract period of July 1, 2017, through December 31, 2022. Sixteen FQHCs agreed to participate in the APM4 model (no RHCs elected to participate).

APM4 was later updated in an amendment to the MOU effective January 1, 2021 through December 31, 2022. The impact of that amendment on calendar years 2021 and 2022 is unknown, due to the timing of claims, MCO payments and the annual reconciliation, and is outside the scope of this evaluation.

Payment under the MOU, July 2017–December 2020

The original APM4 MOU payment method was in effect from July 1, 2017, through December 31, 2020. FQHC APM4 PMPM rates were calculated for each participating FQHC, using calendar year 2015 as the baseline. The APM4 PMPM captured the entire FQHC encounter rate, comprised of both HCA enhancement payments and FQHC service payments from MCOs converted to a fee-for-service equivalency (FFSE). The MOU used the following calculation to convert APM3 encounter rates to a baseline APM4 PMPM rate:

Figure 1: APM4 MOU PMPM calculation (July 2017–December 2020)

$$\frac{\text{(CY2015 encounter rate X CY2015 Encounters)}}{\text{CY2015 Member Months}} = \text{APM4 PMPM Rate}$$

The MOU trended the calendar year 2015 baseline APM4 PMPM rates on a calendar year basis by the MEI. APM4 PMPMs were then linked to the quality incentives described in the previous section. If an FQHC failed to meet the quality measure targets, their APM4 PMPM rate could be adjusted downward; however, per state and federal regulations, payments could never drop below the FQHCs' calendar year APM3 entitlement (APM3 encounter rate X encounters).

MOU budget neutrality concerns

At the time the original APM4 MOU was implemented, WAC 182-548-1450(6)(b) applied an FFSE methodology to MCO payments. The FFSE method did not account for the actual payments received by FQHCs from MCOs. Instead, services provided by FQHCs to managed care enrollees were repriced to Medicaid fee schedule amounts. If an MCO was contracted with an FQHC at a rate that exceeded the Medicaid fee schedule, these payments were unaccounted for in the APM4 PMPM rate.

Each year, HCA is required to perform an annual reconciliation with FQHCs participating in APM4. The first component of the annual reconciliation ensures that participating FQHCs received no less than their full APM3 entitlement by comparing managed care encounter data and annual enhancement payments submitted by FQHCs. The second component of the reconciliation ensures that participating FQHCs received their full APM4 entitlement (APM4 PMPM rate multiplied by MCO enrollment). Under the third component of the reconciliation, HCA considers the FQHC's QIS.

Participating FQHCs that achieved the required QIS threshold were able to retain any enhancement payments that exceeded their APM3 entitlement (up to, but not exceeding the APM4 entitlement). If the QIS threshold was not achieved, the APM4 PMPM rate was prospectively adjusted downward based on the final quality score for that year (but never below the APM3 entitlement).

In the annual APM4 reconciliation, if total payments to FQHCs (HCA enhancements + FFSE) fell below the total APM4 PMPM entitlement amounts, then HCA owed FQHCs additional funds. The additional amounts owed to the FQHCs were in excess of the APM3 entitlement and were retained by FQHCs if they achieved the required QIS threshold. These additional funds exceeded budget neutrality (a central design goal of APM4 program) and required that HCA request additional APM4 funding from the Legislature each year.

APM4 Model Fiscal Impacts – July 1, 2017–December 31, 2020

From July 1, 2017, through December 31, 2020, participating APM4 FQHCs retained a total of $82,216,617 above their APM3 entitlement in monthly enhancement payments. In many cases, FQHC enhancement payments exceeding the APM3 entitlement did not meet the APM4 PMPM entitlement and HCA was required to make additional payments to participating FQHCs.

For the 2017-2020 reconciliations with APM4 participants, HCA made additional payments that totaled $31,256,021. Because these funds exceeded budget neutrality within the APM4 model, they necessitated legislative requests to increase the budget. These requests were funded as follows:

- In fiscal year 2020, HCA requested funding from the Legislature for 2017-2019 APM4 reconciliation amounts owed to APM4 participants. Using actual data for 2017 and 2018, as well as projected data for 2019 (which had not yet been submitted by FQHCs), HCA requested a total of $10,434,716. The Legislature provided $5,162,000 of the requested amounts in proviso SB 6168, which allocated the funds for state fiscal year 2020. The proviso directed HCA to utilize unliquidated state funds for the remaining $5,272,716 owed to APM4 participants. Additionally, HCA was directed to accrue any anticipated amounts owed under the APM4 model in future years. When final reconciliations were submitted by APM4 participants for 2017-2019, the data determined that HCA owed FQHCs a total of $9.95 million, which was approximately $480,000 less than the $10.4 million requested from the Legislature.
- In June 2021, HCA accrued $31,215,002, based on internal projections of amounts owed to APM4 participants in the calendar year 2020 APM4 reconciliations. When accruing these amounts, HCA used projections because final APM4 reconciliations were not submitted by FQHCs until September 30, 2021. When final reconciliations were submitted by APM4 participants, the data determined that HCA owed FQHCs $21,302,224, which fell below the $31.2 million requested in the accrual.

In total, finalized APM4 reconciliation data (submitted by FQHCs) demonstrated that between APM3 overpayments ($82.2 million) and the additional payments requested to bring FQHCs up to the APM4 entitlement ($31.2 million), participants received a total of $112,445,843 above the FQHC APM3 entitlement from 2017-2020.

Table 1: APM4 MOU fiscal impact

Reconciliation Year	APM3 Entitlement (FQHC Encounters x Encounter Rate)	Payments above APM3 (Pmts exceeding APM3 entitlement)	Total Addtl APM4 PMTS (Funds requiring proviso or accrual)	APM4 Entitlement (APM4 PMPM x MCO Enrollment)	Total Payments Made Above APM3	GF-S
July 1 through Dec 31, 2017	$ 95,328,774	$ 8,172,363	$ 2,651,214	$ 104,572,392	$ 10,487,643	$ 3,670,675
2018	$ 213,526,485	$ 12,374,426	$ 2,929,436	$ 222,134,741	$ 14,613,002	$ 5,114,551
2019	$ 226,151,184	$ 15,478,404	$ 4,373,146	$ 236,416,296	$ 19,851,551	$ 6,948,043
2020	$ 210,569,039	$ 46,191,423	$ 21,302,224	$ 275,729,818	$ 67,493,647	$ 23,622,777
Total	$745,575,482	$ 82,216,617	$31,256,021	$838,853,247	$112,445,843	$39,356,045

Detailed settlement information relating to the table above for each FQHC's reconciliation for calendar years 2017-2020 is outlined in Appendix B (participants have been blinded to maintain anonymity).

Enrollment and encounter impacts

APM4 reconciliations and fiscal impacts were influenced by year-over-year changes in encounters and MCO member month enrollment. Member months refer to the number of individuals assigned to a participating FQHC each month throughout the calendar year. From calendar year 2018 to 2019, APM4 FQHCs experienced an increase in encounters of two percent and an increase of MCO member month enrollment of 0.6 percent. Due to the public health emergency caused by the COVID-19 pandemic, in calendar year 2020 participating FQHCs experienced a decline in encounters of 10.6 percent and an increase in MCO member month enrollment of 12.2 percent.

Table 2: APM4 FQHC encounters and MCO member month enrollment

APM4 FQHC Encounters and MCO Member Month Enrollment		
Reconciliation Year	FQHC Encounters	FQHC MCO Member Month Enrollment
July 1 - Dec 31, 2017	399,726	1,913,595
2018	839,140	3,768,507
2019	857,789	3,820,052
2020	766,671	4,253,503
Total	2,863,326	13,755,657

Encounter and enrollment fluctuations within the APM4 model created unpredictable spending, primarily caused by year-over-year increases in managed care enrollment at participating FQHCs. When participating FQHCs experienced increases in MCO enrollment, the total APM4 PMPM entitlement owed to FQHCs also increased regardless of whether or not the new members were engaged in care. Calendar year 2020 was disproportionately impacted, due to unforeseen effects related to the COVID-19 pandemic.

