



**FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
ALTERNATIVE PAYMENT METHODOLOGY (APM) PILOT
CALIFORNIA CONCEPT PAPER – OCTOBER 13, 2016**

FQHC APM PILOT

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I. EXECUTIVE SUMMARY

With California's Medicaid program (Medi-Cal) serving nearly 14 million beneficiaries, of which approximately 10.5 million are in Medi-Cal managed care health plans, the focus of improving our health care delivery system remains top priority. This ongoing commitment to improving the delivery system can be observed with the recent approval of the State's Section 1115 Waiver Renewal (Medi-Cal 2020). While this waiver is a significant milestone toward improving our health care delivery system, no specific strategy for addressing Federally Qualified Health Center (FQHC) payment reform is included in the waiver.

FQHCs, including FQHC look-alikes, in California are a core part of the Medi-Cal delivery system. Since January 1, 2014, Medi-Cal enrollment has grown significantly as result of the Affordable Care Act expanding Medicaid. Coupled with California's continued efforts in shifting populations into the managed care delivery system, these valued safety net providers have absorbed much of the burden to maintain access to primary care services so that care for beneficiaries is delivered in the most appropriate setting. In recognition of their efforts and the changing landscape of health care in California, Department of Health Care Services (DHCS) and much of the stakeholder community supported legislation to implement a delivery system and payment reform program for FQHCs in California.

California State Senate Bill (SB) 147 (Chapter 760, Statutes of 2015) authorized a three-year pilot program for county and community-based FQHCs, with the goal of incentivizing a delivery system and practice transformation through the implementation of a new Alternative Payment Methodology (APM). Under the proposed pilot, participating FQHCs will move away from the traditional volume-based payment system to one that better aligns with the evolving financing and delivery of health services.

As proposed under the FQHC APM pilot, Medi-Cal managed care plans will receive an actuarially sound supplemental capitation rate that will incorporate the participating FQHC's full prospective payment system (PPS) rate. The participating FQHCs in turn will receive for each of their assigned pilot members an actuarially sound clinic-specific capitated payment from the Medi-Cal managed care plan. This clinic-specific capitated payment will provide the flexibility to deliver care in innovative ways that will expand primary and specialty care access and help improve the beneficiary experience, while simplifying the payment structure for these valued safety net providers. By electing to participate in the pilot, FQHCs will no longer have to go through multiple billing steps (the plan, the wraparound payment, and the reconciliation). This will simplify the payment process, alleviating many of the administrative challenges for both the FQHC and the state, while providing FQHCs with the ability to operate more efficiently.

This proposed pilot will also help facilitate greater collaboration between our Medi-Cal managed care plans and the FQHCs. While additional requirements will be placed on the Medi-Cal managed care plans and the participating FQHCs, both plans and clinics see value in better coordination of care, which will help reduce unnecessary utilization of services in more expensive settings, while also improving beneficiary experience.

With a target implementation date set for October 1, 2017, DHCS is looking once again to partner with the Centers for Medicare & Medicaid Services (CMS) in our continued efforts to implement innovative strategies for coordinating care and payment reform in the Medi-Cal program.

II. INTRODUCTION

The purpose of this paper is to share the Department of Health Care Services' (DHCS) proposed concept for a pilot program to implement an alternative payment methodology (APM) for Federally Qualified Health Centers (FQHCs). This concept paper will provide an overview of the enabling legislation and guiding principles, followed by a review of the proposed structure of the APM, and will illustrate DHCS' robust engagement of the stakeholder community throughout the process to date.

A. BACKGROUND

Overview of FQHCs and their requirements

FQHCs were established as a new provider type by Section 4161 of the Omnibus Budget Reconciliation Act of 1990 and became operational beginning October 1, 1991. FQHCs are non-profit or public entities which receive a direct grant from the federal government under Section 330 of the Public Health Service Act or meet the requirements to receive such a grant. Federal law defines the services that can be provided by FQHCs and includes special payment provisions to ensure that they are reimbursed for 100 percent of their reasonable costs associated with furnishing these services. One of the legislative purposes for doing this was to ensure that FQHCs that received Federal Section 330 grant funds were not forced to divert those grants to subsidize health center or program services to Medicaid beneficiaries. State Medicaid programs must pay for all covered services provided by FQHCs.

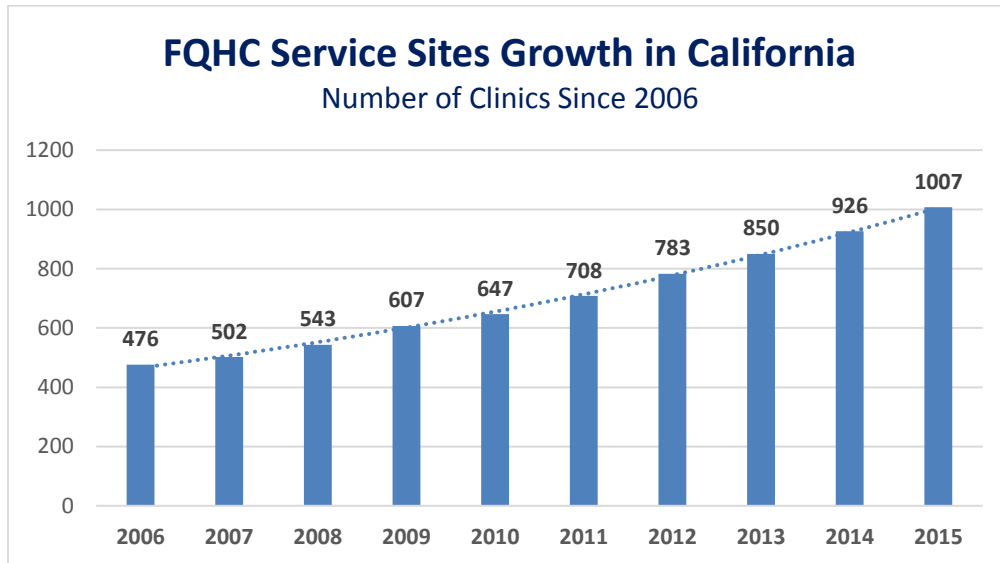
Medicaid (Medi-Cal in California) payments to FQHCs are governed by state and federal law. Section 702 of the Medicare, Medicaid, and Benefits Improvement and Protection Act of 2000 (BIPA) added section 1902 (bb) to the Social Security Act, changed the FQHC payment methodology from a retrospective cost-based system to a prospective payment system (PPS) methodology. For existing FQHCs, BIPA established a per-visit baseline payment rate equal to 100 percent of the center's average costs per visit during 1999 and 2000. Under PPS, State Medicaid programs are required to pay health centers their PPS per-visit rate for each face-to-face encounter between a Medicaid beneficiary and one of the FQHC's billable providers for a covered service. For Medi-Cal managed care members, DHCS is required to reimburse a FQHC for the difference between its per-visit PPS rate and the payment made by the managed care plan. This payment is known as a "wrap-around" payment. The managed care wrap-around rate was established to comply with federal and state regulation to ensure that clinics receive payment for all billable services equal to their PPS rate.

