AMENDED IN SENATE APRIL 7, 2015

SENATE BILL No. 147

Introduced by Senator Hernandez

January 28, 2015

An act to add ~~Section 14132.103 to~~ *Article 4.1 (commencing with Section 14138.1) to Chapter 7 of Part 3 of Division 9 of* the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 147, as amended, Hernandez. Federally qualified health centers.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides that federally qualified health center (FQHC) services, as described, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC and specified health care professionals. Existing federal law authorizes a state plan to provide for payment in any fiscal year to an FQHC for specified services in an amount that is determined under an alternative payment methodology (APM) if it is agreed to by the state and the FQHC and results in a payment to the FQHC of an amount that is at least equal to the amount otherwise required to be paid to the FQHC.

This bill would require the department to authorize a 3-year APM pilot ~~project~~ *project, to commence no sooner than July 1, 2016,* for FQHCs ~~that would be implemented in any county and FQHC willing~~

~~to participate.~~ *that agree to participate. The bill would require the department to determine an APM supplemental capitation amount for each APM aid category to be paid by the department to each principle health plan that contains at least one participating FQHC in its provider network, as specified.* Under the APM pilot project, participating FQHCs would receive ~~capitated monthly payments for each Medi-Cal managed care enrollee assigned to the FQHC in place of the wrap-around, fee-for-service per-visit payments from the department.~~ *a per member per month wrap-cap payment for each of its APM enrollees, as specified. The bill would require each principal health plan to pay a participating FQHC that is in the plan provider network the wrap-cap amounts, as determined, for each APM enrollee of that FQHC.* The bill would require, except as specified, that an evaluation of the APM pilot project be ~~conducted~~ *completed* by an independent entity within 6 months ~~after the APM pilot project is completed,~~ *of the conclusion of the APM pilot project,* and ~~that~~ *would require* the independent entity *to* report the findings to the department and the Legislature.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 4.1 (commencing with Section 14138.1) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 4.1. Payment Reform Pilot Program for Federally Qualified Health Centers.

14138.1. For purposes of this article, the following definitions apply:

(a) "Alternative payment methodology" (APM) has the same meaning as specified in Section 1396a(bb)(6) of Title 42 of the United States Code.

(b) "APM aid category" means a Medi-Cal category of aid designated by the department. For all its APM enrollees in an APM aid category, a participating FQHC site shall receive compensation as described under the APM pilot project. The APM aid categories may include, but are not limited to, all of the following categories of aid:

(1) Adults.
(2) Children.
(3) Seniors and persons with disabilities.
(4) The adult expansion population eligible pursuant to Section 14005.60.

(c) "APM enrollee" means a member who is assigned by a principal health plan or secondary payer to a participating FQHC for primary care services and who is within one of the designated APM aid categories.

(d) "APM enrollee true-up" means the process by which payments are adjusted to reflect changes in the number of APM enrollees, by APM aid category, for participating FQHCs.

(e) "APM pilot project" means the pilot project authorized by this article.

(f) "APM scope of services" means the scope of services for a participating FQHC for which its per-visit rate was determined pursuant to Section 14132.100.

(g) "APM supplemental capitation" means an additional, APM aid category-specific, PMPM amount that is paid by the department to a principal health plan having one or more participating FQHCs in its provider network.

(h) "Base payment" means the amount that would have been paid, in the absence of the APM pilot project, by a principal health plan and any secondary payer, as applicable, to an FQHC for patient services in the APM scope of services with respect to APM enrollees of the FQHC pursuant to its contract, exclusive of any incentive payments.

(i) "FQHC" means any community or public "federally qualified health center," as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code and providing services as defined in Section 1396d(a)(2)(C) of Title 42 of the United States Code.

(j) "Member" means a Medi-Cal beneficiary who is enrolled with a principal health plan or secondary payer.

(k) "Participating FQHC" means a FQHC participating in the APM pilot project at one or more of the FQHC's sites.

(l) "PMPM" and "per member per month" both mean a monthly payment made for providing or arranging health care services for a member and may refer to a payment by the department to a principal health plan, or by a principal health plan to a secondary

payer, or by a principal health plan or secondary payer to an FQHC, or from and to other entities as specified in this article.