MOU amendment

Drafting the MOU amendment

HCA recognized budget neutrality concerns in the APM4 model in late 2018, when the 2017 reconciliations were submitted by FQHCs. HCA engaged with participating FQHCs and the Washington Association of Community Health (WACH) to begin developing potential amendments to the APM4 payment model to achieve budget neutrality. HCA also sought to increase the APM4 QIS threshold and update quality metrics within the model. Amendment designs and concepts were developed with assistance from the actuarial consulting firm, Milliman Inc.

At the same time, the Washington State Legislature and the Office of Financial Management (OFM) directed HCA to amend the APM4 model in budget proviso SB 6168, which stated:

> The authority in collaboration with the representatives in (b) of this subsection must develop an updated APM4 model and memorandum of understanding that:
>
> i. Complies with budget neutrality requirements and spending limits as required under the omnibus appropriations act;
>
> ii. Identifies predictable spending targets;
>
> iii. Clearly defines quality performance standards for participating FQHCs;
>
> iv. Requires progressively increasing standards of quality performance for participating FQHCs;
>
> v. Requires progressively increasing standards of financial performance for participating FQHCs; and requires that reconciliation payments made under APM4 may not fall below the payment level required by the federal law for qualifying face-to-face encounters.

With the onset of COVID-19 in March 2020, development and implementation of the amendment were delayed while FQHCs and HCA prioritized the public health emergency (PHE) response. In November of 2020, HCA and WACH reengaged in efforts to draft a mutually-agreed-upon amendment to the MOU that allowed HCA to meet the requirements of the Legislature and OFM. Additionally, HCA resumed communications regarding proposed amendments to the MOU with OFM/Legislative staff. In May 2021, HCA and WACH finalized amended APM4 MOU in alignment with the requirements outlined above.

Although FQHC participants retained the legal right to maintain the original APM4 MOU contract, all 16 APM4 participants signed the APM4 amendment by June 2021. The revised MOU was retroactive to January 1, 2021, with an end date of December 31, 2022.

APM4 amendment updates to quality benchmarks and payment calculation

The final MOU amendment increased quality improvement thresholds and updated the calculation of the APM4 PMPM. Where the original MOU converted the entire APM3 entitlement into a PMPM, the amended APM4 PMPMs were updated to only include the enhancement (wraparound) portion of FQHC payments. To achieve this, the amended equation subtracted the FFSE or managed care service portion of the payment from the APM4 PMPM base rates. The APM4 PMPM rates were then trended forward using the MEI. The amended MOU used the following formula to calculate APM4 PMPMs:

Figure 2: APM4 MOU amendment PMPM calculation, effective January 1, 2021–December 31, 2022

$$\frac{(\text{CY15 encounter rate} \times \text{CY15 Encounters}) - \text{2015 MCO Pmts converted to FFSE}}{\text{CY15 Member Months}} = \text{APM4 PMPM Rate}$$

APM4 amendment expected fiscal outcomes

The amendment to the MOU achieves budget neutrality requirements as required in SB 6168 and creates more predictable funding within the model for FQHC participants and HCA. In the annual APM4 reconciliation process, HCA ensures participating FQHCs retain enhancement payments made above their APM3 entitlement while also maintaining that payments never fall below the APM3 entitlement.

Additionally, the adjustment to the APM4 PMPM ensures no additional payments are made. These adjustments to the APM4 payment model ensure no further requests for funding are required from the Legislature and OFM for APM4 underpayments to FQHCs.

The APM4 Amendment did meet the fiscal requirements set forth in SB 6168; however, it did not achieve some of the fundamental financial issues within the model regarding predictable spending, and the setting of budgetary maximums or guardrails on payments beyond the federally mandated entitlement.

The actual fiscal impacts of the APM4 amendment will not be available until FQHCs submit their 2021 reconciliations in December 2022. Due to the deadline mandated by the Legislature in SB 5693 (2022), a fiscal review of the 2021-2022 contract periods is outside the scope of this legislative report.

Evaluation limitations and the impact of COVID-19

The following evaluation of patient outcomes and fiscal impacts represents a partial review of the APM4 model. Per the legislative mandate, this evaluation encompasses three and a half years (July 1, 2017–December 31, 2020) of a five-year model, which ended December 31, 2022.

At the time of this evaluation, data for quality, claims, and payment detail for calendar years 2021 and 2022 were not available and are outside of the scope of this evaluation. The following section details the methods, limitations, and results of the evaluation of the APM4 program's impact on quality of care, total cost of care, and utilization of care. It contains a detailed description of the limitations of the data and methods. In addition, HCA solicited independent third-party review of the evaluation from the University of Washington School of Medicine's Value and Systems Science Lab (VSSL). Their evaluation report is included as Appendix C.

Calendar year 2020 — COVID-19-related impacts

One limitation in evaluating the APM4 model is related to the impacts of the COVID-19 pandemic and resulting PHE. The pandemic caused unprecedented and unforeseen decreases in primary care encounters and increases in Medicaid managed care client enrollment throughout 2020 and 2021. In 2020, FQHCs experienced service-volume reductions due to the COVID-19 pandemic and the corresponding PHE.

During this period, FQHC encounters dropped by 10.6 percent, compared to calendar year 2019. FQHC enrollment increased due to a moratorium on Apple Health (Medicaid) disenrollment and the federal Families First Coronavirus Response Act allowed Apple Health enrollment to stay open for most clients during the PHE.

In calendar year 2020, Medicaid member month enrollment for APM4 participants increased by 11.4 percent in comparison to 2019. This created a pronounced disparity between the APM3 and APM4 payment amounts in 2020, as utilization declined (drawing down the APM3 entitlement) and Medicaid enrollment rose (increasing the APM4 entitlement).

Some of the FQHCs reported that the PMPM reimbursement nature of the APM4 model allowed them to sustain care and resources while responding to the COVID-19 pandemic in ways that would not have been possible under the APM3 model (an encounter-based model). In the annual 2020 reconciliation, FQHCs participating in the APM4 model retained enhancement payments exceeding their APM3 encounter-based entitlements. Meanwhile, an unprecedented number of APM3 FQHCs experienced reconciliation overpayment liabilities (owed to HCA) when payments were reconciled to their APM3 encounter entitlement. These overpayments were due to the decrease in encounters and increase in managed care enrollment.

While the PMPM payments within the APM4 model created some financial stability, the simultaneous decrease in encounters and increase in enrollment also created circumstances for a decline in FQHC quality scores. To lessen the revenue reductions potentially caused by COVID-19 trends in utilization, enrollment, and quality, the Legislature passed SB 5693, which granted relief for 2020 overpayments and quality-related adjustments (i.e., missed quality targets) directly associated with COVID-19.

> "ESSB 5963, Sec. 211, (100) $24,600,000 of the coronavirus state fiscal recovery fund—federal appropriation is provided solely for the authority to provide one-time funding to community health centers paid under either APM3 or APM4 that experienced overpayments because of COVID-19 service related reductions or had funds withheld due to missing targeted benchmarks because of extraordinary community pandemic response needs in calendar year 2020."

2017-2020 APM4 program quality, cost, and utilization evaluation

The following section details an evaluation of APM4 for July 1, 2017–December 31, 2020, as required by SB 5693:

> The authority in collaboration with the office of financial management and representatives from fiscal committees of the legislature shall conduct an evaluation of the APM4 model to determine its cost effectiveness and impact on patient outcomes and report its findings and recommendations to the appropriate committees of the legislature by November 15, 2022.

The full proviso language is available in Appendix A.

Evaluating quality of care impacts of the APM4 program

APM4 quality metrics and QIS scores

APM4 used a PMPM payment for FQHCs and linked prospective PMPM payment adjustments to quality performance measures. The APM4 metrics aligned with the metrics used in HCA's contracts with Medicaid MCOs and the Washington State Common Measure Set.

Of note, an additional metric (with two age-based sub-measures) was originally included in the MOU: medication management for people with asthma, medication compliance 50 percent ("MMA", sub-measures for ages 5-11, and for ages 12-18). There were nine quality metrics in the original MOU. However, the MMA measures were removed prior to the annual reconciliation for 2017; only the seven metrics listed below were used to calculate incentives.

