Federally Qualified Health Centers (FQHC) Alternative Payment Methodology (APM) Webinar Frequently Asked Questions (FAQ)

Q: Can you explain how the 70% baseline number is calculated? Is that 70% of 2022 visits?
A: It will be 70% of the baseline Prospective Payment System (PPS) eligible visits from the APM (Per-Member Per-Month) PMPM Calculation. The baseline year has not been decided.

Q: I just want to confirm that this new program is optional and that we can still maintain our PPS reimbursement?
A: This APM is completely optional for the FQHCs.

Q: Had heard through the grapevine that FQHC-Lookalikes may be ineligible for APM. Is this true and if yes, what is the rationale for excluding Look-Alikes (LALs)?
A: FQHC Look-A-Likes are eligible to participate subject to meeting the definition of "FQHC" in Welfare and Institutions Code (WIC) 14138.1(i).

Q: Could you explain that wedge concept once more? Or is there a slide on it to help explain it?
A: Yes, the wedge concept is addressed on an upcoming slide. In short, it is the difference between the FQHC's revenue received under the APM versus revenue under the PPS methodology for current PPS-eligible managed care visits by managed care enrollees.

Q: Is there a modeling worksheet to allow us to plug in clinics specific data to estimate revenue changes and quality incentives?
A: No.

Q: Are the proposed measures aligned with the measures in the Equity and Practice Transformation Payments initiative or designed to be different?
A: The measures are not the same because the Equity and Practice Transformation Payments are initially infrastructure and process measures. DHCS does intend to align the metrics over time as the Equity and Practice Transformation Payment program transitions to a more traditional Value-Based Payment (VBP) quality improvement program.

Q: Could you explain how utilization will be calculated in markets with Request for Proposal (RFP) plan exits (a) in general and (b) for clinics that currently have no relationship with the awarded plan(s) and there is no current utilization?
A: (a) Mercer actuaries will be analyzing utilization to ensure that the PPS visits for MCO members and member month assignments under the APM represent the best estimates possible. Like other FQHCs under the APM, FQHCs participating in the APM in these markets will be eligible to receive PPS if the APM is lower than their actual experience. (b) Clinics with no relationship with the awarded plans will be able to receive the PPS rate if there is no APM calculated.

Q: Are duals excluded? I don't see any specific older adult quality measures.
A: Duals are excluded from the APM.

Q: Are FQHCs submitting encounter data with application or is encounter data Mercer is analyzing coming from health plans?
A: Data will be Managed Care Plan derived.

Q: Clinics may feel a lot of risk at being locked into the APM three months before the PMPMs are finalized. Will there be an assurance PMPMs will not drop between June draft and November finalization?
A: The APM PMPM will only change if the FQHC has an approved Change in Scope or for the Medicare Economic Index (MEI) adjustment.

Q: Is this meant to replace Quality Incentive Pool (QIP), or can we run both programs parallel? Thanks!
A: No, this will not replace QIP.

Q: Timelines states that selection of FQHC is in March 2023. Does it mean not all applicants will qualify for APM?
A: Correct, there will be a selection process.

Q: How many FQHCs will be selected?
A: That is unknown at this time.

Q: Can an FQHC be on PPS and APM at the same time?
A: All FQHCs will continue to receive PPS for non-managed care and dual eligible populations. If an FQHC selects to participate in the APM, then, all sites subject to the particular PPS rate under the APM must participate in the APM for their managed care members. If an FQHC does not participate in the APM, then the FQHC will only be under the PPS methodology.

Q: How final would the draft APM PMPM calculation be in June 2023?
A: The APM PMPM will only change if the FQHC has an approved Change in Scope or for the MEI adjustment.

Q: Is the Letter of Intent (LOI) posted on California Primary Care Association (CPCA) website not the correct format? Has due date been pushed back?
A: The LOI has had some minor updates which will go out October 3rd and is due November 1st.

Q: Will DHCS provide the "plan endorsement" template?
A: Yes, it will be provided.

Q: If FQHC's contract is with an Independent Physician Associations (IPA), does the IPA complete the plan endorsement form?
A: The entity that the clinic submits data to for that health plan should complete the form for each health plan. There should be one form for each health plan. Delegates should complete all the questions that are applicable to the delegate. Once the delegate notes the questions they have completed, it should be forwarded to the health plan to complete the remaining questions and to sign off on the form.

