

AMENDED IN ASSEMBLY JULY 8, 2015

AMENDED IN SENATE APRIL 21, 2015

AMENDED IN SENATE APRIL 7, 2015

**SENATE BILL**

**No. 147**

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**Introduced by Senator Hernandez**

January 28, 2015

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An act to add 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 *an* APM pilot project, to commence no sooner than July 1, 2016, for FQHCs that agree to participate. *The bill would require the department to authorize implementation of an APM pilot project with respect to a county for a period of up to 3 years.* 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~~ *principal* health plan that contains at least one participating FQHC in its provider network, as specified. ~~Under the APM pilot project, participating FQHCs would receive 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 completed by an independent entity within 6 months of the conclusion of the APM pilot project, and 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:*

1 SECTION 1. Article 4.1 (commencing with Section 14138.1)  
 2 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and  
 3 Institutions Code, to read:  
 4  
 5 Article 4.1. Payment Reform Pilot Program for Federally  
 6 Qualified Health Centers  
 7  
 8 14138.1. For purposes of this article, the following definitions  
 9 apply:  
 10 (a) “Alternative payment methodology” (APM) has the same  
 11 meaning as specified in Section 1396a(bb)(6) of Title 42 of the  
 12 United States Code.  
 13 (b) “APM aid category” means a Medi-Cal category of aid  
 14 designated by the department. For all its APM enrollees in an APM  
 15 aid category, a participating FQHC site shall receive compensation  
 16 as described under the APM pilot project. The APM aid categories

1 may include, but are not limited to, all of the following categories  
2 of aid:

3 (1) Adults.

4 (2) Children.

5 (3) Seniors and persons with disabilities.

6 (4) The adult expansion population eligible pursuant to Section  
7 ~~14005.60~~ 14005.60, to the extent the department determines, in  
8 consultation with health plans and interested FQHCs, that  
9 sufficient data is available to allow for inclusion of this population  
10 in the APM pilot project. This paragraph shall not be construed  
11 to prohibit inclusion of the adult expansion population in the APM  
12 pilot project on a date subsequent to initial authorization pursuant  
13 to subdivision (a) of Section 14138.12.

14 (c) “APM enrollee” means a member who is assigned by a  
15 principal health plan or ~~secondary subcontracting~~ payer to a  
16 participating FQHC for primary care services and who is within  
17 one of the designated APM aid categories.

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

21 (e)

22 (d) “APM pilot project” means the pilot project authorized by  
23 this article.

24 ~~(f)~~

25 (e) “APM scope of services” means the scope of services for a  
26 participating FQHC for which its per-visit rate was determined  
27 pursuant to Section 14132.100.

28 ~~(g)~~

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

33 ~~(h) “Base payment” means the amount paid by a principal health~~  
34 ~~plan and any secondary payer, as applicable, to an FQHC for~~  
35 ~~patient services in the APM scope of services with respect to APM~~  
36 ~~enrollees of the FQHC pursuant to its contract, exclusive of any~~  
37 ~~incentive payments. Base payments do not include traditional~~  
38 ~~wrap-around payments or wrap-cap payment amounts.~~

39 (g) “Clinic-specific PMPM” means the monthly, per assigned  
40 member, capitated amount the principal health plan or

1 *subcontracting payer is required to pay to the participating FQHC*  
 2 *for the APM scope of services. The clinic-specific PMPM is*  
 3 *exclusive of any incentive payments and shall be developed to*  
 4 *reflect the amount the participating FQHC would have received*  
 5 *under the prospective payment system methodology set forth in*  
 6 *Section 14132.100.*

7 ~~(i)~~

8 (h) “FQHC” means any community or public “federally qualified  
 9 health center,” as defined in Section 1396d(l)(2)(B) of Title 42 of  
 10 the United States Code and providing services as defined in Section  
 11 1396d(a)(2)(C) of Title 42 of the United States Code.

12 ~~(j)~~

13 (i) “Member” means a Medi-Cal beneficiary who is enrolled  
 14 with a principal health plan or ~~secondary subcontracting~~ payer.