FQHCs impact in California

In California, there are 1,007 active FQHC service sites, of which 350 are located in rural counties. They typically serve California's vulnerable populations, uninsured, or those eligible for Medi-Cal. Consequently, FQHCs are an integral part of California's health care safety net. FQHCs provide primary health care services (family medicine, internal medicine, pediatrics, obstetrics and gynecology) that are furnished by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, licensed clinical social workers, comprehensive perinatal practitioners, dental hygienists and dental hygienists in alternative practice. Services provided at FQHCs may also include: diagnostic lab services, radiologic services, pharmaceutical, preventive health services, appropriate cancer screening, family planning services, and patient case management. While FQHCs generally provide primary care services for Medi-Cal beneficiaries, a significant portion also provide preventive dental care and behavioral health treatment on site. These preventive services provided by FQHCs help decrease utilization of emergency departments for non-emergency care.

Since January 1, 2014, Medi-Cal enrollment has grown over 35% as a result of the Affordable Care Act (ACA), which expanded Medicaid coverage to previously ineligible persons, primarily childless adults, at or below 138 percent of the federal poverty level (FPL). This rapid and significant increase in Medi-Cal enrollment has increased demand on the FQHC network to provide access to primary care services for much of the newly enrolled population. As a result, California has seen the number of clinics increase. Included below is a graph that illustrates the number of FQHCs in California since January 2006.

Figure 1: Growth of FQHCs in California since 2006



FQHCs have grown approximately 19% since 2013; however, when compared to the 70% Medi-Cal enrollment growth over the same period, the impact on access at FQHCs has been significant. With the significant growth of enrollment outpacing the additional facilities each year, the patient coverage distribution at FQHCs has shifted predominately toward Medi-Cal. In 2014, 60% of the patients at FQHCs in California were for Medi-Cal beneficiaries, and 39% were enrolled in a Medi-Cal managed care plan (See Figure 2 located in the Appendix). As the number of Medi-Cal patients seen by FQHCs grow, it becomes more important for the provider community to focus on innovation and the delivery of care in the most appropriate and effective ways—rather than a volume-based payment system that doesn’t incentivize the most appropriate delivery of care.

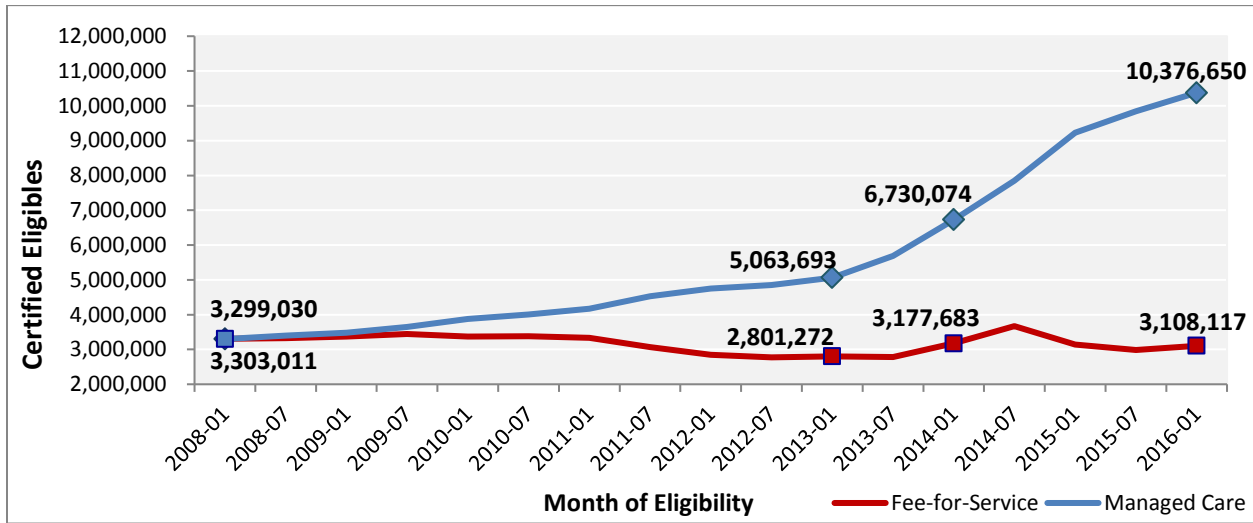
Medi-Cal Enrollment and FQHC Utilization Trends

Medi-Cal beneficiaries receive care through one of two service delivery systems: fee-for-service (FFS) or managed care. Under the FFS delivery system, beneficiaries seek medical services from a Medi-Cal provider and the provider bills the Medi-Cal program for each service administered. Under the FFS system, beneficiaries are responsible for locating their own providers. Under Medi-Cal managed care, DHCS contracts with health care plans to administer health care services to Medi-Cal plan members. The contracting health plans are paid a monthly payment for each Medi-Cal member and assume the financial risk for all delegated health care services. Health plans arrange and coordinate care for each member through a defined network of providers, including a vast network of FQHCs.

In January 2008, Medi-Cal’s 6.6 million certified eligible beneficiaries were evenly split between the two delivery systems, with managed care and FFS serving approximately 3.3 million beneficiaries each. But by January 2016, as the overall Medi-Cal program soared to cover roughly 13.5 million Californians, the

proportion of individuals enrolled in managed care grew in tandem. Of all Medi-Cal beneficiaries enrolled as of January 2016, 77% were enrolled in managed care, while only 23% were enrolled in FFS (Figure 3).

Figure 3: Biannual Trend in Medi-Cal FFS and Managed Care Participation from January 2008-January 2016



As the Medi-Cal population continues to shift into Medi-Cal managed care, the remaining Medi-Cal FFS population largely consists of those individuals entitled to a different or more limited set of benefits as compared with the scope of services provided by Medi-Cal managed care plans.

The populations remaining in FFS today are those with:

- restricted-scope coverage (due to unsatisfactory immigration status),
- pregnant women with higher income (138-212% FPL) receiving pregnancy-only coverage,
- dual eligible beneficiaries,
- individuals who are determined eligible for Medi-Cal and receive retroactive coverage,
- individuals temporarily placed in FFS while they wait to receive information materials for enrolling into Medi-Cal managed care, and
- the Medically Needy population who has a share-of-cost.

Medi-Cal FFS beneficiaries only accounted for 20% of FQHC users and FQHC Visits in 2014. This is not unexpected as Medi-Cal beneficiaries enrolled in FFS tend to either have more intensive medical needs or have limited scope coverage making FQHCs less than other service settings.