Table 3: quality measures in the APM4 program

	Measure number	Description	Measure acronym
Adult measures	Measure 1	Comprehensive Diabetes Care – Poor HbA1c control (>9%)	CDC-HbA1c Poor Control
	Measure 2	Comprehensive Diabetes Care – Blood pressure control (<140/90)	CDC-BP
	Measure 3	Controlling high blood pressure (<140/90)	CBP
	Measure 4a	Antidepressant Medication Management – Effective acute phase treatment	AMM-Acute
	Measure 4b	Antidepressant Medication Management – Effective continuation phase treatment (6 months)	AMM-CONT
Pediatric measures	Measure 5	Childhood Immunization Status – combo 10	CIS
	Measure 6	Well-child visits in the 3rd, 4th, 5th, and 6th years of life	WCV

Each year, performance on each measure is scored against two baselines and a target:

- Baselines:
  - The National Committee for Quality Assurance (NCQA) Quality Compass Medicaid 50th percentile of each measure from 2015 (called the QS baseline)
  - Each FQHC's own prior performance on each measure during the prior performance year (called the IS baseline)
- Target: The NCQA Quality Compass Medicaid 90th percentile from 2015

For each measure, HCA calculates a measure composite score, which reflects the FQHC's performance as compared to both baselines and the target. The total QIS is the sum of these composite scores multiplied by the weight of each measure. Measures are weighted equally at 16.7 percent (one sixth), except for the two sub-measures (4a and 4b), which are half-weighted at 8.3 percent.[4] This formula produces a QIS, which typically ranges from a score of 0 to 1.5.

The QIS threshold for 2017-2019 was 0.2. If an FQHC achieved a QIS of 0.2 or higher, it received 100 percent of potential PMPM adjustments for the following year. If the QIS was below 0.2, the FQHC received PMPM adjustments proportionate to their QIS divided by 0.2. For example, a QIS of 0.15 earns 75

[4] If an FQHC does not have a large enough population to calculate performance for a particular measure, that measure is removed entirely and the other measures are re-weighted accordingly. For example, if one of the six measures is removed, the others would be weighted at 20% (one-fifth) each, except for the two sub-measures, which would be half-weighted at 10% each.

percent of possible adjustments because 0.15/0.2=0.75. A QIS of 0 would result in 0 prospective PMPM adjustments for the following year, but this can never be less than the APM3 entitlement. Each year is assessed independently of the others (that is, poor performance in one year does not prevent earning the full APM4 PMPM adjustment in a future year). In 2020, the QIS threshold was 0.3, and the same PMPM adjustment methodology was applied.

Although APM4 was intended to incentivize quality, several features of the QIS methodology limit the model's ability to drive quality improvements. First, the composite score for each measure only reflects improvement; if an FQHC reports performance below either the QS or IS baseline (worsening performance), that portion of the measure composite score reverts to 0 (zero). As a result, downward trends in performance are not meaningfully reflected in the final QIS.

Second, data show that at time of implementation, the participating FQHCs were generally already achieving the QS baseline (e.g., the national 50th percentile from 2015). Thus, the QIS threshold of 0.2 was a relatively low standard of quality achievement. With this QIS calculation method and low threshold, an FQHC could, in theory, report decreased quality on five out of six measures, but still receive the full PMPM adjustment if it achieved the target on the sixth measure.

From 2017 through 2019, all participating FQHCs reached the minimum QIS threshold, and no payments were adjusted downward. In 2020, four of the 16 APM4 FQHCs did not meet the quality threshold. Consistent with broadly recognized impacts of the COVID-19 pandemic, health systems nationwide experienced a decline in quality performance because of:

- Limits on non-urgent care
- Historic declines in preventive care and primary care utilization
- Historic increases in Medicaid enrollment due to the PHE's moratorium on eligibility reviews.[5]

In calendar year 2021, when HCA reviewed the 2020 QIS, it became evident that 4 of the participating FQHCs did not meet the 2020 QIS thresholds. These FQHCs had their PMPMs prospectively adjusted downward effective on January 1, 2022. However, the Legislature allotted funds under SB 5963 to grant financial relief to these FQHCs. The allotted funds essentially canceled out the downward adjustments.

Quality of care: prior work

A University of Washington team of health economists and health services researchers (Conrad et al., 2020) conducted two separate analyses of the effects of APM4 on quality of care for the period July 2014–December 2018. Conrad et al. included all 16 participating FQHCs in the analysis, and 8 non-participating FQHCs. First, the team analyzed the effect of APM4 across a variety of quality metrics calculated by the Department of Social and Health Services' Research and Data Analysis division. These metrics were not the same as the metrics included in the APM4 contract with the participating FQHCs, though some measures are related. (E.g., HbA1c testing vs. HbA1c clinical outcomes.) This analysis identified substantive effects for the colorectal cancer screening and for three diabetes care metrics that were analyzed (HbA1c testing,

[5] Preventive Health Care Dropped Significantly During First Two Months of Pandemic Lockdown; Study Finds Disparities in Switch to Telemedicine. https://www.rand.org/news/press/2020/11/05.html; and HEDIS® During and After the Pandemic, https://www.ncqa.org/wp-content/uploads/2021/09/Future-of-Hedis-During-and-After-the-Pandemic.pdf.

eye exams, and attention to nephropathy). These effects were concentrated in 2017, for which only the latter six months of the year was included in APM4.

Second, Conrad et al. assessed the 9 quality sub-measures that were included in the original APM4 MOU agreement using a pretest-post-test model design to compare 2016 and 2017 performance. They assessed performance at the FQHC level, rather than at the individual patient level. Conrad et al. found statistically significant improvements across half of the metrics; however, they were unable to draw any conclusions from this finding because there was no control group in the analysis.

Quality analysis: method and limitations

HCA used two distinct analytic methods to assess the impact of APM4 on quality of care.

In method "A," HCA used self-reported quality data submitted by the participating FQHCs to support calculation of the QIS. HCA used this self-reported data to determine the effects of APM4 at the FQHC level, rather than at the individual patient level. The member-month was grouped by member, year, and FQHC, subset to 11 or more months, and joined to the FQHC-submitted data.

There are several limitations with the self-reported quality data. First, the data was inconsistently reported, as not all FQHCs submitted data for all measures and HCA did not validate the data at the time of submission. Second, there is no comparison group in "Method A" analysis, as FQHCs that did not participate in APM4 did not submit any quality data to HCA.

In "Method B," HCA used data from its external quality review organization (EQRO), which is used to support HCA's VBP contract incentives. MCOs submit their plan-wide performance on a broad range of quality metrics to an HCA-funded EQRO that audits the data and supporting chart evidence. MCO data submissions include all the metrics used to calculate the QIS in APM4. Along with this data, MCOs also submit the member level data (MLD) that support their reported quality performance scores.

Using this dataset presented limitations to understanding the impact of APM4 program on patient quality outcomes. First, the EQRO data is a sample of a population, not the entire population.; consequently, there is a possibility that the sample does not adequately represent the measured population. Second, the EQRO data was only available starting in 2016, so this analysis cannot assess pre-implementation trends. Finally, because it is sampled data, the MLD data cannot support the preferred analytic method and the sample is specific, not random.

Despite these limitations of the MLD data, the EQRO and MLD dataset represented the best opportunity to estimate an effect of the APM4 program on the quality measures included in the APM4 program and are the primary source of data for the analysis.

For Method B, HCA used a logistic regression to estimate the effect of APM4 participation on the probability that an enrollee was in a HEDIS-metric numerator (given that the enrollee was in the denominator). The regression compared quality performance of APM4-participating FQHCs to performance of APM3 FQHCs. By comparing these FQHC groups' performance, HCA's analysis acknowledges that the Medicaid population served by these FQHCs are typically associated as serving a patient base that:

- Is more racially and ethnically diverse than the general population (i.e., their patients have been disproportionately impacted by systemic biases due to race, ethnicity, gender, language, etc.).
- Have higher social risk factors (e.g., housing and food insecurity).

HCA did not assess if there are fundamental differences in the populations served by APM3 FQHCs compared to APM4 FQHCs.