15 ~~(k)~~

16 (j) “Participating FQHC” means ~~a~~ *an* FQHC participating in  
 17 the APM pilot project at one or more of the FQHC’s sites.  
 18 “*Participating FQHC*” also refers to a FQHC’s site that is  
 19 *participating in the APM pilot project.*

20 ~~(l)~~

21 (k) “PMPM” and “per member per month” both mean a monthly  
 22 payment made for providing or arranging health care services for  
 23 a member and may refer to a payment by the department to a  
 24 principal health plan, or by a principal health plan to a ~~secondary~~  
 25 ~~subcontracting~~ payer, or by a principal health plan or ~~secondary~~  
 26 ~~subcontracting~~ payer to an FQHC, or from and to other entities as  
 27 specified in this article.

28 ~~(m)~~

29 (l) “Principal health plan” means an organization or entity that  
 30 enters into a contract with the department pursuant to Article 2.7  
 31 (commencing with Section 14087.3), Article 2.8 (commencing  
 32 with Section 14087.5), Article 2.81 (commencing with Section  
 33 14087.96), Article 2.82 (commencing with Section 14087.98),  
 34 Article 2.91 (commencing with Section 14089), or Chapter 8  
 35 (commencing with Section 14200), to provide or arrange for the  
 36 care of Medi-Cal beneficiaries within a county in which the APM  
 37 pilot project is implemented.

38 ~~(n)~~ “~~Secondary~~

39 (m) “*Subcontracting payer*” means an organization or entity  
 40 that subcontracts with a principal health plan to provide or arrange

1 for the care of its members and contains one or more participating  
2 FQHCs in its provider network.

3 (n) “Traditional encounter” means a face-to-face encounter  
4 that is recognized as a billable visit, as described in subdivision  
5 (g) of Section 14132.100.

6 (o) “Traditional wrap-around payment” means the supplemental  
7 payments payable to an FQHC in the absence of the APM pilot  
8 project with respect to services provided to Medi-Cal managed  
9 care enrollees, which are made by the department pursuant to  
10 subdivision (e) of Section 14087.325 and subdivision (h) of Section  
11 14132.100.

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

18 14138.10. The Legislature finds and declares all of the  
19 following:

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

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

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

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

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

1 (f) In an attempt to invest up front in health care services that  
2 can prevent longer term avoidable high-cost services, the *federal*  
3 *Patient Protection and Affordable Care Act* made a significant  
4 investment in FQHCs.

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

8 (h) Today FQHCs face ~~restrictions, however, certain restrictions~~  
9 because the current payment structure reimburses an FQHC only  
10 when there is a ~~face-to-face visit~~ *traditional encounter* with a  
11 provider. Current law prohibits payment for *both* a primary care  
12 visit and mental health visit on the same ~~day, a restriction that~~  
13 ~~inhibits coordination and efficiency.~~ *day*.

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

19 (j) A reformed payment methodology will enable FQHCs to  
20 take advantage of alternative ~~touches.~~ ~~Alternative touches, such~~  
21 ~~as encounters.~~ *Alternative encounters, such as group visits,*  
22 *same-day mental health services and* ~~phone~~ *telephone* and email  
23 consultations, are effective care delivery methods and contribute  
24 to a patient's overall health and well-being.

25 14138.11. It is the intent of the Legislature to test an alternative  
26 payment methodology for FQHCs, as permitted by federal law,  
27 and to design and implement the APM to do all of the following:

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

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

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

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

1 (e) Track alternative ~~touches~~ *encounters* at FQHCs in order to  
2 establish a data set from which alternative ~~touches~~ *encounters* may  
3 be assigned a value that can be used in future ratesetting.