ACA Implementation

Between January 2014 and the end of 2015, nearly 3.5 million adult beneficiaries enrolled in Medi-Cal through ACA implementation, accounting for approximately 26% of the overall Medi-Cal population.

This dramatic increase in the Medi-Cal population had a direct correlation to the utilization observed at the FQHCs. As illustrated below in Figure 4, California’s FQHCs experienced on average 5-8% annual growth in the number of visits between 2009 and 2013. However, as result of the ACA, the change in total number of visits between 2013 and 2014 represented over a 44% increase.

Figure 4: Medi-Cal FQHC Utilization Trends, 2008-2014

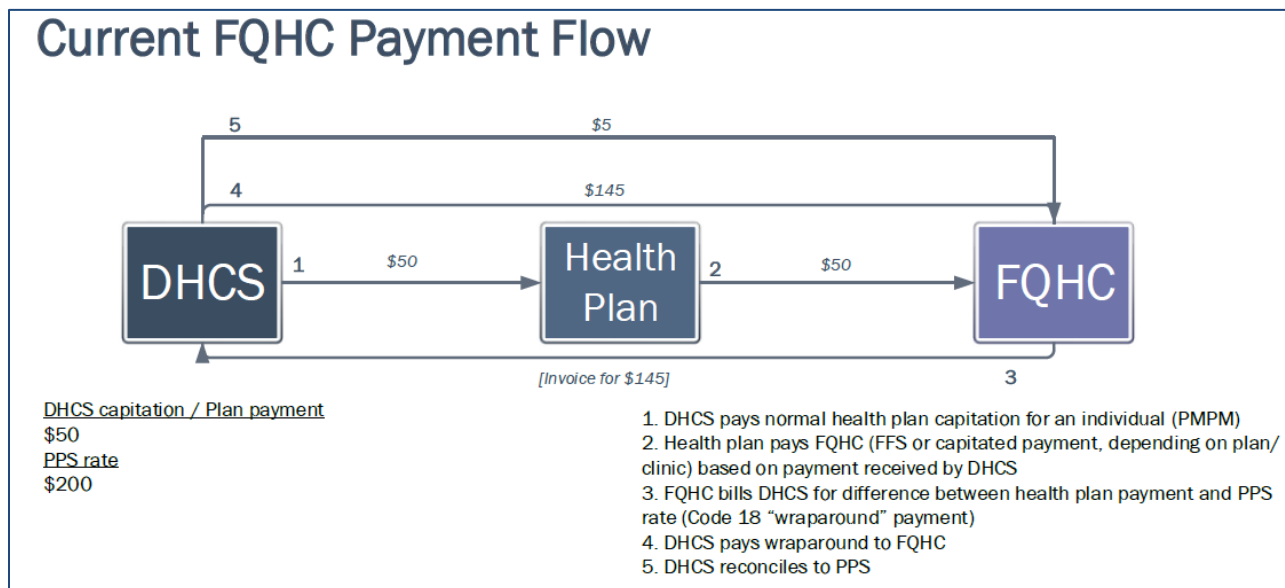
Medi-Cal FQHC Utilization Trends, 2008-2014				
Year	# of Beneficiaries enrolled at least one month in year	Number of Unique Users	Number of Visits	Visits Per User
2008	8,394,507	1,360,151	5,995,328	4.4
2009	8,735,812	1,515,324	6,655,468	4.4
2010	9,018,804	1,608,321	6,984,204	4.3
2011	9,224,275	1,764,913	7,520,703	4.3
2012	9,264,919	1,807,004	7,927,543	4.4
2013	10,181,856	1,992,435	8,259,293	4.1
2014	16,167,686	2,868,611	11,949,188	4.2

Not only has the overall number of visits significantly increased in recent years, but also as Medi-Cal continues to shift to managed care, the proportion of Medi-Cal managed care members receiving services at the FQHCs has as well.

Analysis of the current billing process (initial payment, wraparound, reconciliation)

Existing law requires FQHCs to be reimbursed on a per-visit basis. For each billable visit, FQHCs are paid a PPS rate. Currently, if a Medi-Cal managed care member visits a FQHC for a billable service, the plan reimburses the FQHC a capitated or FFS payment no less than an amount that the plan would make for the same service furnished by a provider that is not an FQHC. If this payment is less than the PPS rate, the FQHC then invoices DHCS and receives an interim wrap-around payment. If the interim wrap-around payment is different than the PPS rate, DHCS will issue a payment or recoupment later after a reconciliation is conducted. Included below is an illustration of the current payment structure assuming the wrap-around payment did not adequately cover the PPS rate.

Figure 5: Current FQHC Payment Flow for a Medi-Cal managed care member



Why an Alternative Payment Method (APM)?

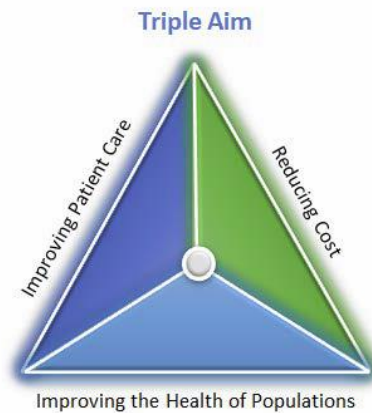
California views the APM as an opportunity to incentivize delivery system reform and practice transformation for clinics to deliver care in more effective ways without jeopardizing the sustainable funding levels afforded to these entities. The proposed pilot payment structure, as further detailed in the next section, will provide FQHCs with greater flexibility for meeting patient care needs, help reduce the unnecessary utilization of services, and improve the overall beneficiary experience.

Even though the number of FQHCs has grown by 19% since 2013, the additional number of visits coupled with the significant increase in the number of Medi-Cal managed care members has created a higher demand for primary care services. In order to accommodate the increased demand for services, clinics today are focused on expanding access through delivering care in more effective and appropriate methods. These methods do not always align with the current payment structure. This unfortunately does not incentivize the transformation efforts and creates additional challenges in the decision making process for clinics when identifying which services they are will to provide without reimbursement.

B. GUIDING PRINCIPLES

DHCS Objectives

As part of the backbone of California’s health care safety net, DHCS is committed to preserving and improving the overall health and well-being of all Californians. In order to meet the health care needs of the state, DHCS continues our commitment to achieving the Triple Aim—better care, better health, and lower costs.