Q: What will happen if we're going to have a new plan in 2024 due to recent changes in Managed Care Organization (MCO) awards?
A: Mercer actuaries will be analyzing utilization to ensure that the PPS visits for MCO members and member month assignments under the APM represent the best estimates possible. Like other FQHCs under the APM, FQHCs participating in the APM in these markets will be eligible to receive PPS if the APM is lower than their actual experience. Clinics with no relationship with the awarded plans will be able to receive the PPS rate if there is no APM calculated.

Q: Has the Health Plan Assessment form/template been updated?
A: No.

Q: Some plans are stating that they will provide letter of support only for the final application and not for the LOI phase. The LOI info to date has stated that that is acceptable, but looking for assurance that this will not negatively affect the application?
A: The Health Plan (HP) Letter of Support will be accepted with the LOI but is not required at that time. The Application will not be accepted without a HP Letter of Support being received by DHCS.

Q: How are the monthly PMPM payments to be disbursed to FQHCs? By DHCS or health plans? What is the timeline for payment disbursement, i.e., within 10 business days after the end of the month for the prior month?
A: Health plans will disburse the APM PMPM under normal contract requirements as long as the FQHC receives at least the APM PMPM even if it is through multiple payments.

Q: Are lookalikes under an interim PPS rate eligible for this program?
A: Yes, any FQHC or look-alike under an interim PPS rate is eligible for this program.

Q: "At any given time, all sites subject to a particular PPS rate must be either under the PPS methodology or APM methodology, not both." How does that work for sites that serve both duals (excluded from APM) and other populations in APM?
A: Only the eligible populations would be included in the APM PMPM calculations. Other populations would still receive their normal PPS reimbursement.

Q: Can we go back to the last slide? Was the message there that all our sites/PPS rates must participate? Or can we enroll one site/PPS and leave the others on PPS?
A: All sites with the same PPS must participate, including intermittent sites. If the sites have different PPS rates, then an FQHC could apply for a specific site.

Q: Please address at some point this afternoon how the recently announced procurement decisions would impact APM. In Los Angeles County where we may have a major plan transition, how will utilization and assigned member data be obtained for rate setting? How will DHCS ensure health plan readiness to operationalize APM - what are the criteria for health plan readiness? How will DHCS require a new Managed Care Plan (MCP) to engage with APM participating FQHCs in 2023, prior to the new contract taking effect? What role would an outgoing plan play in 2023?
A: DHCS will utilize their readiness review process for new MCOs in new markets. Mercer actuaries will be analyzing utilization to ensure that the PPS visits for MCO members and member month assignments under the APM represent the best estimates possible. Like other FQHCs under the APM, FQHCs participating in the APM in these markets will be eligible to receive PPS if the APM is lower than their actual experience. Clinics with no relationship with the awarded plans will be able to receive the PPS rate if there is no APM calculated.

Q: What does "historic utilization" mean? Which 12 months will be chosen?
A: The baseline time period has not been finalized but utilization will be used from that period.

Q: Where do we find the "baselines" on what is viewed/defined as 'not struggling'?
A: As soon as the FQHC submits either an LOI or an application, the State's actuary will examine the FQHC's encounter data. DHCS will communicate directly with each FQHC regarding and data quality findings.

Q: For two-plan model counties, will there be one APM PMPM for a site, or one APM PMPM for each plan?
A: The APM PMPM will be unique to each MCP/PPS rate. So, there would be a different APM PMPM from each MCP in a Two-Plan County.

Q: Is there a planned second round of applications for clinics that are not ready or not selected at this time?
A: There will be an annual application process for any FQHC wishing to join the APM. Accepted FQHCs will not need to apply each year. We have not set a deadline for year two applications but will have that information in the future with plenty of time. We are imagining a similar timeline for each future Calendar Year (CY) as we have with CY 24.

Q: Can you explain more about the PMPM intending to cover patients that come through that were not assigned?
A: The APM PMPM will be built to cover MCP members who are seen by the participating FQHC but are not assigned from the contracted MCP as part of the baseline utilization.

Q: Do we receive a PMPM on lives assigned to a clinic even if they haven't been seen by the clinic and the clinic can demonstrate they have made multiple unsuccessful attempts in getting the member in the clinic for care?
A: Yes, the PMPM will be paid based on the assigned lives roster as well as the historic number of MCP members seen who were not assigned to the FQHC. The PMPM is meant to provide the funding level associated with the baseline period utilization PPS. Any unseen members should be accounted for in the utilization projections.