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

8 14138.12. (a) (1) The department shall authorize a ~~three-year~~  
9 payment reform pilot project for FQHCs using an APM in  
10 accordance with this article. ~~Implementation~~

11 (2) *Implementation* of the APM pilot project shall begin no  
12 sooner than July 1, 2016, subject to ~~any necessary federal approval.~~  
13 *approvals.*

14 (3) *The department shall authorize implementation of an APM*  
15 *pilot project with respect to a county for a period of up to three*  
16 *years.*

17 (4) *At least 90 days prior to implementation of an APM pilot*  
18 *project for a participating FQHC site in a county, the department*  
19 *shall notify a principal health plan in writing of the principal*  
20 *health plan's specific APM supplemental capitation rate and*  
21 *clinic-specific PMPM rates for the participating FQHC in the*  
22 *county. The notification from the department to the principal health*  
23 *plan shall be based on the rates submitted by the department for*  
24 *final approval. If the APM supplemental capitation rates or*  
25 *clinic-specific PMPM rates are modified after the notification to*  
26 *a principal health plan, the department shall notify a principal*  
27 *health plan of the revised rates and, if either the principal health*  
28 *plan or participating FQHC requests, adjust the implementation*  
29 *date of the APM pilot project for a participating FQHC in a county*  
30 *so that it occurs at least 90 days after the revised rate notification.*

31 (5) *The APM pilot project for a participating FQHC site in a*  
32 *county shall begin no sooner than the first day of the month*  
33 *following the month in which the department received federal*  
34 *approval of the rates.*

35 (b) The APM pilot project shall comply with federal APM  
36 requirements and the department shall file a state plan amendment  
37 and seek any federal approvals as necessary for the implementation  
38 of this article. *Nothing in this article shall be construed to authorize*  
39 *the department to seek federal approval to affirmatively waive*  
40 *Section 1396a(bb)(6) of Title 42 of the United States Code.*

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

4 14138.13. (a) ~~To implement this article, the~~ *The* department  
 5 shall notify every FQHC *in the state* of the APM pilot project and  
 6 shall invite any interested FQHC to ~~notify the department that the~~  
 7 ~~FQHC agrees to participate~~ *apply for participation in the APM*  
 8 with respect to one or more of the FQHC’s sites. Consistent with  
 9 federal law, the state plan amendment described in subdivision (b)  
 10 of Section 14138.12 shall specify that the department and *each*  
 11 participating FQHCs ~~agree~~ *FQHC voluntarily agrees* to the APM.

12 (b) (1) (A) *The department shall develop the following, in*  
 13 *consultation with interested FQHCs and principal health plans*  
 14 *and consistent with federal law:*

15 (B) *The selection process that interested FQHCs may apply for*  
 16 *participation in the pilot project, which shall include, but need not*  
 17 *be limited to, the following:*

18 (i) *The FQHC has the demonstrated ability to collect and submit*  
 19 *encounter data in a form and manner that satisfies department*  
 20 *requirements.*

21 (ii) *The FQHC is in good standing with the relevant state and*  
 22 *federal regulators.*

23 (iii) *The FQHC has the financial and administrative capacity*  
 24 *to undertake payment reform.*

25 (2) *In accordance with the process and criteria developed*  
 26 *pursuant to paragraph (1), the department shall approve or deny*  
 27 *an interested FQHC site application for participation in the pilot*  
 28 *project. The department may limit the number of participating*  
 29 *FQHCs in the pilot project and the number of counties in which*  
 30 *the pilot project will operate.*

31 (3) *All principal health plans and applicable subcontracting*  
 32 *payers are required to participate in the APM pilot project*  
 33 *pursuant to this article to the extent that one or more contracted*  
 34 *FQHC sites located in the plan’s county are selected to participate*  
 35 *in the pilot project.*

36 ~~(b)~~

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

40 ~~(e)~~

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

5 (1) A Medi-Cal beneficiary who receives services from any  
6 FQHC to which the beneficiary is not assigned for primary care  
7 services under the APM pilot project by a principal health plan or  
8 ~~secondary subcontracting~~ payer.

