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# Federally Qualified Health Center Alternative Payment Model (FQHC APM)

Overview: September 30, 2022

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## 7. Payments to MCOs

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# APM Overview and Goals

## FQHC APM Overview

The APM will incent care delivery and practice transformation at select FQHCs through flexibilities available under a capitated model.

- Participating FQHCs will move away from traditional, volume-based PPS to support improved quality and health equity.
- Participation is voluntary; FQHCs may apply to be selected or opt out annually.

An APM PMPM rate will be paid for each assigned member from a contracted MCP.

- Actuarially equivalent to projected PPS payments for base year utilization.
- Enables FQHCs to reduce traditional (billable) visits and increase alternative services (not billable) without reducing revenue.

FQHCs are guaranteed at least their PPS rate multiplied by traditional (billable) visits.

### Quality

- Gate and Ladder
- Quality Metrics

## APM Goals

The APM goals are to achieve the following:

- FQHCs from across the State, and across various managed care models, that are committed to pursuing practice transformation will develop and implement transformation plans supported by the reformed payment model.
- Members experience improvements in access to care, quality of care, and a reduction in health disparities.
- Prospective, predictable payments, and flexible use of resources enable and drive care delivery transformation for clinics.
- Providers are more satisfied in their practice and retention in FQHCs increases.

## APM Purpose

- Allow innovative payment reform and quality of care improvement.
- Flexible payment reform, to permit/expand innovative care not reimbursed under traditional volume-based PPS.
- Shifting to Value-Based Payment will allow payment to no longer be volume based.
  - Monthly payment per member (PMPM)
  - Some visits converted to new modes or care (e.g. email, group visits)
  - Care teams (including non-billable providers)
  - PMPM can exceed PPS as encounters decrease
  - Based on PPS priced at historic utilization where FQHCs retain the entire PMPM if they meet quality metrics
- The size of the pay-for-transformation funding (wedge) is unrelated to the alternative care services.
  - The pay-for-transformation funding will equal the historic FQHC encounter utilization priced at the current PPS minus the current encounter utilization priced at the current PPS, where an encounter meets the State's statutory and regulatory definitions of an encounter.
  - An FQHC can increase the size of the pay-for-transformation funding by improving its efficiency (e.g., decreasing costs) while maintaining the quality and access to care for its members.

## APM Guiding Principles

Payment modernization should support the following:

- Patient-centered care allowing members to receive needed services conveniently.
- Alignment of measures in CalAIM, Medi-Cal Managed Care, and Pay-for-Performance programs to ensure greatest impact in quality targets.
- Data informed innovation that encourages deeper health information exchange between managed care plans and FQHCs.
- Integrated whole person care, including physical, behavioral, oral health, and long-term services and supports.
- Delivery reform focused on value, outcomes, and investing in early intervention and primary care resulting in per capita cost decreases to the larger Medi-Cal program.
- Flexibility for FQHCs to reduce disparities and to address member needs, including SDOH.
- Reduced administrative burden, consistent and timely payment, and a strong and resilient safety net in California.

## **AMP Guiding Principles**

### **Agreements:**

- The new payment method will adhere to APM rules.
  - Voluntary
  - Must result in payment that can be documented as at least otherwise received under PPS (attestations are not sufficient)
- DHCS has jurisdiction to develop an APM in a SPA.
- Legislative updates were made as part of Senate Bill 184 (Ch. 47, Stats. 2022).

### **Future Direction:**

- Over time, DHCS would like for the quality metrics of FQHC-served members to improve.
- CMS allows the practice transformation payment that exceeds the current utilization multiplied by the current PPS rate to be at risk (e.g., excess revenues above PPS or “wedge”).

## **DHCS wishes to explore FQHCs taking on some level of risk over time**

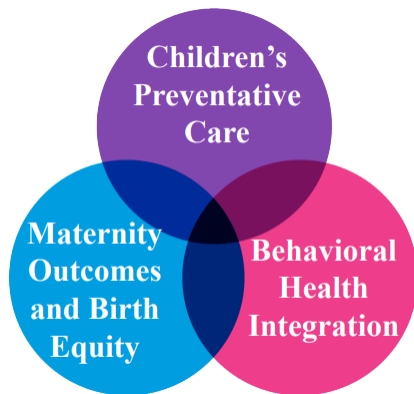
### **Quality Strategy Goals**

- The APM will align with and support DHCS Quality Strategy.

#### DHCS Quality Strategy includes:

- Eliminating health disparities through anti-racism and community-based partnerships.
  - Data driven improvements that address the whole person
- Transparency, accountability, and member involvement.