Q: Sorry - one PMPM per PPS per Site per plan right, in a 2-plan county?
A: One PMPM Per PPS Per Plan.

Q: Sorry, why are there separate PMPMs by plan? Missed the driver for that.
A: Due to the varying volume of assigned members, unassigned member volume, category of aid population mix, and utilization differences, the FQHC will receive an APM PMPM for each plan reflecting these unique differences. The PMPM will be paid on assigned members only but will include the utilization for MCP members who were seen by the FQHC but not assigned.

Q: If PPM is the same for all Categories of Aid, isn't DHCS setting up a situation that favors cherry picking of serving Temporary Assistance to Needy Families (TANF) and no other more complex patients?
A: The PMPM will be based on utilization based on Category of Aid (COA) mix changes, if an FQHC shifted their focus to lower cost COAs, the PMPM (over time) would update to capture that, plus there would be the risk that ignoring certain populations could hurt quality performance.

Q: How will other managed care payments be included/excluded in APM PMPM?
A: The APM PMPM will only include payments for managed care services under the APM PMPM. Excluded managed care services such as the Enhanced Care Management (ECM)/dental, as well as Pay-for-Performance (P4P) payments meeting State requirements in the May 10, 2019, and June 12, 2019, criteria that have been historically documented are outside of the APM PMPM.

Q: Is there an annual application for APM?

A: There will be an annual application process for any FQHC wishing to join the APM. Accepted FQHCs will not need to apply each year.

Q: Will the Prospective Change in Scope (CIS) move all clinics to the same rate instead of site based?

A: No, the CIS methodology for setting the PPS will not change. The prospective CIS will only allow the FQHC to receive some cash anticipated through the CIS process through the APM. The definitions and policies relating to final CIS approval are not changing.

Q: Will FQHCs be allowed to apply to join/add sites at any given time, or will there be a specific period to apply for APM participation?

A: There are specific dates with which applications will be allowed and to leave the program after acceptance. There will be an annual application process for any FQHC wishing to join the APM. Accepted FQHCs will not need to apply each year. The FQHCs in the APM may only leave once a year after the end of the contract year if they have given the 180-day notice required (July of each year).

Q: Are there any changes envisioned for DHCS A&I associated with the move to APM? Are you hiring more people? Still organized the same.

A: A&I will still be managing their current duties relating to FQHCs.

Q: What would be the role of the IPAs, if any, under APM models? Also, for FQHCs with shared-risk arrangements with their IPAs, are there any changes or considerations to be made? Or will those financial incentives continue to be excluded under the APM?

A: FQHCs and MCPs must be able to document that the FQHC received at least the APM from each MCP even if there are more than one payment. Only P4P payments meeting State requirements in the May 10, 2019, and June 12, 2019, criteria that have been historically documented are outside of the APM PMPM.

Q: How does payment work when some health plans assign to providers and not a specific FQHC site?

A: Under the APM, the health plan will need to assign members to a specific FQHC site/PPS rate. If the health plan assigns the members to a provider, then that provider will need to be designated under a specific FQHC PPS rate.

Q: How realistic is it that all claims/encounter filed in 45 days?
A: Department of Health Care Services (DHCS) expects that the vast majority of all claims will be files within 45 days.

Q: Can we assume that a participating FQHC on select sites only follow through to complete both the APM reconciliations for participating sites and the traditional PPS reconciliation for non-participating sites?
A: DHCS will be reconciling at the FQHC level for all payments to ensure at least the full PPS was paid.

Q: So, a plan will pay the PPS rate in full in these non-contracted scenarios, which they never did before?
A: Yes

Q: What happens if the plan experiences declining enrollment, and it assigns fewer lives to the FQHC?
A: The APM PMPM is paid based on assigned lives. If the number of assigned lives decreases, then there will be few PMPMs paid to the FQHC.

Q: Was it mentioned in the beginning that FQHC can be dropped if metrics are not met continuously?
A: Yes, there is an option for the FQHC to be dropped from the APM based on quality/access metrics.

Q: Rodney, please explain again how the APM PMPM is updated on an ongoing basis
A: The middle blue boxes on slide #32 provide a good description for the elements that will lead to prospective updates in the PMPM. Happy to answer detailed follow-up questions

Q: It would be helpful for MCPs to have a comprehensive list of DHCS expectations of the plan as part of the FQHC APM.
A: DHCS will be releasing more information regarding MCP expectations.