Quality of care evaluation results

The "Method A" analysis of APM4 clinics' self-reported performance shows that quality scores improved annually from 2017-2019 on all measures except Childhood Immunization Status (CIS): Combination 10. Given the data set limitations, this analysis cannot assess if the comparator group (non-APM4 FQHCs) experienced the same quality score trends.

The "Method B" analysis found no statistical evidence that APM4 participants had higher quality of care than non-participating FQHCs for qualifying enrollees for seven of the nine original-MOU quality sub-measures (MMA, CBP, WCV, AMM (acute or continuing), or CIS).

There was some evidence that APM4-participating FQHCs improved certain diabetes outcome measures. Qualifying diabetic patients attributed to an APM4 FQHC were 35 percent more likely to have blood pressure under control relative to APM3-attributed patients, though the statistical significance was low. Qualifying diabetic patients attributed to an APM4 FQHC were 50 percent more likely to have hemoglobin A1c levels under control relative to APM3-attributed patients, with high degree of statistical significance. The apparent effects of APM4 program incentives on diabetes metrics warrant further investigation to determine if and how APM4 may have influenced these improved patient outcomes.

These evaluation results were consistent with previous results generated from the mid-program evaluation conducted by the University of Washington (with Conrad et al.).

Evaluating total cost of care impacts of the APM4 program

Cost of care prior work

In its mid-point evaluation, Conrad et. al used a regression analysis to assess costs during the first 18 months of the APM4 program. They found substantial, but marginally statistically significant reductions in PMPM payments for pharmacy prescriptions ($5.21 less PMPM, p=0.094) and inpatient hospitalizations ($9.11 less PMPM, p=0.078) for adult patients attributed to APM4 FQHCs relative to adult patients attributed to non-participating FQHCs.

Conrad et al. also noted a qualitatively substantial reduction in total PMPM costs ($15.05 less PMPM); however, the results were not statistically significant and were concentrated in the first six months of the APM4 program (July-December 2017). For children, Conrad et al. identified a statistically significant reduction in PMPM spending on pharmacy prescriptions ($2.38 less PMPM).

Cost of care analytic method and limitations

Under HCA's managed care model, most services for the majority of Medicaid recipients are paid for by MCOs, rather than HCA's fee-for-service (FFS) program. MCOs often negotiate capitated rates with providers for a wide range of services. Capitation payments are monthly payments made by an MCO to a provider for each patient enrolled in a managed care plan with a capitated contract. While MCOs report claims to HCA, capitated (per-person) payments often obscure the true cost of care for an individual claim.

To overcome this limitation, HCA created a total cost of care method. FFS claims are paid for directly by HCA through the ProviderOne MMIS at the Medicaid fee schedule. In the case of FFS arrangements with

an MCO, the MCO reported payment amount is used. In the case of capitated and contracted MCO services, where no individual price can be assigned to the claim, HCA uses the price it would have paid according to its FFS pricing rules. This type of payment is also known as shadow pricing.

Using this method, HCA can price the majority of claims and encounters, but totaling claims on a monthly or annual basis is likely to represent a slight actuarial undercount of the true cost of care—particularly among provider or payers that are more often paid under capitation. Shadow prices are generally less than an MCO's true paid amounts for a service purchased on an FFS basis. Some encounters, which are paid on a capitated basis, are priced at $0 in the ProviderOne system, which leads to the use of shadow pricing to determine the FFS equivalent for the service provided.

The monthly level cost analysis includes all members assigned to FQHCs, rather than using the continuous enrollment definition in the APM4 MOU, which would be only a subset of FQHCs. All members had to be included to ensure an unbiased sample.

To assess the impact of the APM4 model on total cost of care, HCA used a least-squares dummy variables (LSDV) analysis, where enrollees assigned to a participating FQHC are compared to enrollees assigned to a non-participating FQHC during the same month. This method compares the average change in total cost of care for members assigned a participating FQHC from before and after implementation to the change for members assigned non-participating FQHCs. HCA also assesses total cost of care, and total cost growth trends prior to APM4 implementation.

This analysis includes several limitations. First, as described above, the shadow pricing (or FFS equivalency) methodology could understate the total cost of care for FQHCs—particularly to the extent that the FQHCs and MCOs are contracted under a capitated arrangement. It is unknown if APM4-participating FQHCs are more likely than non-participating FQHCs to contract with MCOs under capitated arrangements. Second, this analysis does not assess if individuals assigned to a participating FQHC actually utilized their assigned FQHC or another provider (FQHC or non-FQHC). Third, the analysis does not track costs that span multiple months (e.g., an acute or chronic care management episode for which treatment spans multiple months).

HCA has no theoretical reason to believe that high-cost acute or chronic events would be more concentrated in enrollees assigned to participating or non-participating FQHCs—especially at different times, though that would require further research to verify. Fourth, the analysis measures total cost of care at the individual level rather than at the FQHC-level. Per independent review by the VSSL team at the University of Washington, there is evidence that measuring effects at a level lower than the treatment (treatment being participation in APM4 program), can potentially lead to the evaluation identifying a treatment effect when one does not exist (see Appendix C). Fifth, total cost of care for enrollees in the data set ranged from $0 to $6,689,991, with a mean of $333 and a median of $0. This represents a highly skewed distribution. While HCA used a form of linear regression to assess the impact of APM4 participation on total cost of care, such a skewed cost distribution suggests that alternative models may have better fit the data, given the high-cost outliers (see Appendix C). HCA did not pursue these models due to limited resources.

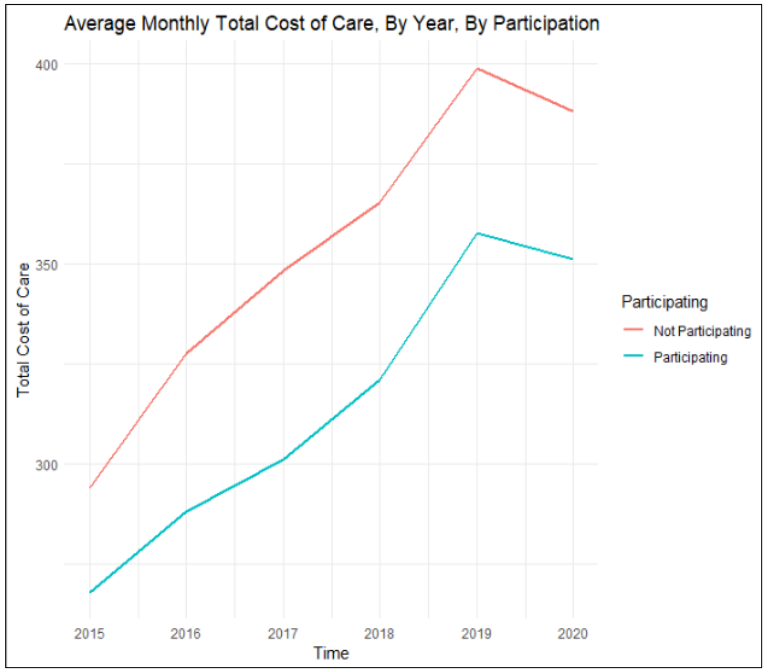
Cost of care and cost growth evaluation results

From 2015 (prior to the start of APM4 program) through 2020, the total cost of health care services was lower for APM4 participants relative to non-APM4 participants. Total cost of care at APM4 participating FQHCs was approximately two percent lower than at non-APM4 FQHCs (roughly $8 PMPM). As shown in

Figure 1, there is evidence that FQHCs that did not participate in APM4 program had higher costs per member month than did APM4 participants prior to implementation of the payment model—a gap that our findings suggest may have slightly widened following implementation.

These findings were statistically significant—though at a low level, given the large scope of data analyzed (more than 38 million observations). With such a robust sample size, analyses are more likely to identify statistically significant conclusions and findings that do not have a robust level of statistical significance (such as the above) should be viewed with caution.[6]

Figure 3: FQHC average monthly total cost of care, by APM4 program participation



Of note, total cost of care includes only the cost of claims and repriced encounters. The total cost does not include the enhancement payments made to FQHCs. Nor does this account for the enhancement payments made to APM4-participating FQHCs beyond that owed to the APM3 participants. Excess enhancement payments to the APM4 FQHCs averaged $7.92 PMPM from 2017-2020—roughly canceling out the $8 PMPM lower total cost of care noted for enrollees assigned to APM4 FQHCs.