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

11 ~~(d)~~

12 (e) (1) A participating FQHC, with respect to one or more sites  
13 of its choosing, may opt to discontinue its participation in the pilot  
14 project subject to a notice requirement of no less than ~~30 days and~~  
15 ~~no greater than 45 days, as established by the department. 120~~  
16 ~~days.~~

17 (2) A principal health plan may opt to discontinue its  
18 participation in the pilot project, subject to a notice requirement  
19 of no less than ~~30 days and no greater than 45 days, as established~~  
20 ~~by the department, if subdivision (f) of Section 14138.14 120 days~~  
21 ~~if Section 14138.16 is amended at any time while the pilot project~~  
22 ~~is in effect. The department shall place a provision in a plan's~~  
23 ~~contract giving the plan the ability to discontinue its participation~~  
24 ~~in the APM pilot project pursuant to this paragraph.~~

25 ~~14138.14. (a) A participating FQHC shall be compensated for~~  
26 ~~the APM scope of services provided to its APM enrollees pursuant~~  
27 ~~to this section.~~

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

1     ~~(A) An estimation of the amount of traditional wrap-around~~  
2 ~~payments that would have been paid to the participating FQHC~~  
3 ~~with respect to APM enrollees for the APM scope of services in~~  
4 ~~the absence of the APM pilot project. For each APM aid category,~~  
5 ~~the estimation shall be no less than the participating FQHC's~~  
6 ~~historical utilization for assigned members for a 12-month period~~  
7 ~~reflected in the data being used, multiplied by its prospective~~  
8 ~~payment system rate, as determined pursuant to Section 14132.100,~~  
9 ~~less any payments for the APM scope of services, exclusive of~~  
10 ~~incentive payments, that were received from principal health plans~~  
11 ~~and any secondary payers for the relevant period for assigned~~  
12 ~~members, and shall be calculated on a PMPM basis.~~

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

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

21     ~~(c) Notwithstanding any other law, each principal health plan~~  
22 ~~shall pay a participating FQHC that is in the plan provider network~~  
23 ~~the wrap-cap amounts determined in subdivision (b) for each APM~~  
24 ~~enrollee of that FQHC, or, in cases where a secondary payer is~~  
25 ~~involved, provide the necessary amounts to the secondary payer~~  
26 ~~and require that secondary payer to make the required wrap-cap~~  
27 ~~payments to the FQHC. The principal health plan, secondary payer,~~  
28 ~~as applicable, and the participating FQHC may choose the manner~~  
29 ~~in which the wrap-cap payments are made, provided the resulting~~  
30 ~~payment is equal to the full amount of the wrap-cap payments to~~  
31 ~~which the participating FQHC is entitled, taking into account,~~  
32 ~~among others, changes in the number of APM enrollees within the~~  
33 ~~APM aid categories. In cases where a secondary payer is involved,~~  
34 ~~the principal health plan shall demonstrate and certify to the~~  
35 ~~department that it has contracts or other arrangements in place that~~  
36 ~~provide for meeting the requirements herein and to the extent that~~  
37 ~~the secondary payer fails to comply with the applicable~~  
38 ~~requirements in this article, the principal health plan shall then be~~  
39 ~~responsible to ensure the participating FQHC receives all payments~~  
40 ~~due under this article in a timely manner.~~

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

7 ~~(e) An FQHC site participating in the APM pilot project shall~~  
8 ~~not receive traditional wrap-around payments pursuant to Sections~~  
9 ~~14132.100 and 14087.325 for visits within the APM scope of~~  
10 ~~services it provides to its APM enrollees.~~

11 ~~14138.15. (a) A principal health plan shall be compensated~~  
12 ~~by the department for the services provided to its APM enrollees~~  
13 ~~pursuant to this section.~~