Q: Will APM PMPM rates be made publicly available? Published by DHCS?
A: PPS rates will be made publicly available for all participating FQHCs under the APM PMPM so that MCPs will know what to pay FQHCs where there is no contact between the FQHC and MCP. MCPs and FQHCs all participating in the APM will receive the APM PMPM rates applicable to that MCP/FQHC combination.

Q: Will health plan requirements address payment if member assigned to a fully capitated non-FQHC primary care provider receives services at FQHC. Are these individuals considered included in the PMPM?
A. These individuals would be considered an unassigned MCP member accessing services under the APM and would be part of the APM PMPM paid to the FQHC

Q: Is it correct to assume a FQHC that has different PPS rates at different sites will have different PMPM for each site?
A: Each PPS rate will have a specific APM PMPM for each MCP.

Q: Sorry, I don't have access to the slides in advance. Basically, I want to understand how often the APM PMPM will be rebased? What will trigger the rebase if not done on a regular basis? Thank you!
A: No worries, DHCS will be sharing the slide deck after the meeting. PMPMs will be inflated using MEI on an annual basis, and we will analyze case mix and adjust for any approved Changes in Scope (prospective or regular). The APM PMPM will not be rebased and will continue to utilize historic utilization so that FQHCs can take advantage of the Payment Transformation/Wedge which is a comparison of the APM PMPM based on historic utilization adjusted for MEI, case mix, and CIS compared to the PPS at current utilization.

Q: When will the quality benchmarks (what 33rd or 50th percentiles are for all the metrics) be available to prospective participants? Even ones for prior years would be very useful so we could get some idea of how much progress we must make.
A: DHCS is exploring options for sharing benchmarks. FQHCs may want to request this data from their health plans until then.

Q: Couldn't each PPS rate have more than one APM PMPM, based on the number of contracted MCOs?
A: That is correct, each PPS rate per MCP will have an APM PMPM.

Q: One slide said that dental is not included in the APM PMPM. One of our sites has dental and medical. How would this work, PMPM cover medical and bill PPS rate for dental?
A: Correct, only the Medi-Cal covered services would be covered in the APM. Dental is statutorily exempted from the APM PMPM and will be paid using PPS in all instances.

Q: Will there be an escalation process if the plan and provider disagree on elements of the reconciliation?
A: Reconciliation will be performed by DHCS. Each MCP is expected to have a dispute resolution process to address data disputes. DHCS will give guidance relating to data dispute resolution.

Q: Are there costs that will be allowable under the APM change in scope that are not currently allowable under the typical CIS?
A: No, the CIS statute and allowable changes are not being changed.

Q: Is calendar 2024, the period for the prospective CIS?
A: Yes, an anticipated CIS for any anticipated change up through 12/31/2024 for a participating FQHC could be applied prospectively.

Q: Why would change in costs of service will not be changing in scope criteria anymore under APM. How would FQHCs address in the future costs which sometimes beyond their control (i.e., legislative salary adjustment, etc.)
A: Change in Scope criteria are not changing under the APM.

Q: What are the minimum months a member should be with their FQHC to be included for the PMPM rate for that year?
A: There is no minimum month that a member would be with the FQHC to be included in the APM PMPM for that year. All historic utilization for assigned and unassigned MCP members seen by the FQHC will be included in the APM PMPM.

Q: Because we need to ensure that the APM does not pay less than the PPS, and this functions as an actual stop-loss, it seems that traditional PPS recons would need to be performed annually per usual. Will these still be required to submitted, even for FQHCs in the APM?
A: Yes, there will still be a DHCS reconciliation for each FQHC.

Q: Following a prospective CIS, would the dual eligible be payable at the new rate, or is that only for the visits under the APM and the old rate would apply?
A: Only the APM PMPM is affected by the prospective CIS. All non-managed care and non-APM visits will be paid at the regular PPS. DHCS reconciliations will only be performed using the regular PPS.

Q: Is the wedge discussed based on only current existing billable encounters. Would alternative visits generated by non-billable providers to improve care be considered.
A: No, the wedge calculation will be based on statutorily billable PPS eligible visits.

Q: New FQHCs have a risk that the interim PPS will not be the final PPS.
A: Yes, this is a possibility. DHCS reconciliation will be based on the official final PPS calculated for that FQHC.