## Clinical Focus Areas



## Access, Engagement, and Quality

- DHCS will employ a Gate and Ladder Approach to access, engagement, and quality
  - In order to participate in the APM and fully retain APM payments exceeding PPS, FQHCs must meet Gate Metrics, which represent the minimum performance threshold for participation. DHCS will initiate corrective action if a participating FQHC does not maintain one or more of these thresholds.
  - In order to retain funding under the APM, the FQHCs must meet Ladder quality metrics, which require quality improvement over time.

## Gate and Ladder Approach

### Gate: Access Thresholds

- Access Measures: FQHC must maintain a floor of 70% PPS visits (sum of PPS visits and alternative care services) to maintain participation in the APM)
- Quality Measures
  - Report on all measures (not just the ones used for ladder)
  - Maintain baseline (PY0) for the following measures:
    - Well Child Visits in the first 30 months (W30+ & W30-2+)
    - Child and Adolescent Well-Care Visits (WCV)
    - Adults' Access to Preventive/Ambulatory Health Services (AAP)
    - Aggregated Quality Factor Score (AQFS; calculated from all reported measures)
- If the FQHC does not maintain either the minimum access threshold or has degradation of 5% or more of the Quality Measures above, a CAP would be triggered. If scores do not return to the Quality PY0 baseline after 12 months, the FQHC may face a 5% penalty or may be removed from the program.

\*An additional domain “Patient Experience of Access and Care” domain will be reporting only

## **Ladder: Quality Measures**

- FQHCs must meet targets on a total of 12 measures, at least two measures from six domains. An additional domain “Patient Experience of Access and Care” will have metrics for reporting only and outside of risk.
- Program Year Benchmarks:
  - Year 1 - Report Only
  - Year 2 - Greater than or equal to the 33<sup>rd</sup> percentile national or state-calculated (up to 1% of excess revenues at risk, evenly distributed across all selected metrics)
  - Year 3 - Greater than or equal to the 50<sup>th</sup> percentile national or state-calculated (up to 3% of excess revenues at risk, evenly distributed across all selected metrics)
  - Year 4 —Greater than or equal to the 50<sup>th</sup> percentile national or state-calculated (up to 5% of excess revenues at risk, evenly distributed across all selected metrics)
  - Year 5 and beyond
    - Maintain the minimum previous performance levels in Year 4
    - Achieve ongoing continuous performance improvement based on gap methodology outlined.
    - The FQHC has the potential to retain up to 100% of the excess revenues above the current PPS payments. The FQHC is at risk for an increasing one-half of 1% per year of excess revenues (not to exceed 10% of excess revenues). The potential risk will be evenly distributed across all selected metrics for that calendar year.
    - Example: In year 10 of participation in the pilot, an FQHC will have 8% of excess revenues (wedge) above the PPS rate at risk spread across all metrics.

## **Gap Closure Target Setting: Year 5 and Beyond**

### **Appendix: Gap Closure Target Setting Methodology**

- FQHCs’ performance rate and final target rounded to the same number of decimal places as the measure’s benchmark
- The “Gap” is defined as the difference between the FQHC’s end of prior-program year performance and the current PY’s high performance benchmark.

- As detailed in the Table below, FQHCs, at a minimum, will be required to perform at or above each FQHC APM Quality measure’s 50<sup>th</sup> percentile national or state-calculated benchmark. FQHCs with performance on a given measure at or above the 90<sup>th</sup> percentile benchmark for that measure will be considered to be at 100 percent of their quality goal and will be required to achieve performance that maintains or exceeds that measure’s 90<sup>th</sup> percentile benchmark for the subsequent PY. FQHCs whose prior year performance at or above the 50<sup>th</sup> percentile (but below the 90<sup>th</sup> percentile) will be required to close the gap by 10%, as described in the following example:
  - Example: Quality Measure X
    - Year 5 90<sup>th</sup> percentile benchmark: 70.0%
    - Year 5 50<sup>th</sup> percentile benchmark: 50%
    - Year 4 performance (AKA Year 5 baseline): 55.0%
    - Year 4 Performance >50<sup>th</sup> percentile and <90<sup>th</sup> percentile
    - Target is 10% gap closure between Year 4 performance and Year 5 90<sup>th</sup> percentile benchmark:
      - Gap: 70%–55% = 15%
      - 10% of 15% = 1.5%
      - 55% + 1.5% = 56.5%
      - Year 5 Target: 56.5%