DHCS experience with Delivery System Reform and APMs

California’s commitment to improving quality and better integrating care through APMs is not a new concept. Rather than paying for services via a FFS delivery system, DHCS has participated in risk-based contracts with managed care plans for several decades. Medi-Cal managed care has grown recently with the expansion of managed care statewide in 2012 and the gradual movement of Medi-Cal populations into managed care. Today, with over 10.5 million beneficiaries in managed care, Medi-Cal managed care is a true testament to providing high quality, accessible, and cost-effective health care. In addition to overseeing an extensive managed care delivery system, DHCS has experience with implementing other delivery system and payment transformation efforts that are currently in effect today.

III. FQHC APM PILOT

A. POLICY GOALS

As California continues to be a leader in the implementation of the Affordable Care Act with the expansion of over 3.5 million beneficiaries, the Medi-Cal program becomes ever more reliant on our primary care provider network for continuing our commitment to improving quality and better integrating care. As illustrated in the background section, one of Medi-Cal’s most important group of primary care providers is our vast network of FQHCs. These clinics provide value to the overall delivery system in access, quality of care, and help minimize the total cost of care. DHCS understands the value of the FQHC network and the recent implications expanding Medi-Cal enrollment has played on their operations.

Through extensive collaboration with the California Primary Care Association (CPCA) and California Association of Public Hospitals and Health Systems (CAPH), who combined represent over 1,000 community clinics and FQHCs, DHCS has established several core policy goals to guide design and implementation of the proposed APM pilot program.

- I. Transition from the volume-based (PPS) system to one that better aligns financing and delivery of health services;
- II. Promote care delivery redesign and allow for flexibility to deliver care in the most effective ways to improve primary care access;
- III. Improve the beneficiary experience;
- IV. Enhance collaboration and coordination between FQHCs and Medi-Cal managed care plans.
- V. Simplify the payment structure for clinics and shift the primary payor responsibility to the Medi-Cal managed care plans;

B. PILOT OVERVIEW

California State Senate Bill (SB) 147 (Chapter 760, Statutes of 2015) authorized a three-year APM pilot program for county and community-based FQHCs willing to participate in the pilot program. SB 147's purpose is to incentivize delivery system and practice transformation at FQHCs through flexibilities available under a capitated model which would move the clinics away from the traditional volume-based, PPS, to a payment methodology that better aligns the evolving financing and delivery of health services. The proposed APM structure provides participating FQHCs the flexibility to deliver care in the most effective manner, without having to worry about the more restrictive traditional billing structure that is in place today. With the flexibility of payment reform, FQHCs will begin to provide and/or expand upon the innovative forms of care which are not reimbursed under traditional volume-based PPS. Examples of non-traditional services could include but are not limited to: integrated primary and behavioral health visits on the same day, group visits, email visits, phone visits, community health worker contacts, case management, and care coordination across systems.

Under the proposed APM pilot, for beneficiaries who are assigned to a FQHC as their primary care provider, the direct payor for full FQHC payment would transition from the state to Medi-Cal managed care plans. The clinic-specific capitated payment methodology would ensure participating clinics are reimbursed at no less than the PPS rate, as prescribed under federal law, while incentivizing delivery system reform and practice transformation at FQHCs through funding flexibilities available under a full capitation payment structure. Participating clinics will be able to promote more cost-effective and higher value care to their assigned pilot members. This structure will reward the provision of care via more appropriate methods that will improve the beneficiary's experience while also improving access for beneficiaries who may not access primary care services on a regular basis. This is especially true for those beneficiaries residing in rural areas, where long distances and provider shortages are common barriers to care.

By virtue of implementing a capitated model, the pilot is also structured to allow for more administrative flexibility for the clinics. For those assigned members, clinics will no longer need to submit claims for wrap-around payments to the state and wait years for a reconciliation to PPS to occur. The simplicity of receiving a capitation from the Medi-Cal managed care plans directly each month for their assigned pilot members, will provide a more expeditious reimbursement to the clinics. The response so far from the clinics to this proposed structure has been positive as they believe this will help alleviate cash flow implications and administrative challenges regarding the lengthy process to receive full reimbursement to PPS.

Pursuant to the provisions within SB 147, DHCS will invite all FQHCs (including FQHC look-alikes) to participate in the proposed APM pilot. There will be a formal application period for those clinics who are interested to apply and DHCS will make the final determination as to whether a clinic will participate in the

proposed pilot, using a robust set of criteria. While it is optional for FQHCs to apply and to participate if selected, Medi-Cal managed care plans will be required to amend their contracts with participating network clinics to incorporate the specific provisions and requirements of the proposed APM pilot.

Given that there are unknowns when switching to new payment methodologies there are several risk mitigation elements incorporated into the structure of the pilot. On the plan side, the use of supplemental capitation assists in mitigating the risk of the number of members actually assigned to pilot clinics and additionally there are risk corridors included in the structure of the supplemental capitations which will help alleviate risk for the Medi-Cal managed care plans. Secondly, there are triggers in place for the FQHCs, in the event traditional visit utilization of the assigned pilot members is above/below certain levels as compared to the expected utilization in the absence of the pilot in order to ensure compliance with the PPS-level reimbursement.

DHCS has an implementation target date of October 1, 2017, for the proposed pilot.

C. PAYMENT STRUCTURE

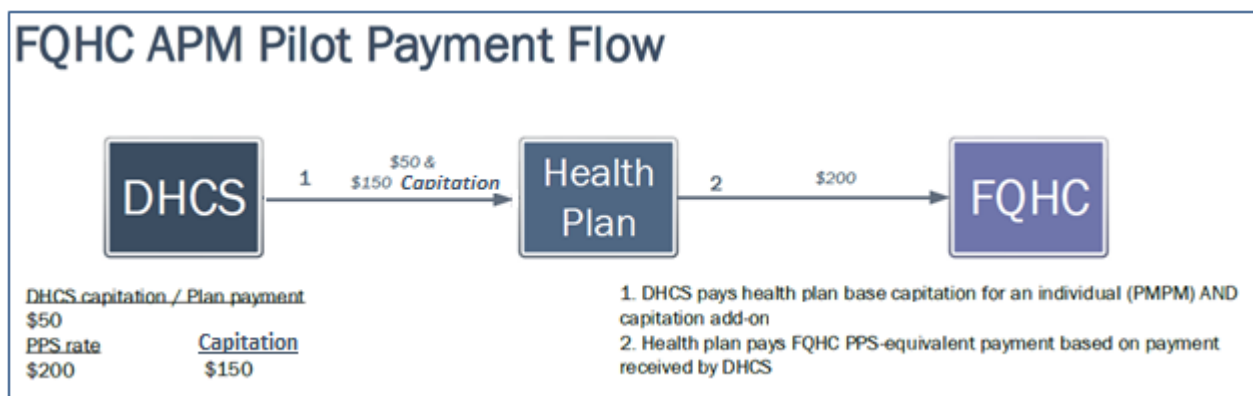
Proposed payment structure

Under the proposed APM pilot, DHCS would be responsible for calculating an actuarially sound health plan specific supplemental capitation payment and a clinic-specific per-member-per-month (PMPM) payment for each category of aid included in the pilot target population. The Medi-Cal managed care plan supplemental capitation payment will be paid to each health plan on a monthly basis for the assigned pilot members. Health plans would then be responsible for paying each participating FQHC payments equivalent to that clinic’s specific PMPM rate (also calculated by DHCS) for members who are assigned to the clinic as their primary care provider.