(m) "Principal health plan" means an organization or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.82 (commencing with Section 14087.98), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200), to provide or arrange for the care of Medi-Cal beneficiaries within a county in which the APM pilot project is implemented.

(n) "Secondary payer" means an organization or entity that subcontracts with a principal health plan to provide or arrange for the care of its members and contains one or more participating FQHCs in its provider network.

(o) "Traditional wrap-around payment" means the supplemental payments payable to an FQHC in the absence of the APM pilot project with respect to services provided to Medi-Cal managed care enrollees, which are made by the department pursuant to subdivision (e) of Section 14087.325 and subdivision (h) of Section 14132.100.

(p) "Wrap-cap" means a prospective PMPM amount that is determined by APM aid category for each participating FQHC site, and is paid monthly by a principal health plan or secondary payer to the participating FQHC with respect to its APM enrollees in each APM aid category in lieu of a traditional wraparound payment.

14138.10. The Legislature finds and declares all of the following :

(a) The federal Affordable Care Act has made and continues to make significant progress in driving health care delivery system reforms that emphasize health outcomes, efficiency, patient satisfaction and value.

(b) California has expanded Medi-Cal to cover more than 12 million residents, roughly one-third of the state's population. To meet the needs of the state's growing patient population, California must continue to explore new strategies to expand access to high quality and cost effective primary care services.

(c) With such a large portion of the state's population receiving health care services through Medi-Cal, it is imperative that patient-centered innovations drive Medi-Cal reforms.

(d) Health care today is more than a face to face visit with a provider, but rather a whole-person approach, often including a physician, a care team of other health care providers, technology inside and outside of a health center, and wellness activities including nutrition and exercise classes, all of which are designed to be more easily incorporated into a patient's daily life.

(e) Accessible health care in a manner that fits a patient's needs is important for improving patient satisfaction, building trust, and ultimately improving health outcomes.

(f) In an attempt to invest up-front in health care services that can prevent longer-term avoidable high cost services, the Affordable Care Act made a significant investment in FQHCs.

(g) FQHCs are essential community providers, providing high quality, cost-effective comprehensive primary care services to underserved communities.

(h) Today FQHCs face restrictions, however, because the current payment structure reimburses an FQHC only when there is a face-to-face visit with a provider. Current law prohibits payment for a primary care visit and mental health visit on the same day, a restriction that inhibits coordination and efficiency.

(i) A more practical approach financially incentivizes FQHCs to provide the right care at the right time. Restructuring the current visit based, fee-for-service model with a capitated equivalent affords FQHCs the assurance of payment and the flexibility to deliver care in the most appropriate patient-centered manner.

(j) A reformed payment methodology will enable FQHCs to take advantage of alternative touches. Alternative touches, such as same-day mental health services and phone and email consultations, are effective care delivery methods and contribute to a patient's overall health and well-being.

14138.11. It is the intent of the Legislature to test an alternative payment methodology for FQHCs, as permitted by federal law, and to design and implement the APM to do all of the following:

(a) Provide patient centered care delivery options to California's expansive Medi-Cal population.

(b) Promote cost efficiencies, and improve population health and patient satisfaction.

(c) Improve the capacity of FQHCs to deliver high quality care to a population growing in numbers and in complexity of needs.

(d) Transition away from a payment system that rewards volume with a flexible alternative that recognizes the value added when Medi-Cal beneficiaries are able to more easily access the care they need and when providers are able to deliver care in the most appropriate manner to patients.

(e) Track alternative touches at FQHCs in order to establish a data set from which alternative touches may be assigned a value that can be used in future rate setting.

(f) Implement the APM where the FQHC receives at least the same amount of funding it would receive under the current payment system, and in a manner that does not disrupt patient care or threaten FQHC viability.

14138.12. (a) The department shall authorize a three-year payment reform pilot project for FQHCs using an APM in accordance with this article. Implementation of the APM pilot project shall begin no sooner than July 1, 2016, subject to federal approval.

(b) The APM pilot project shall comply with federal APM requirements and the department shall file a state plan amendment as necessary for the implementation of this article.

(c) Nothing in this article shall be construed to limit or eliminate services provided by FQHCs as covered benefits in the Medi-Cal program.

14138.13. (a) To implement this article, the department shall notify every FQHC of the APM pilot project and shall invite any interested FQHC to notify the department that the FQHC agrees to participate with respect to one or more of the FQHC's sites. Consistent with federal law, the state plan amendment described in subdivision (b) of Section 14138.12 shall specify that the department and participating FQHCs agree to the APM.