**Table: Target Setting by Prior Year Performance**

<b>Measure Performance in Prior Year</b>	<b>Current Year Target</b>
≥ 90 <sup>th</sup> Percentile Benchmark	Performance ≥ 90 <sup>th</sup> Percentile Benchmark
≥ 50 <sup>th</sup> Percentile Benchmark and < 90 <sup>th</sup> Percentile Benchmark	Gap to 90 <sup>th</sup> Percentile closed by 10%
< 50 <sup>th</sup> Percentile Benchmark	Performance ≥ 50 <sup>th</sup> Percentile

## Payment Link to Quality

To fully retain APM payments exceeding the PPS rate, FQHCs must meet quality targets established by DHCS.

- FQHCs will be required to meet performance targets for two measures from six domains (12 metrics in total) that will be tied to payment. The additional domain “Patient Experience of Access and Care” will have two metrics that are reporting only.
- Target goals and the percentage of excess revenue at risk will increase over the length of participation in the program to allow time for the FQHC to adjust to the requirements and improve care quality.



## Final Quality Metrics

APM Quality Category	Measure Name	Measure Abbreviation	Measure Steward	Equity Metrics	Proposed Required Measure (if sufficient N)	Comments
Prevention – Adult	Cervical Cancer Screening	CCS	NCQA			
Prevention – Adult	Colorectal Cancer Screening	COL	NCQA	X	X	
Prevention – Adult	Breast Cancer Screening	BCS	NCQA			
Prevention – Adult	Chlamydia Screening in Women	CHL	NCQA			
Access to Care	Child and Adolescent Well-Care Visits	WCV	NCQA	X	X	
Access to Care	Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	W30-6+	NCQA			Measure added since last workgroup review
Access to Care	Well-Child Visits for Age 15 Months – 30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	W30-2+	NCQA			Measure added since last workgroup review
Access to Care	Adults' Access to Preventive/Ambulatory Health Services	AAP	NCQA		X	

Prevention - Peds	Childhood Immunization Status (CIS 10)	CIS	NCQA	X		
Prevention - Peds	Immunization for Adolescents	IMA	NCQA	X		
Prevention - Peds	Fluoride Varnish		DQA			
BH Integration	Pharmacotherapy for Opioid Use Disorder	POD	NCQA			
BH Integration	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA		X	
BH Integration	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA			
Chronic Care	Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%)	CDC-H9	NCQA	X	X	
Chronic Care	Controlling High Blood Pressure	CBP	NCQA	X	X	
Chronic Care	Asthma Medication Ratio	AMR	NCQA			Measure change recommended instead of diabetes eye exam to align with MCAS
Maternity Care	Prenatal and Postpartum Care (Postpartum Care)	PPC-Pst	NCQA	X	X	
Maternity Care	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC-Pre	NCQA	X		
Maternity Care	Prenatal depression	PND-E	NCQA	X		

	screening and follow-up					
Maternity Care	Postpartum depression screening and follow-up	PDS-E	NCQA	X		
Patient Experience of Access and Care (reporting only)	CG-CAHPS: Getting Needed Care	CG-CAHPS	NCQA			FQHC able to substitute w/ alternate tool if CG-CAHPS is not available
Patient Experience of Access and Care (reporting only)	CG-CAHPS: Getting Care Quickly		NCQA			FQHC able to substitute w/ alternate tool if CG-CAHPS is not available
Note: Patient Experience of Access and Care measures will be outside of risk						