The FQHC clinic-specific PMPM payment will initially be based on historical utilization for those assigned pilot members and will be projected at the equivalent level of PPS funding. In exchange for the capitated PMPM payments, the clinic would be responsible for all services required by the beneficiary that are within the clinic’s scope of services.

The capitated payments will provide greater flexibility in health care delivery for the FQHC by enabling the FQHC to provide different types of health care services without having to meet the per-visit billing requirement to generate Medi-Cal revenue. Included below is an illustration of the proposed APM payment:

Figure 6: Proposed FQHC APM pilot payment flow



Comparison of proposed payment structure to the current payment structure

Today as established in the existing payment structure, DHCS is responsible for reimbursing a FQHC for the difference between its per-visit PPS rate and the payment made by the plan. It depends on how quickly the clinic can submit an invoice to DHCS for the wrap-around payment, but it's highly unlikely the clinic will receive a payment in the same month that services are rendered. After the wrap-around payment occurs, as required by federal and state law, DHCS then is required to reconcile each visit with the PPS rate. Due to the overwhelming amount of visits rendered at FQHCs each year, there is over a two-year timeframe for reconciliations to occur. Each reconciliation can yield two possibilities: the clinic wrap around payment was either greater or less than their PPS. In the event the received less than their PPS rate, DHCS would issue a reconciliation payment to the clinics. If that wrap-around payment was more than their PPS rate, DHCS would recoup the overpayment from the clinics, which can create a cash flow issue in future years for clinics.

As illustrated above in Figure 6, the proposed APM pilot payment flow is designed to shift the primary payor responsibility for the full FQHC PPS payment from DHCS to the Medi-Cal managed care plan. This shift allows for a more expeditious payment to the participating FQHCs for those assigned pilot members. The Medi-Cal managed care plans will be required via their contract, to pay clinics each and every month the clinic-specific PMPM payments (calculated by DHCS) for the assigned pilot members. This should be as close to real-time as possible—for which the stakeholder community has expressed their support. Their interest in this modification to payment is understandable when comparing the proposed structure to the traditional process where clinics can wait years before receiving full reimbursement or having to repay DHCS for overpayments.

D. CONTRACTING***State and Managed Care Plan***

As structured in the proposed pilot, Medi-Cal managed care plans will become the primary payor for full FQHC payment for those assigned pilot members. This will require a modification in the existing contracts between the Medi-Cal managed care plan and DHCS, which will make the plan responsible for paying clinic specific PMPMs to the participating FQHCs. This and other modifications to the contract would include:

- Requirement that plans must pay FQHCs according to the CMS-approved APM methodology, for contracted FQHCs that serve in the plan's county and have been approved by DHCS for participation in the pilot;
- Applicable reporting requirements on number of assigned pilot members;
- Risk corridor structure (inclusion in contracts required by legislation).

Managed Care Plan and Clinic

While DHCS will standardize contract language for the State/Medi-Cal managed care plan level, DHCS will also issue guidance to plans via All Plan Letters (APL) which will include suggested practice for plan efforts to modify their contracts with participating FQHCs. Some examples of the suggested modifications are:

- Contract revision implementation timeline,
- Rate methodology (via an Attachment),
- Medi-Cal populations covered and not covered by the APM payment methodology,
- Scope of services included in the APM,
- The role of plans in working with DHCS and its contractors to set the APM rates,

- Timing of DHCS notification to the plans of the supplemental capitation rate and the clinic-specific PMPM,
- FQHC payment requirements,
- Detailed reporting requirements (e.g. format, frequency, and timing of assigned pilot member reporting),
- Reconciliation process.

E. RATE DEVELOPMENT

DHCS today has entered into full-risk capitation arrangements with 23 contracted health plans in order to arrange for the provision of covered Medi-Cal services to more than 10 million statewide Medi-Cal eligible members. Regardless of the plan, county, or populations within the county, the rate setting process remains consistent. DHCS’ actuaries or contracted actuaries (Mercer) adhere to federal Medicaid law and the Actuarial Standard of Practice (ASOP) No. 49: Medicaid Managed Care Capitation Rate Development and Certification, from the Actuarial Standards Board.

Target populations

There are four specific populations in Medi-Cal that have a disproportionately high representation at FQHCs when compared to the Medi-Cal population as a whole. Together, they reflect over 93% of the FQHC user population and they are all enrolled in Medi-Cal managed care. In an effort to strike a balance between covering a majority of the clinic’s population to incent true delivery system transformation, while not being administratively complicated to administer, the proposed pilot is structured to target these four Medi-Cal managed care populations.

Populations:	
1	Non Expansion Adults
2	Children
3	Seniors and Persons with Disabilities (SPD)
4	Expansion Adults

Member assignment

The proposed pilot payment structure would only be in place for those managed care members in one of the four targeted populations, and for whom the FQHC is the assigned primary care provider. Those who are eligible for the pilot payment structure are referred to as “assigned pilot members,” which means both the Medi-Cal managed care plan and the clinic have agreed to designate the participating FQHC as their primary care provider.

If a managed care member is seen at an FQHC participating in the pilot but that member does not have the FQHC as his or her primary care provider, the normal FQHC payment process will occur as they do today. Limiting the pilot to assigned pilot members of the FQHCs helps address concerns with regard to risk and steerage of Medi-Cal beneficiaries as the plans would not have the financial incentive to over or underutilize clinic providers.

Historical data

Early in the rate development process, each Medi-Cal managed care plan and the participating clinics will work together in reconciling historical data (claims experience and assigned pilot members) and will submit

up to 24 months of the most recent and complete information available. This data will be submitted to DHCS via a specific Supplemental Data Request (SDR) to help inform the rate development for both the Medi-Cal managed care plan supplemental capitation and the clinic-specific PMPMs. The SDR will collect detailed information for all managed care members enrolled in an FQHC. Data elements collected on the SDR will include but not be limited to:

- A. Detail requested at Client Index Number (Medi-Cal ID) level,
- B. Enrollment, utilization, and cost information by month,
- C. Category of Aid groups: Children, Non Expansion Adult, SPD, Expansion Adult,
- D. FQHC utilization and costs information for all assigned pilot members and their PPS-related visits:
 - i. Health Plans and IPAs—report payment made to FQHC for each claim and/or capitation arrangement,
 - ii. FQHCs—report payment received from health plans, PPS amount, and wrap around payment for each claim. Also, report payments received as part of a capitation arrangement.

