



Federally Qualified Health Center Alternative Payment Methodology Pilot

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Presentation Outline

Background on California's FQHCs

Quick Overview

- Framework of California's FQHC APM pilot

Project Goals

Status update on October 2017 implementation



Background on FQHCs

Established in 1990, FQHCs are public or tax-exempt entities which are deemed to have “federally qualified” to receive a direct grant from the United States under Section 330 of the Public Health Service Act

- Established and assured that all FQHCs are reimbursed at cost

There are 954 active FQHCs in California (346 active Rural Health Centers) that serve vulnerable populations and medically underserved communities

Primarily engaged in providing services that are typically furnished in an outpatient clinic; services include:

- Physician services
- Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), Certified Social Worker (CSW), Medical Nutrition Therapy (MNT) services



APM Pilot Overview

SB 147 (Chapter 760, Statutes of 2015) established a 3-year pilot program

Under the pilot, the payor of FQHC services for certain Medi-Cal managed care beneficiaries would transition wholly from the state to Medi-Cal managed care plans

- Moving away from a per-visit payment, DHCS would calculate clinic-specific per-member-per-month (PMPM) capitation payment. The PMPM would be developed in a manner so that it is equivalent to what the Prospective Payment System (PPS) reimbursement would have otherwise been

Instead of clinics receiving 1) plan payment, 2) wrap around payment, and 3) reconciliation adjustment, they would receive monthly capitation payments for specified managed care members



APM Pilot Overview

The transition to PMPM payments would be for the following populations:

- Children
- Non-Disabled Adults
- Seniors and Persons with Disabilities
- Expansion Adults

The pilot payment structure would only be in place for those beneficiaries for whom the FQHC is the assigned 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.

The full scope of services of the pilot clinic's PPS rate would be covered under the pilot for the applicable members, this would include specialty services and behavioral health to the degree those services are a part of the clinic's PPS

This structure provides clinics the flexibility to provide services in the best manner for the beneficiary without needing to worry about the particular billing rules that trigger a traditional FQHC billable "visit" (e.g. only with billable providers, limit to 1 visit per day)



APM Pilot Overview

Under the pilot, since clinics are being paid a PMPM for assigned members there will no longer be a traditional reconciliation process

The PMPM is developed to be equivalent to PPS payment for expected utilization for the various categories of members, which is based on historical data and trend factors

However, under the federal APM requirements, there need to be mechanisms for the clinic and the state to agree that the PMPM is equivalent to what would have been paid under PPS

Under the pilot, this is done through the establishment of triggers wherein if utilization is above/below certain levels as compared to the expected utilization, a reconciliation would occur. Those levels are:

- 1st year: >105% or <70% of expected utilization at the clinic
- 2nd year: >107.5% or <70% of expected utilization at the clinic
- 3rd year: >110% or <70% of expected utilization at the clinic



Project Goals

Primary goal is to transition from the volume-based (PPS) system to one that better aligns the financing and delivery of health services

Allow clinics the flexibility to deliver care in the most effective ways to enhance the beneficiary experience without worrying about reimbursement (i.e. same day multiple visits, telehealth, care management, etc.)

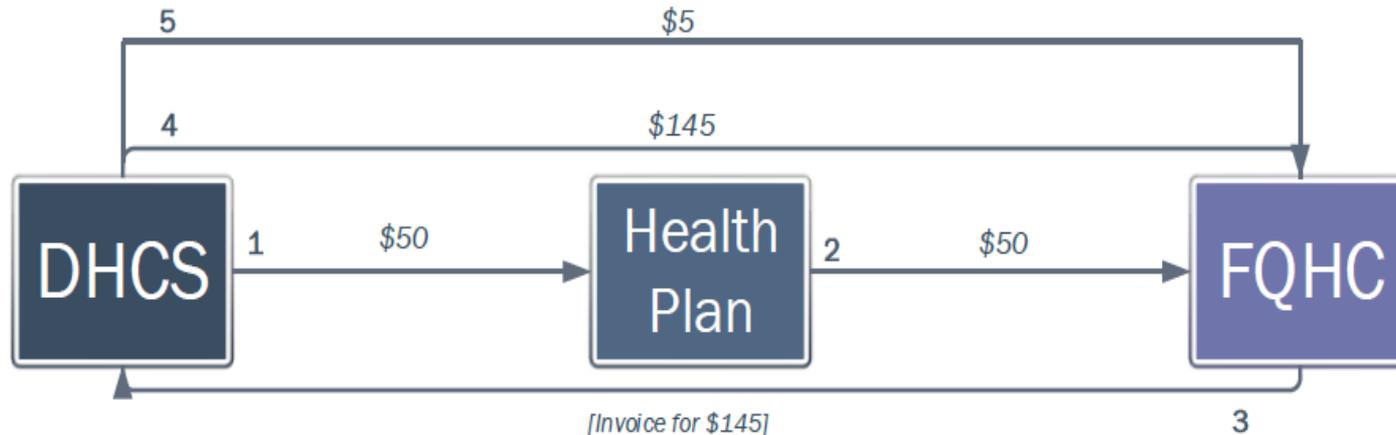
Shift the primary payor responsibility to the plan

Simplify the payment structure for the clinics



Payment Structure

Current FQHC Payment Flow



DHCS capitation / Plan payment

\$50

PPS rate

\$200

1. DHCS pays normal health plan capitation for an individual (PMPM)
2. Health plan pays FQHC (FFS or capitated payment, depending on plan/clinic) based on payment received by DHCS
3. FQHC bills DHCS for difference between health plan payment and PPS rate (Code 18 "wraparound" payment)
4. DHCS pays wraparound to FQHC
5. DHCS reconciles to PPS



Proposed Payment Structure

FQHC APM Pilot Payment Flow



<u>DHCS capitation / Plan payment</u>	
\$50	
<u>PPS rate</u>	<u>"Wrap-cap"</u>
\$200	\$150

1. DHCS pays health plan base capitation for an individual (PMPM) AND capitation add-on ("wrap-cap")
2. Health plan pays FQHC PPS-equivalent payment based on payment received by DHCS



Timeline

Summer
2016

- Finalize pilot concept paper; submit to CMS for review

Fall
2016

- Finalize SPA; submit to CMS for approval
- Notify all clinics of pilot; start the application process

Winter
2016

- Plans/Clinics reconcile data; Mercer develops “wrap cap”

Spring
2017

- Release draft rate to plans/clinics
- Begin readiness activities with plans/clinics

Summer
2017

- Notify plans/clinics of final rates; Submit rates to CMS

October
2017

- Pilot begins



Further Questions

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