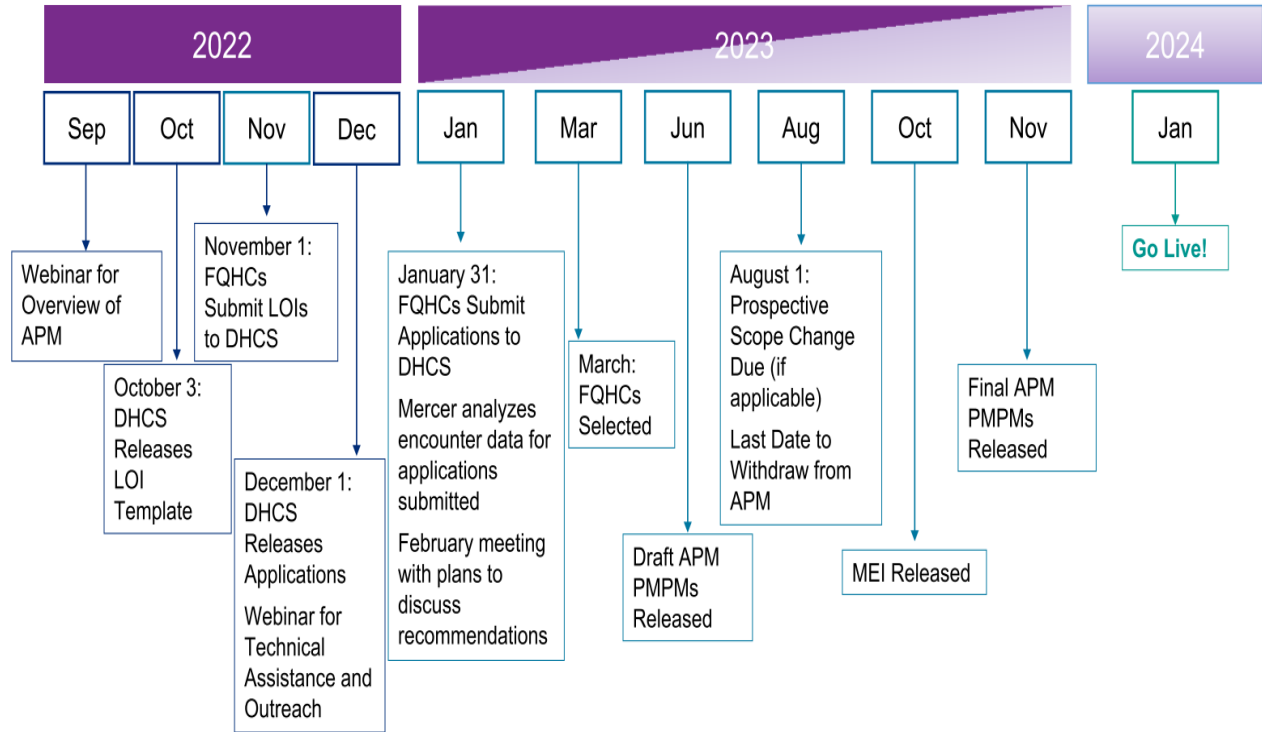
2023 MCAS: <https://www.dhcs.ca.gov/Documents/MCQMD/MY2022-RY2023-MCAS.pdf>

## Collaborative Planning Process

- DHCS meets bi-weekly with CAPH, CPCA, and LHPC to continue developing and working through the APM design.
- Wider stakeholder workgroup meetings are held regularly to solicit feedback from a broader base.
  - The most recent meeting (Formal Meeting #9) took place on August 26.
  - Narrower sub-workgroups are scheduled on an ad-hoc basis.
- DHCS will launch wider stakeholder education/technical assistance in the Fall and Winter 2022 and will coordinate efforts with all stakeholders.

# Timeline

## Draft APM PMPM Timeline – Subject to Change



## Current Status and Next Steps

- Reviewing feedback from select stakeholders and various sub-workgroups to finalize open decisions.
- Publish a Program Guide and continue to build on it over the course of the next year.
- Solicit Letters of Interest to gauge FQHC interest in participating in the APM.
- Finalize and publish a formal application and selection process for FQHCs to apply and be selected for the APM.

# Background

## Federal Requirements

Federal law allows Medicaid to pay FQHCs using an APM as long as it does the following:

- Results in payment to the center or clinic of an amount which is at least equal to the amounts otherwise required to be paid to the center or clinic” under PPS
- Is voluntarily agreed to by the state and the individual FQHC.

*Note: A FQHC attestation of receipt of PPS is not sufficient, the FQHC must be able to document receipt of at least PPS*

## Excluded Populations

FQHC services to the following populations are excluded from APM PMPM and will continue to be paid as they are currently paid today.

- Any population not in managed care including Medi-Cal FFS
- Dual Eligible (full and partial duals)
  - Duals (MCO Medi-Cal/Medicare Advantage)
  - Duals (MCO Medi-Cal/Medicare FFS)
  - Duals (FFS Medi-Cal/Medicare Advantage)
  - Duals (FFS Medi-Cal/Medicare FFS)

## Services Included/Excluded from the APM

The APM includes all services included in the clinic’s PPS rate and covered under the managed care contract. Examples of included services are:

- Primary Care
- Non-Specialty Mental Health Services
- Specialty Care in PPS (cardio, ophthalmology, dermatology) – For FQHCs that have included specialty services in their PPS rate, those services would also be part of the APM
- Podiatry
- Chiropractic to the extent it is in the MCO contract
- Acupuncture
- Vaccine/Select supplies to the extent included in the MCO contract and PPS

Examples of services in the managed care contract that are excluded from the APM:

- ECM and associated CHWs tied to ECM delivery
- Community Supports (formerly In Lieu of Services)

Examples of services that may be in the clinic's PPS rate that are excluded from the APM:

- Specialty Mental Health
- Dental

# FQHC Participation

## Application Timeline

- Letter of Interest
  - LOI format will be released October 3.
  - The LOI will be due November 1.
- Application
  - Application format will be released December 1.
  - The Applications will be due January 1.