(b) The APM shall be applied only with respect to a participating FQHC for services the FQHC provides to its APM enrollees that are within its APM scope of services.

(c) Payment to the participating FQHC shall continue to be governed by the provisions of Sections 14132.100 and 14087.325 for services provided with respect to both of the following categories of patients:

(1) A beneficiary who receives services from any FQHC to which the beneficiary is not assigned for primary care services under the APM pilot project by a principal health plan or secondary payer.

(2) A person who is not a Medi-Cal beneficiary within a designated APM aid category.

(d) (1) A participating FQHC, with respect to one or more sites of its choosing, may opt to discontinue its participation in the pilot project subject to a notice requirement of no less than 30 days and no greater than 45 days, as established by the department.

(2) A principal health plan may opt to discontinue its participation in the pilot project, subject to a notice requirement of no less than 30 days and no greater than 45 days, as established by the department, if subdivision (f) of Section 14138.14 is amended at any time while the pilot project is in effect. The department shall place a provision in a plan's contract giving the plan the ability to discontinue its participation in the APM pilot project pursuant to this paragraph.

14138.14. (a) A participating FQHC shall be compensated for the APM scope of services provided to its APM enrollees pursuant to this section.

(b) (1) A participating FQHC shall, in addition to its base payment, and any applicable incentive payment, receive a PMPM wrap-cap payment for each of its APM enrollees as described in subdivision (d). The department shall determine the wrap-cap amount specific to each participating FQHC, and for each APM aid category. For this purpose, the department shall, in consultation with each participating FQHC and health plan, use the best available data for a recent agreed-upon time period that reflects the audit and reconciliation payment adjustments for the participating FQHC, which may be composite data from different or multiple periods. The determinations shall, at a minimum, take into account the following factors:

(A) An estimation of the amount of traditional wrap-around payments that would have been paid to the participating FQHC with respect to APM enrollees for the APM scope of services in the absence of the APM pilot project. For each APM aid category, the estimation shall be no less than the participating FQHC's historical utilization for assigned members for a 12 month period reflected in the data being used, multiplied by its prospective

payment system rate, as determined pursuant to Section 14132.100, less any payments for the APM scope of services, exclusive of incentive payments, that were received from principal health plans and any secondary payers for the relevant period for assigned members, and shall be calculated on a PMPM basis.

(B) An estimation of service utilization for each APM aid category in the absence of the APM pilot project, including estimates of the utilization of services to be provided, and utilization and types of services not previously provided, reflected or identifiable in the prior period data.

(2) The wrap-cap payments shall not be decreased for the first three years of the APM pilot project, unless agreed to by the department and the applicable participating FQHC.

(c) (1) For each principal health plan that contains at least one participating FQHC in its provider network, the department shall determine an APM supplemental capitation amount for each APM aid category to be paid by the department to the principal health plan, which shall be expressed as a PMPM amount. The APM supplemental capitation amount shall be a weighted average of the aggregate wrap-cap amounts determined in subdivision (b), that at a minimum takes into account an estimation of the distribution of APM enrollees among the participating FQHCs for each APM aid category.

(2) The APM supplemental capitation amounts shall not be decreased for the first three years of the APM pilot project, unless agreed to by the department and the principal health plan.

(d) Notwithstanding any other law, each principal health plan shall pay a participating FQHC that is in the plan provider network the wrap-cap amounts determined in subdivision (b) for each APM enrollee of that FQHC, or, in cases where a secondary payer is involved, provide the necessary amounts to the secondary payer and require that secondary payer to make the required wrap-cap payments to the FQHC. The principal health plan, secondary payer, as applicable, and the participating FQHC may choose the manner in which the wrap-cap payments are made, provided the resulting payment is equal to the full amount of the wrap-cap payments to which the participating FQHC is entitled, taking into account, among others, changes in the number of APM enrollees within the APM aid categories. In cases where a secondary payer is involved, the principal health plan shall demonstrate and certify

to the department that it has contracts or other arrangements in place that provide for meeting the requirements herein and to the extent that the secondary payer fails to comply with the applicable requirements in this article, the principal health plan shall then be responsible to ensure the participating FQHC receives all payments due under this article in a timely manner.