Additionally, DHCS will utilize the several years of clinic-specific reconciliation data and PPS rate information—including any prior year requests for changes in scope or services.

Data collection/reconciliation process

Following the submission of the SDRs, DHCS and Mercer, will work with the Medi-Cal managed care plans to address any discrepancies in the submitted data. This data validation step will help control for a review of the completeness of each submission, enrollment discrepancies, and cost and utilization information.

Initial year of the pilot rate setting process

Participating FQHCs and Medi-Cal managed care plans will work together to reconcile their historical data and submit a completed SDR to DHCS in order to begin the rate development process. For the initial year of the proposed pilot, the rate setting process will incorporate the historical experience between clinics and the plans as well as the clinics' PPS payment levels, as well as adjustments necessary to ensure the rates developed reflect the amount the pilot clinic would have received absent the pilot.

Future years of the pilot rate setting process

Following the initial year of the rate setting process, for years two and three of the proposed pilot, DHCS will take into account pilot utilization experience (both traditional and non-traditional services) into informing the rate setting process. As clinics begin providing and expanding upon the innovative forms of care not currently reimbursed under the traditional volume-based PPS system, the need to capture this experience at a detailed level will be a critical component in the future rate setting, especially as we move into year three. Other adjustments, such as the annual Medicare Economic Index (MEI) increase and any clinics that change their scope of their PPS rates, will be factored into years two and three supplemental capitations and clinic-specific PMPM payments.

Rate development when multiple clinics are participating in the same region

While the rate setting process described above will be consistently applied to all managed care plans and participating clinics, there will be additional steps during the development of the rates to account for counties or managed care regions that have multiple clinics participating in the pilot. As illustrated above in Figure 6, this payment structure would occur in the most simplistic scenario where one clinic is participating with one plan and assumes utilization is once per month for each assigned member. In this scenario, the Medi-Cal managed care plan will receive the current base capitation (which in this example assumes \$50 for

utilization at FQHCs) and, for each assigned member of the APM pilot, an APM supplemental capitation of \$150 per month. The combined funding provided to the Medi-Cal managed care plan will allow them to pay the participating clinic-specific \$200 PMPM for each assigned member.

However, when there are multiple clinics participating in the pilot located within the same managed care region, additional steps will be required in order to convert the multiple clinic-specific PMPMs into a single APM supplemental capitation for the health plan. The APM supplemental capitation the plans receive from DHCS will be based on the average across all assigned members in all participating clinics, for each pilot population. Included below is a simplified example for the steps necessary in developing the single blended APM supplemental capitation for one pilot population, for one health plan.

Figure 7: Proposed FQHC APM pilot payment flow with multiple clinics

(A)	(B)	(C)	(D)	(E)	(F)	(G) = (F) - (E)	(H)	(I)
		No. of Members	No. of Visits	HP to FQHC	PPS	Clinic-Specific PMPM	Blending Clinic A&B	Weighted APM Sup Capitation for Health Plan
Health Plan	Clinic A	100	100	\$50.00	\$200.00	\$150.00	20%	
	Clinic B	200	400	\$50.00	\$150.00	\$100.00	80%	
	Total	300	500					\$110.00

While the example above is a simplified version of the steps necessary to accomplish the single weighted APM supplemental capitation, the process to determine the clinic-specific PMPM (column (G)) for the participating clinics is the same as illustrated in the Figure 6 example above. The only difference is when converting from column (G) to column (I), where projected utilization from each clinic will be weighted across the participating clinics, creating a blended APM supplemental capitation for the health plans.

F. ENCOUNTERS

Overview of existing encounter process

Medi-Cal managed care plans are required by contract to submit encounter data representing all services for which they have any financial liability to DHCS on at least a monthly basis. This includes health care services covered through FFS and capitated payment arrangements, as well as services covered by Medi-Cal managed care subcontractors. Medi-Cal managed care plans submit encounter data to DHCS utilizing the ASC X12 837 P, ASC X12 837 I and NCPDP standards for Professional, Institutional and Pharmacy encounters respectively. As encounter files are uploaded to specific SFTP sites, DHCS’ Post-Adjudicated Claims and Encounters (PACES) system processes them and returns response files to the submitter. DHCS monitors the quality of the encounter data in terms of completeness, accuracy, reasonability and timeliness and may impose technical assistance, corrective action plans and financial penalties when encounter data quality requirements are not met.

Reporting requirements and expectations under the pilot

Medi-Cal managed care plans will continue to be held to their reporting requirements as stated in their contracts. FQHCs that participate in the pilot will be expected to submit high-quality encounter data to Medi-Cal managed care plans so that they meet their contractual obligations to DHCS. This requirement will be taken into account when DHCS selects the potential clinics for the pilot.

Traditional vs Non-Traditional Services

Today, Medi-Cal defines a patient visit in the FQHC setting to require a “face-to-face encounter” between a FQHC patient and a FQHC billable provider in order for the FQHC to be reimbursed by Medi-Cal for the encounter via the FQHC’s PPS rate. This face-to-face visit or “traditional service” requirement with a billable provider, limits FQHCs to only providing services that are reimbursable. One of the main goals for the proposed FQHC APM pilot, is to allow participating FQHCs the flexibility to better respond to patient needs and provide more patient-centered care. The pilot payment structure will allow for clinics to provide “alternative touches” or “non-traditional services” to assigned pilot members without having to worry about reimbursement restrictions.

An “alternative touch” or “non-traditional service” can be defined as any contact not billable under PPS with a Medi-Cal member or on behalf of a member that is designed to improve patient activation, health outcomes and/or health system efficiency, regardless of the modality or member of the care team who renders the service. Alternative touches will allow pilot clinics to respond to increases in patient demand for access to health services via internet and mobile devices, and take advantage of other innovations in health technology such as sending medical images to specialists for interpretation electronically.

Recognizing the growing body of evidence on the effectiveness of using care teams where each member operates at the top of his/her license, alternative touches could include but are not limited to:

Email visits	Marriage and Family Therapist visits
Phone visits	Integrated Primary and Behavioral health visits
Group visits	Community health worker contacts
Case Management	Care management and coordination for low to moderate risk beneficiaries
Wellness visits	Pharmacist consultation
Nurse Advice line	Patient Support Groups

G. PROPOSED RECONCILIATION PROCESS

Under the proposed pilot, since clinics will be paid a clinic-specific PMPM payment for their assigned members in lieu of receiving a PPS rate for traditional utilization, there will no longer be the need for the traditional reconciliation process. However, DHCS will employ a new type of reconciliation process to mitigate any possible risks for the clinics. As required in SB 147, DHCS will monitor the traditional utilization during the pilot for the clinics and if the utilization were to fall outside a specified range of expected utilization levels, it would trigger DHCS to conduct a full reconciliation for the clinic. Included below is the structure for when DHCS would conduct a reconciliation for the clinics:

Figure 8: Proposed FQHC APM reconciliation triggers

Reconciliation Triggers	Year 1	Year 2	Year 3
Traditional utilization greater than expected	+5.0%	+7.5%	+10.0%
Traditional utilization less than expected	-30.0%	-30.0%	-30.0%

Under this proposal, if the trigger level is met, a complete data analysis will be conducted to analyze the trigger. If after the analysis is completed, the trigger level is confirmed the following steps will occur.