## Two-Step Application Process

- DHCS will release a voluntary LOI in October 2022 that will be helpful with the State's planning process.
- FQHCs will apply to DHCS to participate in the APM. DHCS will release the mandatory applications late in 2022 with a due date in early 2023. This will be repeated every year thereafter, year-over-year for new FQHCs applying for participation in the APM.
- FQHCs will request plan endorsements from all health plans in the FQHC's geographic area. The health plan endorsement may be submitted as early as the FQHC's LOI submittal but must be submitted no later than the submittal of the FQHC's application,
- DHCS will vet applications based on criteria outlined on the next slide and minimum readiness standards.
- DHCS will review applications to ensure the FQHC as an organization appears committed to transformation.

## Application Criteria

- Data Capabilities
- Capacity for Care Transformations
  - Capacity for Care Transformation
  - APM Strategy
  - Experience with Strategic Practice Transformation
  - Organizational Commitment to Transforming Primary Care Practices
  - Staffing Capacity to Enact Transformation
- Quality Improvement Infrastructure
- Collaboration with MCOs
- Financial and Operational Considerations
- Willingness to Participate in FQHC Quality Collaborative

## **FQHC APM Participation**

While the APM is voluntary, all sites under each PPS in a participating FQHC must participate.

If a PPS rate/site is selected and there are intermittent and mobile sites affiliated with that PPS/site, then those intermittent/mobile locations must be included in the APM.

## **FQHC Ability to Leave APM**

- Prior to the first year of participation, selected FQHCs may withdraw from the APM by providing their contracted plans and DHCS notice no later than August 1 of the year prior to the start date of the contract year.
- FQHCs may exit the APM after providing notice not less than 180 days prior to the start of the date of the contract year if the FQHC is already participating in the APM.
  - FQHCs cannot drop out of the process mid-year.



# APM PMPM Rate Setting Model

## The APM PMPM

- The APM PMPM will be health plan and FQHC specific and cover all Medi-Cal managed care plan covered services not specifically excluded. The APM PMPM will be prospectively set by the State's actuary.
  - The plan will need to ensure that FQHCs receive at least the APM PMPM for each member assigned to the FQHC, even if there are multiple payments
  - The FQHC will need to provide documentation that it has received the APM PMPM for each member assigned to the FQHC from each MC
  - The APM PMPM be based on the FQHC's current PPS at health plan historic utilization
  - The APM PMPM will include payment for MCO members who are both assigned and unassigned to the FQHC
- The FQHC PPS-specific, plan-specific PMPM payment methodology ensures participating FQHCs receive at least what they would have under PPS, as prescribed under federal law, if their utilization does not increase. To meet this requirement, the APM PMPM will be developed to include the health plan membership's historic utilization at the FQHC, including encounters with both unassigned and assigned Medi-Cal members.