(e) The department shall adjust the amounts in subdivisions (b) and (c) at least annually for any change to the prospective payment system rate for participating FQHCs, including changes resulting from a change in the Medicare Economic Index pursuant to subdivision (d) of Section 14132.100, and any changes in the FQHC's scope of services pursuant to subdivision (e) of Section 14132.100.

(f) During the duration of the APM pilot project, the department shall establish a risk corridor structure for the principal health plans relating to the payment requirement of subdivision (d), designed within the following parameters:

(1) (A) The principal health plan is fully responsible for the total aggregate costs of the wrap-cap payments for all APM aid categories to participating FQHCs in its network in excess of the total aggregate APM supplemental capitation amount for all APM aid categories up to one half of one percent.

(B) The principal health plan shall fully retain the aggregate APM supplemental capitation amount in excess of the total aggregate costs of the wrap-cap payments for all APM aid categories incurred up to one half of one percent.

(2) (A) The principal health plan and the department shall share responsibility for the total aggregate costs of the wrap-cap payments for all APM aid categories to participating FQHCs in the principal health plan's network that are between one half of one percent above and up to one percent above the total aggregate APM supplemental capitation amount for all APM aid categories.

(B) The principal health plan and the department shall share the benefit of the aggregate APM supplemental capitation amount in excess of the total aggregate costs of the wrap-cap payments for all APM aid categories incurred that are between one half of one percent and up to one percent below the total aggregate APM supplemental capitation amount.

(3) (A) The department shall be fully responsible for the total aggregate costs of the wrap-cap payments for all APM aid

categories to participating FQHCs in the principal health plan's network that are more than one percent in excess of the principal health plan's total aggregate APM supplemental capitation amount for all APM aid categories.

(B) The department shall fully retain the aggregate APM supplemental capitation amount in excess of the total aggregate costs of the wrap-cap payments for all APM aid categories to participating FQHCs in the principal health plan's network that are greater than one percent below the total aggregate APM supplemental capitation amount.

(g) In order to ensure participating FQHCs have an incentive to manage visits and costs, while at the same time exercising a reasonable amount of flexibility to deliver care in the most efficient and quality driven manner, during the duration of the APM pilot project the department shall, in accordance with this subdivision, establish a rate adjustment structure. The rate adjustment structure shall be developed with stakeholder input and shall meet the requirements of Section 1396a(bb)(6)(B) of title 42 of the United States Code.

(1) The rate adjustment structure shall be applicable on a site-specific basis.

(2) The rate adjustment structure shall permit an aggregate adjustment to the wrap-cap when actual utilization of services for a participating FQHC's site exceeds or falls below expectations that were reflected within the calculation of the rates developed pursuant to subdivisions (b), (c), and (d). For purposes of this rate adjustment structure, both actual and expected utilization shall be expressed as the total number of visits that would be recognized pursuant to subdivision (g) of Section 14132.100 for the APM enrollees of the participating FQHC's site across all APM aid categories and averaged on a per member per year basis.

(3) An adjustment pursuant to this subdivision shall occur no more than once per year per participating FQHC's site during the three years of the APM pilot project and shall be subject to approval by the department.

(A) An adjustment to the wrap-cap payments in the case of higher than expected utilization shall be triggered when utilization exceeds projections by more than five percent for the first year, seven and one-half percent for the second year, and ten percent for the third year. If the trigger level is reached, the affected

FQHC's site shall receive an aggregate payment adjustment that is based upon the difference between its actual utilization for the year and one hundred five percent of projected utilization for the first year, the difference between actual utilization and one hundred seven and one-half percent of projected utilization for the second year, and the difference between actual utilization and one hundred ten percent of projected utilization for the third year. The payment adjustment in each instance shall be calculated as follows:

(i) The difference in the applicable utilization levels shall be multiplied by the per-visit rate that was determined pursuant to Section 14132.100 for the participating FQHC's site.

(ii) The total number of member months for the APM enrollees of the participating FQHC's site for the year shall be divided by twelve.

(iii) The amount in clause (i) shall be multiplied by the amount in clause (ii), yielding the aggregate wrap-cap payment adjustment for the participating FQHC's site. The rate adjustment shall be paid to the participating FQHC site by the principal health plan, or secondary payer as applicable, in one aggregate payment.

