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
- Challenges so far
- 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 <u>at cost</u>

Currently in CA, there are 954 active FQHCs (346 active RHCs) 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, NP, PA, CNM, CP, CSW, DSMT, MNT services

Background on FQHCs

Medi-Cal FQHC Utilization Trends, 2008-2014

Year	# of Benes 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
Compound Annual Growth	**11.5%**	**13.2%**	**12.2%**	**-0.8%**

Source: DHCS Research and Analytic Studies Division

APM Pilot Overview

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

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

- Moving away from a per-visit payment, DHCS would calculate a PPS equivalent, clinic specific capitation payment PMPM

Instead of FQHCs receiving a 1) plan payment, 2) wraparound payment, and 3) reconciliation payment, they would receive one capitation payment equivalent to what they would have received under the previous payment system

Reconciliation would only occur under certain triggers (>105% expected utilization, <70% utilization for first year of pilot)

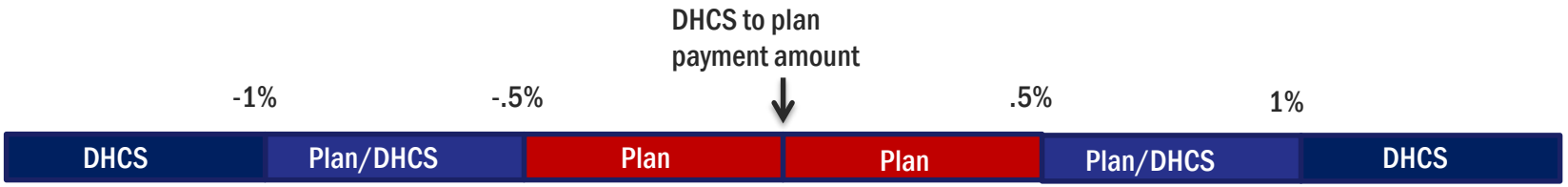
APM Pilot Overview
Why participate?

FQHCs

- Simplifies payment structure and receive full payment in a more timely manner
  - No longer have to bill for wraparound or reconcile and wait for reimbursement
- Flexibility to provide alternative services (not currently billable today)

Plans

- Less incentive for plans to participate
- As such, SB 147 included risk mitigation structures:
  - Plan payments would adjust based on any PPS changes (CSOSR, Annual MEI)
  - Capitation payments to plans are based on actual member assignment to clinics, so payment will be adjusted if a large number of members are assigned / removed from the clinic
  - A risk corridor is established on DHCS to plan "wrap-cap" payments (see below)



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.

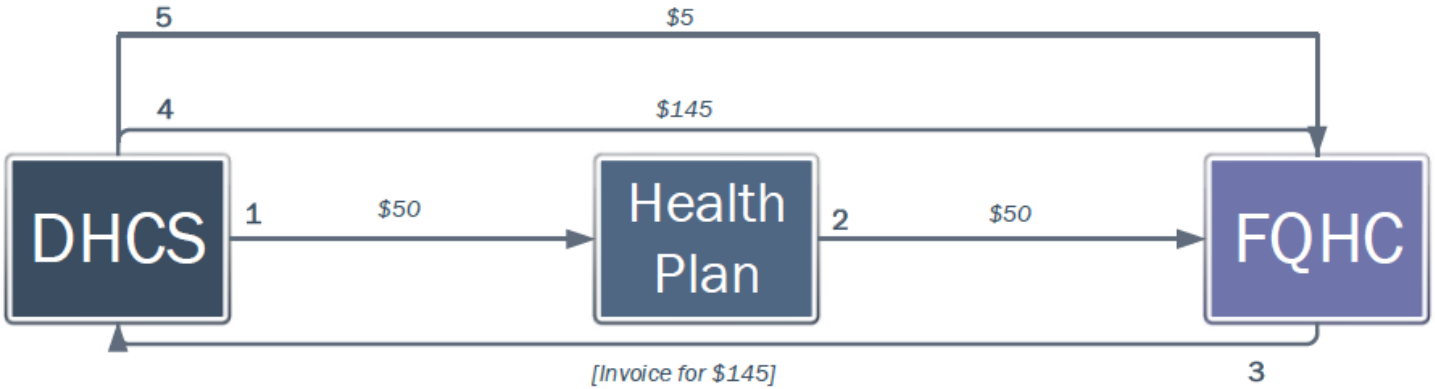
Shift the primary payor responsibility to the plan

Simplify the payment structure for the clinics which will help with cash flow

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.)

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

Payment Structure

FQHC APM Pilot Payment Flow

DHCS capitation / Plan payment
$50

PPS rate	"Wrap-cap"
$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

Challenges So Far

Getting SB 147 enacted (Legislature and Governor's support)

- Collectively working with clinics and plans on a structure that helped mitigate risk, while maintaining the key objectives of the pilot

Working through the requirements of the pilot and understanding the administrative needs/start-up challenges for clinics/plans (reporting, data, etc.)

Defining alternative encounters and working on the valuation for the purposes of the reconciliation and future rate development

Working the estimated CMS approval into the timeline (paper/SPA, rates)

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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