14 ~~(b) (1) For each principal health plan that contains at least one~~  
15 ~~participating FQHC in its provider network, the department shall~~  
16 ~~determine an APM supplemental capitation amount for each APM~~  
17 ~~aid category to be paid by the department to the principal health~~  
18 ~~plan, which shall be expressed as a PMPM amount. The APM~~  
19 ~~supplemental capitation amount shall be a weighted average of~~  
20 ~~the aggregate wrap-cap amounts determined in subdivision (b) of~~  
21 ~~Section 14138.14, that at a minimum takes into account an~~  
22 ~~estimation of the distribution of APM enrollees among the~~  
23 ~~participating FQHCs for each APM aid category.~~

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

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

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

38 ~~14138.16. During the duration of the APM pilot project, the~~  
39 ~~department shall establish a risk corridor structure for the principal~~

1 health plans relating to the payment requirement of Section  
2 14138.15, designed within the following parameters:

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

8 (2) The principal health plan shall fully retain the aggregate  
9 APM supplemental capitation amount in excess of the total  
10 aggregate costs of the wrap-cap payments for all APM aid  
11 categories incurred up to one-half of 1 percent.

12 (b) (1) The principal health plan and the department shall share  
13 responsibility for the total aggregate costs of the wrap-cap  
14 payments for all APM aid categories to participating FQHCs in  
15 the principal health plan's network that are between one-half of 1  
16 percent above and up to one percent above the total aggregate  
17 APM supplemental capitation amount for all APM aid categories.

18 (2) The principal health plan and the department shall share the  
19 benefit of the aggregate APM supplemental capitation amount in  
20 excess of the total aggregate costs of the wrap-cap payments for  
21 all APM aid categories incurred that are between one-half of 1  
22 percent and up to one percent below the total aggregate APM  
23 supplemental capitation amount.

24 (c) (1) The department shall be fully responsible for the total  
25 aggregate costs of the wrap-cap payments for all APM aid  
26 categories to participating FQHCs in the principal health plan's  
27 network that are more than one percent in excess of the principal  
28 health plan's total aggregate APM supplemental capitation amount  
29 for all APM aid categories.

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

36 *14138.14. (a) A participating FQHC shall be compensated*  
37 *for the APM scope of services provided to its APM enrollees*  
38 *pursuant to this section.*

39 *(b) A participating FQHC shall receive from the principal health*  
40 *plan or applicable subcontracting payer reimbursement for each*

1 APM enrollee in the form of a clinic-specific PMPM for the  
2 applicable APM aid category. The department shall determine the  
3 clinic-specific PMPM for each APM aid category taking into  
4 account all the following factors:

5 (1) Historical utilization of FQHC services by assigned members  
6 in each APM aid category.

7 (2) The participating FQHC's prospective payment system rate  
8 and applicable adjustments relevant for the fiscal year, such as  
9 annual rate adjustments.

10 (3) Other trend and utilization adjustments as appropriate in  
11 order to reflect the level of reimbursement that would have been  
12 received by the participating FQHCs in the absence of the APM  
13 pilot project.

14 (c) A participating FQHC and applicable principal health plan  
15 or subcontracting payer may enter into arrangements in which  
16 the clinic-specific PMPM amount required in subdivision (b) is  
17 paid in more than one capitated increment, as long as the total  
18 capitation each month received by the participating FQHC is  
19 equivalent to the clinic-specific PMPM.

20 (d) In cases where a subcontracting payer is involved, the  
21 principal health plan shall demonstrate and certify to the  
22 department that it has contracts or other arrangements in place  
23 that provide for meeting the requirements in subdivision (b) and  
24 to the extent that the subcontracting payer fails to comply with the  
25 applicable requirements in this article, the principal health plan  
26 shall then be responsible to ensure the participating FQHC  
27 receives all payments due under this article in a timely manner.

28 (e) The department shall adjust the amounts in subdivision (b)  
29 as necessary to account for any change to the prospective payment  
30 system rate for participating FQHCs, including changes resulting  
31 from a change in the Medicare Economic Index pursuant to  
32 subdivision (d) of Section 14132.100, and any changes in the  
33 FQHC's scope of services pursuant to subdivision (e) of Section  
34 14132.100.