(B) (i) To incentivize care delivery in ways that may vary from traditional delivery of care, participating FQHCs shall have the flexibility to experience a lower than expected visit utilization of up to thirty percent of projected utilization. If an FQHC site's actual utilization is at a level that is more than thirty percent lower than the projected utilization, the principal health plan, or secondary payer as applicable, shall review the FQHC site's relevant data to identify the cause or causes of the difference. If the principal health plan or secondary payer determines that the lower than expected utilization was due to factors unrelated to delivery system transformation and enhancements, it may require the FQHC's site to refund a portion of the wrap-cap payments.

(ii) The total amount refunded by the participating FQHC's site to the principal health plan or secondary payer shall be limited to an amount calculated as follows:

(I) The difference between the participating FQHC site's actual utilization and seventy percent of the projected utilization shall be multiplied by the site's per-visit rate that was determined pursuant to Section 14132.100.

(II) The total number of member months for the APM enrollees of the participating FQHC's site for the year shall be divided by twelve.

(III) The amount in subclause (I) shall be multiplied by the amount in subclause (II), yielding the maximum amount of the refund to be made by the participating FQHC's site. The refund shall be paid in one aggregate payment.

(iii) Any adjustment made pursuant to this subparagraph shall be requested by a principal health plan, secondary payer, or FQHC, no later than 90 days after the last day of the fiscal year for which the adjustment is sought.

(4) The department, in consultation with FQHCs and principal health plans interested in participating in the APM pilot project, may modify the adjustment process or methodology specified in this section to the extent necessary to comply with federal law and obtain federal approval of necessary amendments to the Medi-Cal state plan.

(h) The total APM supplemental capitation amounts paid to principal health plans shall be adjusted by the department as necessary to take into account adjustments to the number of APM enrollees by APM aid category no later than the 10th day of each month.

(i) A participating FQHC or principal health plan or the department may request an APM enrollee true-up to assure the total amount of the APM supplemental capitation or wrap-cap payments, as applicable, are adjusted to accurately reflect the number of applicable APM enrollees.

(j) An FQHC site participating in the APM pilot project shall not receive traditional wrap-around payments pursuant to Sections 14132.100 and 14087.325 for visits within the APM scope of services it provides to its APM enrollees.

14138.15. (a) (1) Within six months of the conclusion of pilot project, an evaluation shall be completed by an independent entity. This independent entity shall report its findings to the department and the Legislature. The evaluation shall be contingent on the availability of nonstate General Fund moneys for this purpose.

(2) A report submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(b) The evaluation shall assess whether the APM pilot project produced improvements in access to primary care services, care quality, patient experience, and overall health outcomes for APM enrollees. The evaluation shall include existing FQHC required quality metrics and an assessment of how the changes in financing allowed for alternative types of primary care visits and alternative touches between the participating FQHC and the patient. The evaluation shall also assess whether the APM pilot project's efforts to improve primary care resulted in changes to patient service utilization patterns, including the reduced utilization of avoidable high cost services.

~~SECTION 1. Section 14132.103 is added to the Welfare and Institutions Code, to read:~~

~~14132.103. (a) Notwithstanding any other law, the department shall authorize a three-year alternative payment methodology (APM) pilot project for federally qualified health centers (FQHCs) in accordance with this section.~~

~~(b) The APM shall be implemented in any county and FQHC willing to participate.~~

~~(c) Under the APM pilot project, participating FQHCs shall receive capitated monthly payments for each Medi-Cal managed care enrollee assigned to the FQHC in place of the wrap-around, fee-for-service per-visit payments from the department.~~

~~(d) The APM shall include all necessary protections and safeguards, for both the FQHCs and the health plans, to ensure that neither are financially harmed by the implementation of the APM in relation to both rates and number of enrollees assigned.~~

~~(e) (1) Within six months after the APM pilot project is completed, an evaluation of the pilot project shall be conducted by an independent entity that takes into consideration payment adequacy, delivery system transformation, and quality measures. The independent entity shall report its findings to the department and the Legislature. An evaluation pursuant to this subdivision shall be completed only if there are nonstate General Fund moneys available for this purpose.~~

~~(2) A report submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.~~

~~(f) The department shall seek any federal approvals necessary for the implementation of this section.~~

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