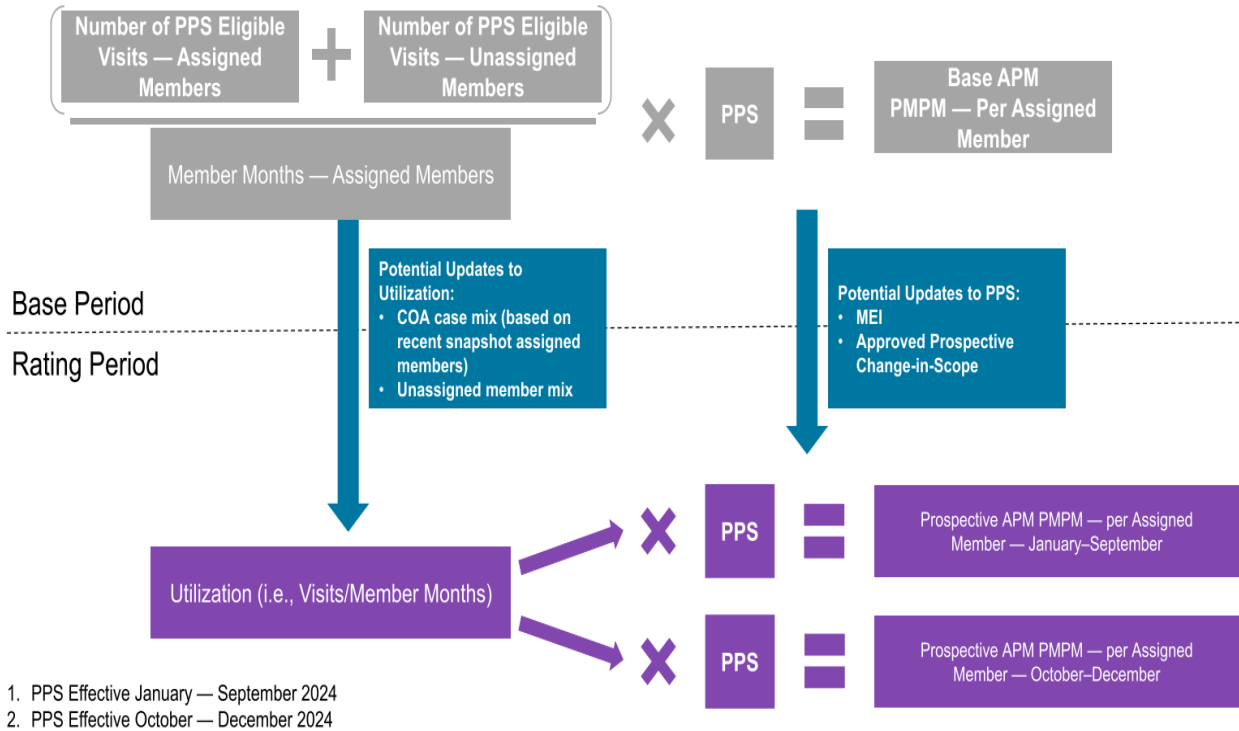
## PMPM Rate Setting Model

The APM sets a PMPM reimbursement associated with historical utilization at the current PPS rate and, if the FQHC delivers fewer traditional encounters while it maintains access and achieves quality targets, the FQHC retains the full APM PMPM.

For 2024, the APM PMPM will convert the FQHC's PPS encounter rate into an equivalent APM PMPM rate for each FQHC using historic managed care beneficiary utilization for each MCO from the selected base period. DHCS will use the actual MCO assignment for that FQHC in the selected base period for the denominator.

APM PMPM = (Base Period Encounters, including walk-in utilization, by MCO members to the FQHC x 2023 PPS for the FQHC) / MCO members assigned (member months) to the FQHC in the Base Period

# APM PMPM Calculations



## Calculating the APM PMPM

The APM PMPM based on Assigned Members (not patients)

- Assigned Members only in denominator
- All MCO Members utilization, including unassigned member walk-ins, in the numerator. Unassigned Member Walk-ins are defined under the APM as MCO members who visit the FQHC but who are not assigned to the FQHC by the MCO.

One PMPM per Site

- There will be one APM PMPM per PPS rate. To prevent the need for reconciliation, FQHC payment reconciliation structures will need to remain consistent between PPS and APM PMPM.

## One Rate for All Aid Categories

- Each FQHC will have one APM PMPM per plan per PPS to reflect the utilization under that health plan. All intermittent sites under that PPS rate will be included in the APM.
- Each participating FQHC site with its own PPS rate would receive a different APM PMPM from each health plan it contracts with since the encounters by health plan members and the number of health plan members assigned (two of the three elements of the formula) vary by FQHC. If an FQHC is contracted with a COHS and has 10 sites with 10 different PPS rates, that FQHC will have 10 different APM PMPM rates. If an FQHC has contracts with both plans in a two-plan county and has four sites with four different PPS rates, that FQHC would have eight different APM PMPM rates.

## Annual Updates Including Case Mix Adjustment

- At the conclusion of each calendar year, DHCS will update the APM PMPM for participating FQHCs based on any changes in the following:
  - Beneficiary COA experience to account for projected population changes
  - Upcoming PPS (MEI)
  - Any approved changes in scope
- The State will monitor the number of MCO members who have walked into the FQHC without assignment (walk-in) relative to the number of MCO members assigned to the clinic to determine if an adjustment is necessary for utilization beyond the control of the FQHC.