35 (f) An FQHC site participating in the APM pilot project shall  
36 not receive traditional wrap-around payments pursuant to Sections  
37 14132.100 and 14087.325 for visits within the APM scope of  
38 services it provides to its APM enrollees.

1 14138.15. (a) A principal health plan shall be compensated  
2 by the department for the services provided to its APM enrollees  
3 pursuant to this section.

4 (b) For each principal health plan that contains at least one  
5 participating FQHC in its provider network, the department shall  
6 determine an APM supplemental capitation amount for each APM  
7 aid category to be paid by the department to the principal health  
8 plan, which shall be expressed as a PMPM amount. This  
9 supplemental capitation amount will be in addition to the funding  
10 for the APM scope of services already contained in the principal  
11 health plan's capitated rates paid by the department and shall be  
12 actuarially sound. The department shall determine the APM  
13 supplemental capitation amount for each APM aid category, taking  
14 into account all of the following factors:

15 (1) The clinic-specific PMPM amounts for each APM aid  
16 category for each participating FQHC in the plan's network.

17 (2) The funding for the APM scope of services already contained  
18 in the principal health plan's capitated rates.

19 (3) The historical wrap-around payments paid by the department  
20 for participating FQHCs for assigned members in each APM aid  
21 category.

22 (4) As applicable, the likely distribution of members among  
23 multiple participating FQHCs.

24 (c) The principal health plan shall report to the department, in  
25 a form to be determined by the department in consultation with  
26 the principal health plan, the number of APM enrollees for each  
27 APM aid category in the plan each month.

28 (d) The department shall pay each principal health plan its  
29 applicable APM supplemental capitation amount for the number  
30 of APM enrollees for each APM aid category reported by the  
31 principal health plan pursuant to subdivision (c).

32 (e) The department, in consultation with the principal health  
33 plans, shall develop methods to verify the information reported  
34 pursuant to subdivision (c), and may adjust the payments made  
35 pursuant to subdivision (d) as appropriate to reflect the verified  
36 number of APM enrollees for each APM aid category.

37 (f) The department shall adjust the amounts in subdivision (b)  
38 as necessary to account for any change to the prospective payment  
39 system rate for participating FQHCs, including changes resulting  
40 from a change in the Medicare Economic Index pursuant to

1 subdivision (d) of Section 14132.100, and any changes in the  
2 FQHC's scope of services pursuant to subdivision (e) of Section  
3 14132.100.

4 14138.16. (a) For the duration of the APM pilot project, the  
5 department shall establish a risk corridor structure for the  
6 principal health plans relating only to the APM supplemental  
7 capitation payments pursuant to Section 14138.15, to the extent  
8 consistent with principals of actuarial soundness.

9 (b) The risk sharing of the costs under this section shall be  
10 constructed by the department so that it is symmetrical with respect  
11 to risk and profit, and so that all of the following apply:

12 (1) The principal health plan is fully responsible for all costs  
13 in excess of the APM supplemental capitation amounts up to  
14 one-half of one percent.

15 (2) The principal health plan shall fully retain the revenues paid  
16 through the APM supplemental capitation amounts in excess of  
17 the costs incurred up to one-half of 1 percent below the APM  
18 supplemental capitation amounts.

19 (3) The principal health plan and the department shall share  
20 equally in the responsibility for costs in excess of the APM  
21 supplemental capitation amounts that are greater than one-half  
22 of 1 percent but less than 1 percent above the APM supplemental  
23 capitation amounts.

24 (4) The principal health plan and the department shall share  
25 equally the benefit of the revenues paid through the APM  
26 supplemental capitation amounts in excess of the costs incurred  
27 that are greater than one-half of 1 percent but less than 1 percent  
28 below the APM supplemental capitation amounts.

29 (5) The department shall be fully responsible for all costs in  
30 excess of the APM supplemental capitation amounts that are more  
31 than 1 percent above the APM supplemental capitation amounts.

32 (6) The department shall fully retain the revenues paid through  
33 the APM supplemental capitation amounts in excess of the costs  
34 incurred greater than 1 percent below the supplemental capitation  
35 amounts.