[6] Larsen, Richard J. and Morris L. Marx. Introduction to Mathematical Statistics and Its Applications (5th Edition).

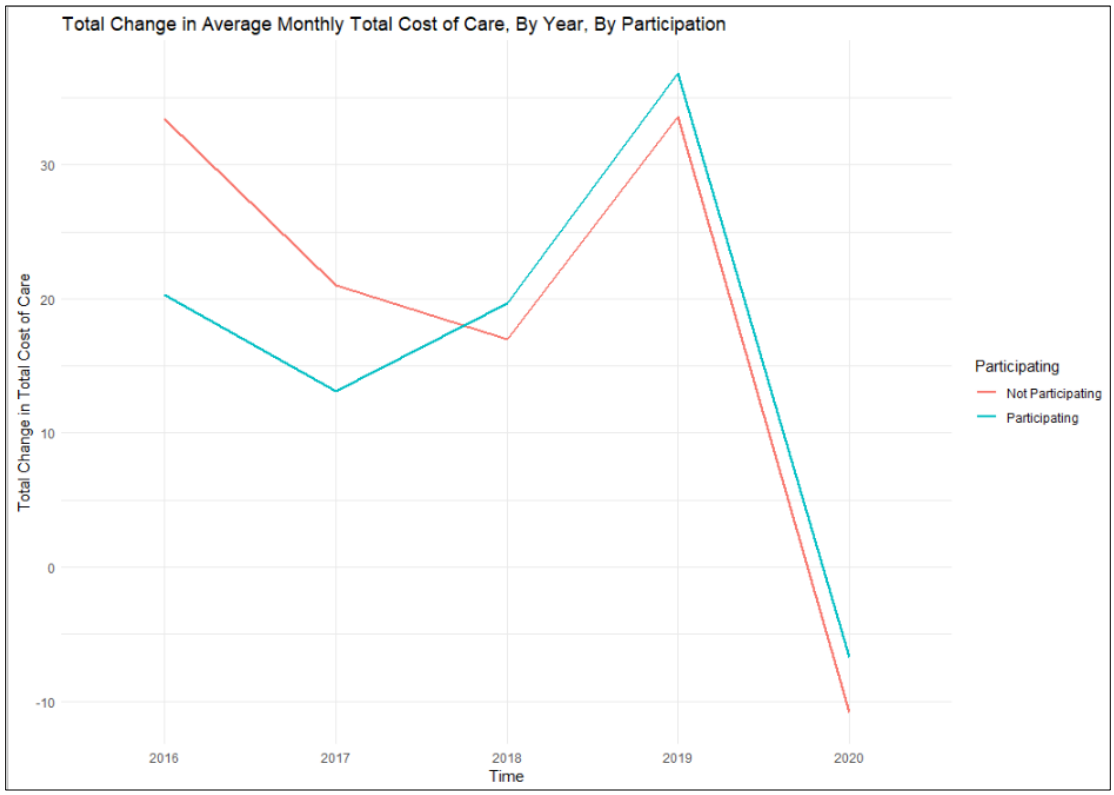
Table 4: summary of APM4 payments exceeding APM3 (July 2017–December 2020)

Year	Total payments above APM3	MCO member months	Overpayment PMPM	Months
July-Dec 2017	$10,487,643	1,913,595	$5.48	6
2018	$14,613,002	3,768,507	$3.88	12
2019	$19,851,551	3,820,052	$5.20	12
2020	$67,493,647	4,253,503	$15.87	12
		Weighted Avg	$7.92	

In addition to evaluating total cost of care, HCA's analysis also assessed cost growth over time. In this assessment, cost growth is defined as total cost of calendar year "x" minus total cost of care in calendar year "x-1". Between 2015-2020, cost growth was $0.62 slower for APM4-participants than for non-participating FQHCs. This analysis shows that prior to APM4 implementation, the FQHCs that would eventually participate in APM4 already demonstrated slower cost growth compared with FQHCs that would never participate.

This difference in cost containment holds true from 2015-2020. Given that the FQHCs participating in the APM4 model already had a slower rate of cost growth prior to implementation, HCA cannot conclude that the APM4 model caused the rate of slower cost growth for model participants.

Figure 4: total change in average monthly total cost of care, by year and APM4 participation



The results of the cost of care analysis demonstrated a significant positive correlation between chronic illness and disability payment system (CDPS) score and total cost of care. This means sicker patients consumed more care overall. The evaluation also found a notable effect of continuous enrollment in an FQHC on cost control in APM4 program participating and non-participating FQHCs. This means that an individual with an established provider care relationship consumed fewer services overall relative to a new patient. This effect held true when averaged across all clinics. The continuity noted here stemmed from continuity of assignment to an FQHC, not necessarily any provider within that assigned FQHC.

Evaluating utilization of care impacts of the APM4 program

This evaluation analyzed three areas of care utilization: ED services, primary care services, and the count of claims. The APM4 model was intended to reduce ED visits and to promote alternative care options to traditional primary care. Overall, the expectation was that there would be fewer claims reported.

Prior work

In their mid-program evaluation, Conrad et al. also analyzed utilization of care. They were able to identify effects of APM4 on ED utilization for adults, professional services, and pharmacy claims for children. These effects were small and appeared almost exclusively during the transition period in 2017. While the effects in children were negative—fewer professional services and pharmacy claims—the ED utilization effects for adults were positive: participation in APM4 was associated with higher probability of ED utilization. The reason for this effect was not explained or explored by the team.

Utilization of care analytic method and limitations

For this analysis, the member-month dataset used in the total cost of care analysis was grouped by member, year, FQHC, and benefit type (i.e., all fully integrated managed care as opposed to each individual eligibility category (e.g. blind and disabled.) Costs are expected to be higher for certain care types with more coverage.

For each grouping, the analysis used a count of ED visits, primary care visits, and total claims. The benefit type term was included as a grouping term because variation in benefit type is expected to impact types and quantity of care. The groups were then subset to only those with 11 or 12 months in the year (the same standard used for FQHC attribution). This means a member had to be enrolled in Medicaid, assigned the same FQHC, and have a consistent benefit type for 11 or 12 months in a calendar year to be included in this analysis

The year was preferred to the member month for the simple reason that most member-months would be expected to include no primary care utilization, and which months those are for a given recipient is likely random. There is no covariate to give the model that will help it distinguish why someone had a primary care visit in March as opposed to February. This is less of an issue at the annual level where not having a primary care visit in a year is a much more meaningful concept.

HCA conducted an exploratory analysis to assess the impact of APM4 implementation on the probability of an enrollee utilizing the ED, utilizing primary care, and total utilization (measured by number of claims). The exploratory analysis used crosstabulations and logistic regression analyses (for ED and primary care provider (PCP)) and negative binomial regression analysis for total claims.

There are numerous limitations to this analysis. First, utilization from calendar year 2015 was unavailable for this analysis, so HCA cannot evaluate multi-year trends prior to implementation. Rather, we assume parallel trends, which could overestimate the effect of the APM4 program on utilization of care. Second, given the data set, continuous eligibility requirements in the analysis decrease the number of enrollees evaluated.

Third, the COVID-19 pandemic led to a notable decline in utilization in 2020. Fourth, this assessment does not parse out the clinical appropriateness of any utilization. Future analyses of utilization could assess avoidable or preventable ED visits rather than all ED visits. Fifth, the assessment does not parse the types of primary care visits (e.g., preventive care visits, sick visits, chronic disease visits, procedures or other events). Without such distinctions, there are limitations in interpreting findings regarding primary care utilization. Finally, the analysis does not assess the intensity of utilization (e.g., if overall claims count increased in primary or outpatient care but decreased inpatient care utilization).

Utilization evaluation results

The findings are summarized in table five. For ED events, in the pre-APM4 period there was an approximately 34 percent chance that a member assigned a participating FQHC will utilize ED services in a year, while in the APM4 implementation period, that chance dropped to approximately 29 percent. This decrease is mirrored in the members assigned to non-participating FQHCs, where the probability drops from approximately 30 percent to approximately 25. For primary care events (i.e., visits), we see a similar dynamic. For those assigned to participating FQHCs, we see a drop in probability from approximately 79 percent to approximately 77 percent. For those assigned non-participating FQHCs, we observe a drop from approximately 74 percent to approximately 71 percent.