For increased visits:

- Step A: The actual level of visits will be determined = (A)
- Step B: The number of visits above the trigger level will be calculated by subtracting from the actual visits the number of visits equal to the trigger (B) = trigger level visits – (A)
- Step C: The health plan will pay the clinic an amount equal to the excess visits times the clinic PPS rate reconciliation owed to clinic (C) = (B) x PPS rate

For decreased visits:

- Step A: The actual level of visits will be determined = (A)
- Step B: The number of visits below the trigger level will be calculated by subtracting from the number of visits equal to the trigger the actual number of visits (B) = (A) – trigger level visits
- Step C: Based on the results from (B) if traditional utilization falls below the 30% threshold, the clinic can choose to provide additional encounter level detail to show that some of the decreases in traditional visits were due to the delivery of alternative services.
- Step D: Based on pre-determined methodologies for equating “alternative” services to “visits” the number of “alternative service equivalent visits” will be determined = (D)
- Step E: The revised number of visits below the trigger level will be calculated by subtracting the value in Step D from Step B. (E) = (B) – (D)
- Step F: If the value from Step E is greater than 0, the clinic will repay the health plan an amount equal to the PPS rate times the “alternative service equivalent visits” from Step E. (F) = (E) x PPS rate.

H. PROPOSED RISK MITIGATION ON HEALTH PLANS

As currently structured within the proposed pilot, there are three key elements that will help mitigate the risk to health plans. These key elements were designed to protect health plans from any unintended consequences through the implementation of this proposed pilot.

First, the APM supplemental capitation to the health plans will be adjusted for any change to the PPS rate for a specific clinic participating in the pilot. This adjustment will ensure that sufficient funding is being factored into the APM supplemental capitation. This would include any annual increases to the clinic’s PPS rate as well as any changes in scope of services.

Second, since the APM supplemental capitation is tied to the assigned members reported monthly by the health plan, any changes in the assigned members (increase or decrease in caseload) will adjust their total supplemental payment accordingly. This monthly reporting will provide health plans the ability to manage their cash flow in real-time, which will provide them with the resources necessary to maintain their obligation with the participating clinics.

Lastly, to help mitigate the new financial risks related to this pilot project, DHCS is proposing instituting risk corridors for the APM supplemental capitation paid to plans. The risk corridors will be structured symmetrically as follows:

- Health plans will be responsible for costs/profits up to 0.5% of the APM supplemental capitation
- The state and health plan would share 50%/50% in costs/profits above 0.5% and up to 1.0% of the APM supplemental capitation
- Any costs/profits beyond 1.0% will be borne fully by the state.

This risk corridor would protect the health plans from the averaging nature of the APM supplemental capitation since rates for different clinics vary and the APM supplemental capitation could potentially be too high or too low, based on the actual member assignment to each clinic. In addition, it would protect the health plans in case of a PPS reconciliation between the health plan and each participating clinic that would result in additional costs.

I. PROPOSED PARTICIPATION AND READINESS CRITERIA (CLINICS)

DHCS, in consultation with various stakeholders (CPCA, CAPH, California Association of Health Plans (CAHP), Local Health Plans of California (LHPC)), have begun the development of a process by which interested FQHCs may apply for participation in the pilot. This includes criteria and minimum readiness standards to be used when selecting FQHCs for participating in the pilot. While the pilot is structured for DHCS to make the final determination as to whether a clinic participates or not, there has been extensive collaboration with the stakeholder community so the decision is consistently applied based on agreed upon criteria.

Criteria as outlined in SB 147

- The FQHC has the demonstrated ability to collect and submit encounter data in a form and manner that satisfies the department requirements.
- The FQHC is in “good standing” with the relevant State and federal regulators.
- The FQHC has the financial and administrative capacity to undertake payment reform.

Additional criteria based on collaboration with stakeholders:

- **Experience with Strategic Practice Transformation:** FQHC pilot sites will demonstrate their capacity and commitment for transformation through any of the following:
 - 1) Certified or in the process of receiving certification by a nationally recognized accrediting organization for patient-centered medical home;
 - 2) Participation in performance improvement/care redesign efforts facilitated by organizations like the Center for Care Innovations or via engagement with performance improvement consultants/coaches;
 - 3) Participation in federal initiatives or other grant programs to promote care transformation (i.e. those managed by the CMS Innovation Center or private foundations).
- **Data capabilities:** FQHCs should demonstrate the ability to transmit data to the plans in an agreed-upon electronic format. FQHCs will need to pass system testing for any new data collection requirements in advance of implementation.
- **APM Strategy:** FQHCs should demonstrate a strategy to move to the APM, as evidenced by a narrative submitted by applicant FQHCs.
- **Organizational Commitment to Transforming Primary Care Practices:** As evidenced by a letter of support signed by clinic leadership.
- **Quality Improvement Infrastructure:** As evidenced by an active quality improvement plan or strategic plan inclusive of quality improvement initiatives, and documentation of the staff/resources dedicated to improvement efforts. FQHCs must have demonstrated their ability to meet the minimum performance levels for all applicable Healthcare Effectiveness Data and Information Set (HEDIS) metrics under the Medi-Cal managed care program.
- **Staffing Capacity:** As evidenced by documentation of the FQHC’s care team model, including numbers of staff by type/function.
- **Adequate pilot membership to drive FQHC’s transformation:** As evidenced by the number of assigned Medi-Cal managed care members compared to the overall patient population served by the FQHC site.

J. PROPOSED SELECTION PROCESS (CLINICS)

Pursuant to the provisions within SB 147, DHCS will invite all FQHCs (including FQHC look-alikes) to participate in the APM pilot. There will be a formal application period for those clinics who are interested in applying. Following the application period, DHCS will review all applications and make the final determination as to whether a clinic is selected for the APM pilot. Notifications will be distributed to those clinics selected, along with the associated Medi-Cal managed care plans who operate in the same county where the selected clinic is located. Medi-Cal managed care plans will not have a choice whether to participate or not, and will be required to amend their contracts with the participating clinics to incorporate the specific provisions and requirements of the proposed FQHC APM pilot.