## Annual Updates

APM PMPM = ([Base Period Encounters, including walk-in utilization, by MCO members to the FQHC updated by recent COA mix] x upcoming PPS for the FQHC) / Base Period MCO members assigned (member months) to the FQHC

## Unassigned Member Walk-Ins

- Currently health plans may deny claims/encounters from an FQHC for walk-in claims where the member was not assigned to that FQHC
- Under the APM, health plans will need to ensure that all encounters for covered services from a participating FQHC are accepted.
- Health plan capitated rates will build in the historic claims and the PPS/wrap payment paid FFS to each participating FQHC for each health plan's members (not just those members assigned to the FQHC)
- Unassigned health plan member walk-ins will be included in the numerator of the calculation for each FQHC's MCO specific APM PMPM
- The State will monitor the number of MCO members who have walked into the FQHC without assignment (walk-in) relative to the number of MCO members assigned to the clinic to determine if an adjustment is necessary for utilization beyond the control of the FQHC
- Each FQHC will receive at least their PPS x utilization.
- The health plan will be fully funded to pay each FQHC an APM PMPM calculated as all assigned and unassigned members' costs (total PPS + that health plan's payments to the FQHC for the base period) divided by the member months assigned to that FQHC.
  - The APM PMPM would then include all historic managed care and FFS PPS/wrap payment for each FQHC even if the MCO had historically denied walk-in claims to FQHCs where the member was not assigned.
  - The payments to FQHCs would not be limited to those members assigned to that FQHCs.
  - The total costs will include assigned members and those members who are walk-ins.

## Change in Scope Under the APM

The prospective change in scope process is voluntary and is anticipated to be an annual process with an August 1 deadline (i.e., not one-time only)

The definition of triggering events is not changing for change in scope requests.

All scope changes must follow the current retrospective process. FQHCs will file a final change in scope under the current traditional process consistent with existing timelines.

- A change in scope of service is defined as a change in the type, intensity, duration, and/or amount of services. DHCS will follow existing, established processes to update the encounter rate, and subsequently the PMPM APM rate, if the FQHC can show they will experience or have experienced a valid change in scope of service.
- For changes in scope that will occur during the calendar year, the FQHC will develop a budget with approval from DHCS, upon which the interim PPS will be set for the upcoming calendar year.
- Once the FQHC has 12 months of cost data from a change in scope, the FQHC must submit the required documentation of the costs to the State, which will set a final PPS rate using the standard PPS methodology.
- DHCS will reconcile any APM PMPM payments resulting from a change in scope from past calendar years once the final PPS rate is set.
- Future APM PMPMs will be set using the final PPS rate and historic utilization adjusted for any increase or decrease in services in the scope change.

## Change in Scope

Defined at Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 4, Section 14132.100(e) and evaluated in accordance with Medicare reasonable cost principles in 42 CFR Part 413 including:

- The addition of a new FQHC service or a deletion of an FQHC service in the PPS rate
- A change in service due to changes in rules
- A change in service resulting from relocating or remodeling an FQHC
- A change in applicable technology and medical practice
- An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, homeless, elderly, migrant, or other special populations
- Changes in any of the services outlined or in the provider mix of an FQHC or RHC, or one of its sites
- Changes in operating costs attributable to capital expenditures associated with a scope change including new or expanded service/facilities, regulatory compliance, or changes in technology or medical practices
- Indirect medical education adjustments, and direct graduate medical education costs
- Changes in the scope of a project approved by the federal HRSA
- A change in the cost of a service is not considered, in and of itself, a change in the scope of services unless:
  - Attributable to an increase or decrease in the scope of services
  - Allowable under Medicare reasonable cost principles in 42 CFR 413
  - A change in the type, intensity, duration, or amount of services, or any combination thereof

- The net change in the FQHC's rate equals or exceeds 1.75 percent for the affected FQHC site or the average per-visit rate of all sites if calculated for multiple sites. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

# Payments to FQHCs

## Pay-for-Performance

P4P payments will be separate from the APM PMPM that MCOs must ensure is paid to each participating FQHC.

- Paid by the MCO to the FQHC, subject to the agreement(s) negotiated between the MCO and the FQHC.
- Must meet the DHCS May 10, 2019 and June 12, 2019, policy criteria:
  - Clear objective criteria —Meet audit and claiming conditions
  - Specific metrics —Written agreements prior to start
  - Not less than other provider incentives —Evaluated to be effective
  - Policies and procedures available to DHCS, upon request
  - Does not pertain to grants to add capacity or infrastructure
  - Meet all state and federal requirements

FQHCs are guaranteed the current PPS per eligible visit, which will act as a one-sided stop-loss protection for all FQHCs participating in the APM.