These results suggest that we should not expect APM4 model participation to affect these outcomes, but that time trends are likely to be very important. This general drop may be a COVID-19 effect, but the analysis was not designed to test why time matters, only account for it.

For the total claims, there were no similar time effects. For members assigned to APM4 FQHCs there was an average number of claims per member of approximately 24.4. This declined to approximately 24.2 following participation in the APM4 model. For non-APM4 FQHCs, the drop is very similar in magnitude: approximately 26.4 average claims per member to approximately 26.2. This could be due to pharmacy claims: recurring prescriptions are relatively stable and drive a lot of claims; however, this analysis was not set up to test such hypotheses.

Table 5: probability of utilization before and during APM4 Program among Medicaid enrollees assigned to FQHCs

FQHC category	Likelihood of ED visit		Likelihood of primary care visit		Number of claims	
Period	Pre-APM4	Post APM4	Pre APM4	Post APM4	Pre-APM4	Post APM4
APM3	30%	25%	74%	71%	26.4	26.2
APM4	34%	29%	79%	77%	24.4	24.2

There is no detectable effect, given the model specifications, in the primary care claims. There was a small (though statistically significant) decrease in the count claims, though it was less than one claim a year (roughly a two percent reduction in claims count). There was also a small increase in ED utilization, though this was approximately one percent and statistical significance is quite low, especially given the scale of the data.

There were no large or material effects of APM4 implementation on ED utilization, primary care utilization, or the count of total claims. This result was largely consistent with the prior work by the University of Washington evaluation team where only effects for ED utilization were observed for adults—identical to those identified in this evaluation—and other effects were only present for children—a group not distinctly evaluated in this report.

Anecdotal evidence regarding transformation of care delivery

Participating FQHCs reported that the flexible but predictable financing of the APM4 program allowed them to expand care teams to include, for example, patient engagement specialists, community health workers and health educators, care coordinators for high-utilizing patients, nutritionists, mobile medicine teams, and pharmacists. FQHCs also report that the increased flexibility in funding allowed them to rapidly scale COVID-19 testing and vaccination campaigns. Some FQHCs also invested in technology and infrastructure, allowing them to analyze patient data, identify gaps in care, and drive clinical quality improvement initiatives. APM4 program participants report that these expanded care teams resulted in improved patient outcomes.

Of note, many of these services and practitioners could be indirectly reimbursed as practice costs related to transformation efforts, which are allowable in the calculation of FQHC encounter rates. When FQHCs experience a qualifying triggering event, they can submit change in scope (CIS) requests to adjust their encounter rate in accordance with WAC 182-548-1500.

Qualifying CIS events include any change in the cost, type, intensity, duration, or amount of health care services provided. Approved CIS requests may account for costs of practice transformation efforts that may have expanded during APM4. FQHCs can also be indirectly reimbursed for the provision of allowable Medicaid program covered services that are not encounter eligible. For example, while COVID-19 testing and vaccine administration are not encounter-eligible; however, FQHCs can be indirectly reimbursed for these covered services each time the FQHC bills an encounter eligible service.

Next steps

Concluding the APM4 model

While HCA maintains its commitment to exploring future VBP efforts with FQHCs, the APM4 model concluded on December 31, 2022, in accordance with the MOU and the legislative directive in SB 5693:

> "The authority shall not enter into any future value-based arrangements with federally qualified health centers or rural health clinics prior to receiving approval from the office of financial management and the appropriate committees of the legislature."

HCA did not receive funding or authority from OFM or the Legislature to continue the APM4 model or any other FQHC value-based arrangements with FQHCs.

At the conclusion of the APM4 model, participating FQHCs will revert to the APM3 encounter-based payment model. While both the original and the amended APM4 MOUs expired on December 31, 2022, HCA also sent written notification to each APM4 participant in March 2022 reminding them of the program expiration. HCA has encouraged any impacted FQHC to determine if they have experienced an eligible CIS-triggering event. If eligible, FQHCs may request to rebase their encounter rates to account for infrastructure and care team investments.

Recommendations

HCA is committed to continuing sustainable and meaningful value-based purchasing arrangements with FQHCs and has begun preliminary concept development of future FQHC VBP models. HCA recommends the development of a future FQHC VBP model that:

- Holds FQHCs financially accountable to evidence-based practice transformation activities and to meaningful cost and quality targets.
- Incentivizes meaningful and tangible annual improvements in quality of care and patient outcomes, and reduced disparities in health outcomes among patients of different races, ethnicities, genders, and primary languages.
- Ensures that FQHCs never receive less than their federally mandated entitlement.
- Sustainably maintains transparent and predictable spending, including setting a budgetary maximum on any payments beyond the federally mandated entitlement.
- Is mutually agreed upon by FQHCs, HCA, the Legislature, OFM, and CMS.
- Establishes clear productivity standards and methods to measure productivity in alignment with the clinical transformation goals.

Appendix A: Reference Statutes

Engrossed Substitute Senate Bill 6168; Section 211(62); Laws of 2020

(62)(a) $1,192,000 of the general fund—state appropriation for fiscal year 2020 and $3,970,000 of the general fund—federal appropriation are provided solely for reconciliation of payment under alternate payment methodology four (APM4) for federally qualified health centers (FQHC) for state fiscal year 2020. The authority shall use unliquidated prior accrual balances to reconcile state fiscal years 2018 and 2019.

(b) By August 1, 2020, the authority shall convene representatives from FQHCs participating in the APM4 methodology, the FQHC association, the office of financial management, and fiscal committees of the legislature to evaluate and amend the APM4 model and memorandum of understanding.

(c) The authority in collaboration with the representatives in (b) of this subsection must develop an updated APM4 model and memorandum of understanding that:

(i) Complies with budget neutrality requirements and spending limits as required under the omnibus appropriations act;

(ii) Identifies predictable spending targets;

(iii) Clearly defines quality performance standards for participating FQHCs;

(iv) Requires progressively increasing standards of quality performance for participating FQHCs;

(v) Clearly defines financial performance expectations for participating FQHCs;

(vi) Requires progressively increasing standards of financial performance for participating FQHCs; and

(vii) Requires that reconciliation payments made under APM4 may not fall below the payment level required by the federal law for qualifying face-to-face encounters.

(d) The authority in collaboration with the office of financial management and representatives from fiscal committees of the legislature shall conduct an evaluation of the APM4 model to determine its cost effectiveness and impact on patient outcomes and report its findings and recommendations to the appropriate committees of the legislature by November 15, 2022.

(e) The authority shall not enter into any future value-based arrangements with federally qualified health centers or rural health clinics prior to receiving approval from the office of financial management and the appropriate committees of the legislature.

(f) The authority shall require all managed care organizations to provide information to the authority to account for all payments to FQHCs to include how payments are made, including any additional payments and whether there is a sub-capitation arrangement or value based purchasing arrangement.

(g) Beginning with fiscal year 2021 and for each subsequent year thereafter, the authority shall reconcile on an annual basis with FQHCs contracting under APM4.

(h) Beginning with fiscal year 2021 and for each subsequent year thereafter, the authority shall properly accrue for any anticipated reconciliations with FQHCs contracting under APM4 during the fiscal year close process following generally accepted accounting practices.

Engrossed Substitute Senate Bill 5693, Section 211(44)(a), Chapter 297, Laws of 2022

(44)(a) The authority in collaboration with the office of financial management and representatives from fiscal committees of the legislature shall conduct an evaluation of the APM4 model to determine its cost effectiveness and impact on patient outcomes and report its findings and recommendations to the appropriate committees of the legislature by November 15, 2022.

(b) The authority shall not enter into any future value-based arrangements with federally qualified health centers or rural health clinics prior to receiving approval from the office of financial management and the appropriate committees of the legislature.

(c) The authority shall not modify the reconciliation process or the APM4 program with federally qualified health centers or rural health clinics without notification to and the opportunity to comment from the office of financial management.