IV. ADDITIONAL PROGRAM ELEMENTS AND TIMELINE

A. INDEPENDENT PROGRAM EVALUATION

Requirements per SB 147 (W&I 14138.21)

SB 147 requires an evaluation of the pilot project to be conducted by an independent entity that takes into consideration payment adequacy, delivery system transformation, and quality measures. The evaluation must, to the extent practicable, be completed within six months of the pilot project being completed, and the independent entity must report its findings to DHCS and the California Legislature.

B. STAKEHOLDER ENGAGEMENT

Workgroups

Shortly after the introduction of SB 147, DHCS convened a group of stakeholders to provide input on policy issues related to a possible pilot and obtain stakeholder buy-in. Participants included the California Primary Care Association (CPCA), the California Association of Public Hospitals and Health Systems (CAPH), the California Association of Health Plans (CAHP), the Local Health Plans of California (LHPC), individual health plans, and legislative staff. To date, the Policy Work Group has met five times. In addition, DHCS convened three sub-workgroups to develop recommendations for the Policy Work Group in the following areas: rate development, contracting, and alternative encounters.

The Policy Work Group and the sub-workgroups addressed proposed pilot design, rate development, clinic selection and readiness, and evaluation. DHCS also engaged Mercer to collect historical data from a small sample of clinics and health plans in three counties (Alameda, Monterey and Los Angeles), conduct an analysis, and develop a sample rate methodology. The findings from Mercer's analysis provided useful information for the sub-workgroups on rate calculation, payment structure, and the elements, process, and timing of collecting the data required for developing the clinic-specific rates for the pilot.

Following the submission of the concept paper to CMS, DHCS will continue the ongoing stakeholder engagement throughout the implementation process.

C. IMPLEMENTATION PLAN

Proposed Timeline

FQHC APM Pilot – Draft Timeline 10/13/2016	
Date	Deliverable/Activity
May-July 2016	Stakeholder Workgroups
August-September 2016	Finalize pilot concept paper
	Notify all FQHCs of Pilot
October-December 2016	Submit concept paper to CMS
	Release pilot applications to clinics
	Finalize proposed SPA and publication of SPA notice
	DHCS completes application review/selection
	Plans/Clinics begin to reconcile data
January-March 2017	Plans submit data to DHCS/Mercer
	Plan calls with DHCS/Mercer begin
	Mercer develops plan supplemental capitations and clinic-specific PMPMs
	Release draft rates to plans/clinics
	Begin readiness activities with clinics and plans
April-June 2017	Notify plans/clinics of final rates
	Submit final rates to CMS for approval
	Continue readiness activities
October 2017	Pilot implementation (contingent upon approval of rates by CMS, plan/clinic readiness); there is a possibility this is the first phase of multiple phases (however, we will minimize it to only a couple at the most)

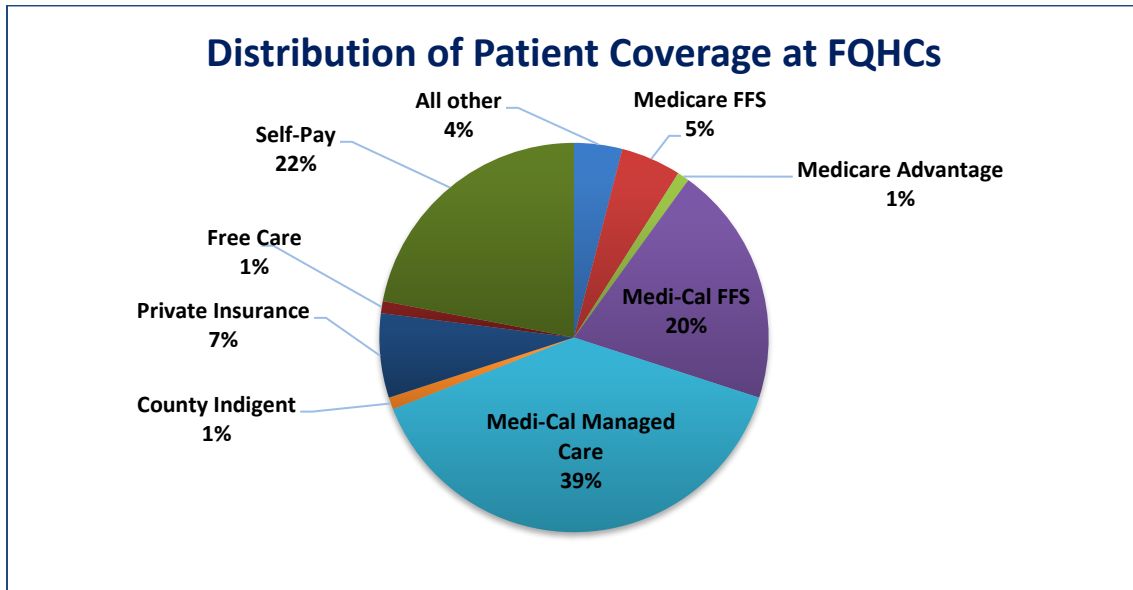
Clinic/Plan Readiness

DHCS recognizes that readiness includes the readiness of the health plan, and the pilot clinics. With support from CAPH, CPCA, CAHP and LHPC, DHCS will develop a readiness assessment protocol to ensure that all parties are ready in advance of implementation. As part of their contracts, plans and clinics will be required to commit to and demonstrate their ability to meet the identified duties and that they have the ability to serve all eligible members of the pilot in their clinic and/or plan.

DHCS will continue to develop readiness requirements, such as outcome measures and service requirements, which DHCS will share in the coming months.

APPENDIX

- California State Senate Bill (SB) 147 (Chapter 760, Statutes of 2015) http://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB147
- Figure 1: Growth of FQHCs in California since 2006. Source: 2015 data from the DHCS Audits and Investigations Division.
- Figure 2: Distribution of patient coverage at FQHCs; Calendar Year 2014. Source: OSHPD Primary Care Clinic Annual Utilization Data; 2014. <http://www.oshpd.ca.gov/HID/PCC-Utilization.html#Complete>



- Figure 3: Biannual Trend in Medi-Cal FFS and Managed Care Participation from January 2008-January 2016. Source: Created by DHCS Research and Analytic Studies Division.
- Figure 4: Medi-Cal FQHC Utilization Trends, 2008-2014. Source: Source: Created by DHCS Research and Analytic Studies Division.
- Figure 5: Current FQHC Payment Flow for a Medi-Cal managed care member.
- Figure 6: Proposed FQHC APM pilot payment flow.
- Figure 7: Proposed FQHC APM pilot payment flow with multiple clinics.
- Figure 8: Proposed FQHC APM reconciliation triggers. Outlined in SB 147 (Chapter 760, Statutes of 2015)