Plans will ensure that FQHCs receive at least the FQHC APM PMPM for each assigned member, even if there are multiple payments.

## Reconciliation

- DHCS will review and annually reconcile the total payments made to each FQHC that participates in the APM PMPM to ensure the APM PMPM payment made by the MCO is at least equal to the PPS rate in effect for that calendar year, on a per managed care encounter basis, for that FQHC.
- If the payments are less than the total amount that would have been paid under the PPS rate methodology for that FQHC, DHCS will pay the FQHC the difference between the amount paid and the amount the FQHC would have been due under the PPS rate methodology for the total number of encounters provided.
  - Payments related to yearly reconciliations will be made in accordance with the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A.
- DHCS will require FQHCs to submit records of all encounter claims to the appropriate managed care health plans no later than 45 days after the conclusion of the calendar year to ensure sufficient time to complete the reconciliation.

## **Member Assignment Scenarios Under the APM**

- If a health plan member visits a participating FQHC site to which the member is not assigned, that FQHC does not receive a separate payment; those funds have been incorporated into the FQHC's APM PMPM.
- The exception is visits to FQHCs that are not contracted with the health plan; in that case, the plan pays the non-contracted FQHC participating in the APM the PPS rate.
- If an FQHC performs a traditional PPS-eligible encounter with Medi-Cal enrollees from non-contracted plans, they will bill the non-contracted plan their FFS PPS rate.
- Health plans will need access to the PPS rates for non-contracted FQHC sites participating in the APM so that the plans can pay the correct PPS rate if/when those FQHCs see a health plan member.



# MCO Payments and Responsibilities

## Medi-Cal Requirements

- Medi-Cal contracted managed care plans shall reimburse FQHCs at least the DHCS set APM PMPM rate, even if using multiple payments, for each MCO assigned beneficiary on a monthly basis.
- For participating FQHCs that furnish services under the managed care contract to beneficiaries enrolled in managed care, the State will verify annually that the payments are made consistent with the APM PMPM and no increases in utilization were experienced by the FQHC

## Contracting

- Suggested contract language will be established for all plans and FQHCs to implement the APM.
- Suggested contract language between the State and plan to implement the APM would be shared with participating FQHCs.

While DHCS will suggest contract language for the State/Medi-Cal managed care plan level, DHCS will also issue guidance to plans via APL which will include suggested practice for plan efforts to modify their contracts with participating FQHCs. DHCS will require plans to ensure that FQHCs receive the APM PMPM amount in a manner than can be documented to the State.

## Health Plan Encounter Data Processing

- Edits for Non-assigned Members and Alternative Touches
- The health plan needs to be able to accept encounter data for all State plan approved services and alternative touches for any MCO member who visits an APM participating FQHC.

## Payments to Health Plan

- The State will pay health plans a capitation rate including consideration for the full APM PMPMs based on PPS-equivalent amounts for all health plan members seeking care at FQHCs participating in the APM.
- The health plan capitated payment will be Aid Category specific
- The health plan is responsible for ensuring that the FQHC participating in the APM receives at least the APM PMPM calculated for each FQHC by the State and its actuary, even if there are multiple payments.
- Only health plan members and covered services in managed care will be included in the APM PMPM to comply with actuarial soundness and Medicaid claiming regulations.

## Health Plan Risk Corridor

- The health plans will have a risk corridor on total FQHC payments for both upside and downside risk.

## LOI Release Information

- Due to some edits to the LOI, we will not be able to post the LOI to our FQHC APM website on October 3rd.
- We will instead be distributing through email communications through internal contacts as well as with assistance from the Associations.
- DHCS will be collecting contact information for all interested FQHCs through our mailbox: <mailto:FQHCAPM@dhcs.ca.gov>

## Acronyms

APL	All Plan Letter
APM	Alternative Payment Model
CAPH	California Association of Public Hospitals
CHW	Community health worker
CMS	Centers for Medicare & Medicaid Services
COHS	County Organized Health Systems
CPCA	California Primary Care Association
DHCS	State of California Department of Health Care Services
ECM	Enhanced care management
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
HRSA	Health Resources and Services Administration
LHPC	Local Health Plans of California
LOI	Letter of interest
LTSS	Long-Term Service and Supports
MCO	Managed care organization
MCP	Managed care plan
MEI	Medicare Economic Index
P4P	Pay for performance
PMPM	Per member per month
PPS	Prospective payment system
RHC	Rural health clinic
SDOH	Social determinants of health
SFY	State fiscal year
SPA	State Plan Amendment