(d) The authority shall require all managed care organizations to provide information to the authority to account for all payments to federally qualified health centers to include how payments are made, including any additional payments and whether there is a sub-capitation arrangement or value-based purchasing arrangement.

(e) Beginning with fiscal year 2021 and for each subsequent year thereafter, the authority shall reconcile on an annual basis with federally qualified health centers contracting under APM4.

(f) Beginning with fiscal year 2021 and for each subsequent year thereafter, the authority shall properly accrue for any anticipated reconciliations with federally qualified health centers contracting under APM4 during the fiscal year close process following generally accepted accounting practices.

Appendix B: APM4 fiscal analysis detail

Background

The following tables and explanation provide detailed inputs related to each APM4 participant's reconciliation for July 1, 2017–December 31, 2017, and calendar years 2018-2020. The data below reflects payments and encounters reported by FQHCs to HCA as part of the annual managed care reconciliation process. This data was used in the final reconciliation settlement with each FQHC for each calendar year to ensure they received their APM3 and APM4 entitlements.

Table 6: APM4 2017-2020 reconciliation

APM4 2017-2020 reconciliation	
FQHC designator	To maintain anonymity, this column represents an assigned random letter to each FQHC participating in the APM4 model. This letter is consistent throughout the tables below for each center.
APM3 entitlement **(FQHC encounters X encounter rate)**	This column represents each center's APM3 entitlement, which is calculated by multiplying the number of FQHC encounters by the FQHC's encounter rate.
Total paid by state **(MCO FFSE + MCO enhancements)**	Total amounts received by each FQHC for managed care encounters (repriced to the Medicaid fee schedule (FFSE)) and enhancement payments.
Total APM3 underpayments **(Payments below the APM3 entitlement)**	This represents APM4 FQHCs who received FFSE and enhancement payments that fell below the APM3 entitlement, otherwise known as an APM3 underpayment. In these cases, HCA paid the clinic up to their APM3 entitlement and the FQHC did not achieve a quality payment and was not owed under APM4.
Payments above APM3 **(Payments exceeding the APM3 entitlement)**	This column represents the annual payments (FFSE and monthly enhancements) provided to the FQHC which exceeded the APM3 entitlement. If there is a blank cell, it means the clinic's total payments fell below the APM3 entitlement.
APM4 entitlement **(APM4 PMPM x MCO enrollment)**	This column represents each FQHC's APM4 entitlement. This amount is calculated for each FQHC by multiplying their annual managed care enrollments by the APM4 PMPM rate for the corresponding year. The APM4 PMPM is unique to each center.
Total additional APM4 payments **(Funds requiring proviso or accrual)**	Displays the amounts owed to participating APM4 FQHCs who received FFSE and enhancement payments above the APM3 entitlement and were owed additional funds by HCA to meet the APM4 PMPM entitlement. These funds exceeded budget neutrality and therefore required legislative requests to increase the budget.

Total payments made above APM3	Total payments made to APM4 FQHCs above the APM3 entitlement which was created by adding "payments above APM3" and "total additional APM4 payments".
Annual APM3/APM4 Reconciliation status	**APM4 underpayment:** payments made to the FQHC through FFSE and monthly enhancement payments fell below the APM4 entitlement. The values associated with this status represent additional funds required (requested from the Legislature via proviso or accrual) to bring FQHC payment up to the APM4 entitlement amount. **APM4 overpayment:** payments made to the FQHC through FFSE from the MCOs and monthly enhancement payments were greater than the APM4 entitlement. The values associated with this status represent funds the FQHC was required to pay back to HCA. **APM3 underpayment:** the amounts owed APM3 entitlement was greater than the APM4 entitlement, and the payments made to the FQHC through FFSE from the MCOs and monthly enhancements fell below the APM3 entitlement. HCA owed the FQHC funds to bring their payment up to the APM3 entitlement amount. **APM3 overpayment:** the APM3 entitlement was greater than the APM4 entitlement, and the payments made to the FQHC through FFSE from the MCOs and monthly enhancements was greater than the APM3 entitlement. FQHCs were paid above their APM3 entitlement and were required to pay these funds back to HCA.

Table 7: calendar year 2017 APM4 FQHC reconciliation data

CALENDAR YEAR 2017 APM4 FQHC RECONCILIATION DATA								
A	B	C	D	E	F	G	H	I
FQHC Designator	APM3 Entitlement (FQHC Encounters X Encounter Rate)	Total Paid by State (MCO FFSE + Enhancements)	Total APM3 Underpayments (Payments below the APM3 entitlement)	Payments Above APM3 (Payments Exceeding the APM3 Entitlement)	APM4 Entitlement (APM4 PMPM X MCO Enrollment)	Total Addtl APM4 PMTS (Funds requiring proviso or accrual)	Total Payments Made Above APM3	Annual APM3/APM4 Reconciliation Status
			C-B=D	C-B+E		F-C=G	E+G=H	
CLINIC P	$ 13,116,362	14,083,953		967,591	14,637,189	553,236	1,520,827	APM4 Underpayment
CLINIC A	$ 8,023,972	9,156,713		1,132,741	10,335,203	1,178,490	2,311,231	APM4 Underpayment
CLINIC C	$ 4,904,429	6,275,455		1,371,026	6,408,640	133,185	1,504,211	APM4 Underpayment
CLINIC L	$ 2,387,726	2,982,428		594,702	3,477,405	494,977	1,089,679	APM4 Underpayment
CLINIC M	$ 2,383,122	2,294,016	(89,106)		2,437,789	143,773	143,773	APM4 Underpayment
CLINIC N	$ 17,276,108	17,564,743		288,635	18,147,269	582,526	871,161	APM4 Underpayment
CLINIC F	$ 3,464,884	3,892,501		427,617	3,913,925	21,424	449,041	APM4 Underpayment
CLINIC G	$ 369,989	517,889		147,900	522,943	5,053	152,953	APM4 Underpayment
CLINIC D	$ 2,629,302	2,813,065		183,764	2,833,941	20,875	204,639	APM4 Underpayment
CLINIC J	$ 3,592,879	3,742,180		149,301	4,009,596	267,416	416,717	APM4 Underpayment
CLINIC B	$ 5,096,630	6,091,477		994,847	5,802,963	(288,514)	706,332	APM4 Overpayment
CLINIC E	$ 3,793,381	4,345,749		552,367	4,162,429	(183,319)	369,048	APM4 Overpayment
CLINIC H	$ 762,819	1,052,018		289,199	900,216	(151,802)	137,397	APM4 Overpayment
CLINIC K	$ 2,702,221	3,438,961		736,739	3,312,857	(126,104)	610,635	APM4 Overpayment
CLINIC O	$ 19,244,925	18,931,579	(313,346)		18,158,432		-	APM3 Underpayment
CLINIC I	$ 5,580,024	5,915,958		335,935	5,511,598			APM3 Overpayment
	$ 95,328,774	**$ 103,098,685**	**$ (402,452)**	**$ 8,172,363**	**$ 104,572,392**	**$ 2,651,214**	**$ 10,487,643**	

Table 8: calendar year 2018 APM4 FQHC reconciliation data

CALENDAR YEAR 2018 APM4 FQHC RECONCILIATION DATA								
A	B	C	D	E	F	G	H	I
FQHC Designator	APM3 Entitlement (FQHC Encounters X Encounter Rate)	Total Paid by State (MCO FFSE + Enhancements)	Total APM3 Underpayments (Payments below the APM3 entitlement)	Payments Above APM3 (Payments Exceeding the APM3 Entitlement)	APM4 Entitlement (APM4 PMPM X MCO Enrollment)	Total Addtl APM4 PMTS (Funds requiring proviso or accrual)	Total Payments Made Above APM3	Annual APM3/APM4 Reconciliation Status
			C-B=D	C-B+E		F-C=G	E+G=H	
CLINIC P	$ 28,701,595	30,612,418		1,910,822	31,739,982	1,127,564	3,038,386	APM4 Underpayment
CLINIC A	$ 15,977,215	19,096,444		3,119,230	19,452,078	355,634	3,474,863	APM4 Underpayment
CLINIC C	$ 10,849,279	12,732,392		1,883,113	13,256,381	523,989	2,407,102	APM4 Underpayment
CLINIC B	$ 10,784,333	12,838,565		2,054,233	12,938,465	99,900	2,154,133	APM4 Underpayment
CLINIC L	$ 5,551,604	7,413,521		1,861,917	7,890,298	476,777	2,338,694	APM4 Underpayment
CLINIC D	$ 6,510,220	6,367,905	(142,315)		6,803,188	435,283	435,283	APM4 Underpayment
CLINIC K	$ 5,985,784	6,313,962		328,178	6,392,117	78,155	406,333	APM4 Underpayment
CLINIC M	$ 4,490,609	4,617,900		127,290	4,549,419	(68,480)	58,810	APM4 Overpayment
CLINIC F	$ 7,072,545	7,339,351		266,807	7,301,566	(37,785)	229,022	APM4 Overpayment
CLINIC H	$ 2,142,642	2,274,618		131,976	2,213,019	(61,599)	70,377	APM4 Overpayment
CLINIC N	$ 37,657,833	36,916,069	(741,763)		37,141,174		-	APM3 Underpayment
CLINIC J	$ 8,468,313	7,838,123	(630,190)		8,056,845		-	APM3 Underpayment
CLINIC O	$ 46,320,119	44,062,590	(2,257,529)		41,542,745		-	APM3 Underpayment
CLINIC E	$ 9,907,237	10,482,056		574,820	9,902,972			APM3 Overpayment
CLINIC G	$ 1,911,404	1,928,652		17,248	1,909,856			APM3 Overpayment
CLINIC I	$ 11,195,753	11,294,546		98,793	11,044,636			APM3 Overpayment
	$ 213,526,485	**$ 222,129,114**	**$ (3,771,798)**	**$ 12,374,426**	**$ 222,134,741**	**$ 2,929,436**	**$ 14,613,002**	

Table 9: calendar year 2019 APM4 FQHC reconciliation data

CALENDAR YEAR 2019 APM4 FQHC RECONCILIATION DATA								
A	B	C	D	E	F	G	H	I
FQHC Designator	APM3 Entitlement (FQHC Encounters X Encounter Rate)	Total Paid by State (MCO FFSE + Enhancements)	Total APM3 Underpayments (Payments below the APM3 entitlement)	Payments Above APM3 (Payments Exceeding the APM3 Entitlement)	APM4 Entitlement (APM4 PMPM X MCO Enrollment)	Total Addtl APM4 PMTS (Funds requiring proviso or accrual)	Total Payments Made Above APM3	Annual APM3/APM4 Reconciliation Status
			C-B=D	C-B+E		F-C=G	E+G=H	
CLINIC P	$ 31,389,953	38,012,754		6,622,801	40,346,811	2,334,057	8,956,857	APM4 Underpayment
CLINIC A	$ 17,139,746	17,887,457		747,711	17,907,763	20,306	768,017	APM4 Underpayment
CLINIC C	$ 10,900,418	12,473,362		1,572,944	13,357,060	883,698	2,456,642	APM4 Underpayment
CLINIC E	$ 9,454,450	10,769,938		1,315,488	10,824,681	54,743	1,370,231	APM4 Underpayment
CLINIC L	$ 5,121,522	7,157,275		2,035,753	7,905,327	748,052	2,783,804	APM4 Underpayment
CLINIC N	$ 39,327,483	39,955,808		628,325	40,167,027	211,219	839,544	APM4 Underpayment
CLINIC H	$ 1,765,060	2,223,956		458,896	2,412,018	188,062	646,958	APM4 Underpayment
CLINIC K	$ 5,662,258	6,274,666		612,408	6,476,328	201,662	814,070	APM4 Underpayment
CLINIC B	$ 12,887,707	14,371,785		1,484,078	14,103,132	(268,653)	1,215,426	APM4 Overpayment
CLINIC M	$ 4,390,139	4,327,708	(62,431)		4,267,127		-	APM3 Underpayment
CLINIC F	$ 7,547,633	7,526,631	(21,002)		7,480,155		-	APM3 Underpayment
CLINIC G	$ 2,322,484	2,112,207	(210,277)		2,032,028		-	APM3 Underpayment
CLINIC I	$ 11,807,223	11,502,743	(304,480)		11,110,798		-	APM3 Underpayment
CLINIC D	$ 11,080,918	8,312,729	(2,768,189)		8,105,616		-	APM3 Underpayment
CLINIC J	$ 7,848,541	7,413,102	(435,439)		7,812,785		-	APM3 Underpayment
CLINIC O	$ 47,505,649	43,890,858	(3,614,791)		42,107,640		-	APM3 Underpayment
	$ 226,151,184	**$ 234,212,979**	**$ (7,416,608)**	**$ 15,478,404**	**$ 236,416,296**	**$ 4,373,146**	**$ 19,851,551**	

Table 10: calendar year 2020 APM4 FQHC reconciliation data

CALENDAR YEAR 2020 APM4 FQHC RECONCILIATION DATA								
A	B	C	D	E	F	G	H	I
FQHC Designator	APM3 Entitlement (FQHC Encounters X Encounter Rate)	Total Paid by State (MCO FFSE + Enhancements)	Total APM3 Underpayments (Payments below the APM3 entitlement)	Payments Above APM3 (Payments Exceeding the APM3 Entitlement)	APM4 Entitlement (APM4 PMPM X MCO Enrollment)	Total Addtl APM4 PMTS (Funds requiring proviso or accrual)	Total Payments Made Above APM3	Annual APM3/APM4 Reconciliation Status
			C-B=D	C-B+E		F-C=G	E+G=H	
CLINIC P	$ 28,750,533	41,703,594		12,953,061	46,927,148	5,223,554	18,176,615	APM4 Underpayment
CLINIC A	$ 18,128,589	20,008,708		1,880,119	22,126,221	2,117,513	3,997,632	APM4 Underpayment
CLINIC C	$ 10,800,612	13,525,368		2,724,755	14,991,095	1,465,727	4,190,483	APM4 Underpayment
CLINIC B	$ 12,677,574	16,282,588		3,605,014	17,482,716	1,200,128	4,805,142	APM4 Underpayment
CLINIC E	$ 7,491,900	10,042,690		2,550,790	11,369,985	1,327,295	3,878,085	APM4 Underpayment
CLINIC M	$ 3,959,117	4,217,715		258,598	4,374,363	156,648	415,246	APM4 Underpayment
CLINIC N	$ 31,401,138	45,940,926		14,539,789	52,039,285	6,098,359	20,638,147	APM4 Underpayment
CLINIC F	$ 7,288,256	7,479,724		191,468	8,093,283	613,559	805,027	APM4 Underpayment
CLINIC H	$ 1,632,629	2,232,845		600,216	2,494,186	261,341	861,557	APM4 Underpayment
CLINIC I	$ 13,997,927	13,883,985	(113,942)		14,056,197	172,212	172,212	APM4 Underpayment
CLINIC K	$ 4,946,473	6,793,351		1,846,878	7,924,946	1,131,595	2,978,473	APM4 Underpayment
CLINIC J	$ 7,496,336	7,391,721	(104,615)		8,236,431	844,710	844,710	APM4 Underpayment
CLINIC O	$ 41,822,600	43,476,109		1,653,509	44,527,139	1,051,030	2,704,539	APM4 Underpayment
CLINIC L	$ 5,223,677	8,610,903		3,387,226	8,249,456	(361,447)	3,025,780	APM4 Overpayment
CLINIC G	$ 4,283,118	3,032,873	(1,250,245)		2,692,650		-	APM3 Underpayment
CLINIC D	$ 10,668,561	9,405,071	(1,263,490)		10,144,719		-	APM3 Underpayment
	$ 210,569,039	**$ 254,028,170**	**$ (2,732,292)**	**$ 46,191,423**	**$ 275,729,818**	**$ 21,302,224**	**$ 67,493,647**	

Appendix C: Systems Science Lab at the University of Washington: assessment of HCA's APM4 valuation

Please view this full report online at HCA's website. If you need an electronic copy, please contact HCA and one will be provided for you.