36 (c) The department shall develop specific contract language to  
37 implement the requirements of this section that shall be  
38 incorporated into the contracts of each affected principal health  
39 plan.

1 (d) *This section shall be implemented only to the extent that any*  
2 *necessary federal approvals or waivers are obtained.*

3 14138.17. (a) In order to ensure participating FQHCs have an  
4 incentive to manage visits and costs, while at the same time  
5 exercising a reasonable amount of flexibility to deliver care in the  
6 most efficient and quality driven manner, ~~during for the duration~~  
7 of the APM pilot project the department shall, in accordance with  
8 this subdivision, establish a ~~rate payment~~ adjustment structure.  
9 The ~~rate payment~~ adjustment structure shall be developed with  
10 stakeholder input and shall meet the requirements of Section  
11 ~~1396a(bb)(6)(B)~~ 1396a(bb)(6) of Title 42 of the United States  
12 Code.

13 (b) The ~~rate payment~~ adjustment structure shall be applicable  
14 on a site-specific basis.

15 (c) The ~~rate payment~~ adjustment structure shall permit an  
16 aggregate adjustment to the ~~wrap-cap payments received~~ when  
17 actual utilization of services for a participating FQHC's site  
18 exceeds or falls below expectations that were reflected within the  
19 calculation of the rates developed pursuant to Sections 14138.14  
20 and 14138.15. For purposes of this ~~rate payment~~ adjustment  
21 structure, both actual and expected utilization shall be expressed  
22 as the total number of ~~visits~~ *traditional encounters* that would be  
23 recognized pursuant to subdivision (g) of Section 14132.100 for  
24 the APM enrollees of the participating FQHC's site across all APM  
25 aid categories and averaged on a per member per year basis.

26 (d) An adjustment pursuant to this section shall occur no more  
27 than once per year per participating FQHC's site during ~~the three~~  
28 ~~years of the APM pilot project~~ and shall be subject to approval by  
29 the department.

30 (1) An adjustment to the ~~wrap-cap~~ payments in the case of  
31 higher than expected utilization shall be triggered when utilization  
32 exceeds projections by more than 5 percent for the first year, 7½  
33 percent for the second year, and 10 percent for the third year. If  
34 the trigger level is ~~reached, the affected FQHC's~~ *reached in a*  
35 *given year, the participating FQHC* site shall receive an aggregate  
36 payment adjustment *from the principal health plan or applicable*  
37 *subcontracting payer* that is based upon the difference between  
38 its actual utilization for the year and 105 percent of projected  
39 utilization for the first year, the difference between actual  
40 utilization and 107½ percent of projected utilization for the second

1 year, and the difference between actual utilization and 110 percent  
2 of projected utilization for the third year. The payment adjustment  
3 in each instance shall be calculated as follows:

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

7 ~~(B) The total number of member months for the APM enrollees~~  
8 ~~of the participating FQHC's site for the year shall be divided by~~  
9 ~~12.~~

10 ~~(C) The amount in subparagraph (A) shall be multiplied by the~~  
11 ~~amount in subparagraph (B), yielding the aggregate wrap-cap~~  
12 ~~payment adjustment for the participating FQHC's site. The rate~~  
13 ~~adjustment shall be paid to the participating FQHC site by the~~  
14 ~~principal health plan, or secondary payer as applicable, in one~~  
15 ~~aggregate payment.~~

16 ~~(2) (A) To incentivize care delivery in ways that may vary from~~  
17 ~~traditional delivery of care, participating FQHCs shall have the~~  
18 ~~flexibility to experience a lower than expected visit utilization of~~  
19 ~~up to 30 percent of projected utilization. If an FQHC site's actual~~  
20 ~~utilization is at a level that is more than 30 percent lower than the~~  
21 ~~projected utilization, the principal health plan, or secondary payer~~  
22 ~~as applicable, shall review the FQHC site's relevant data to identify~~  
23 ~~the cause or causes of the difference. If the principal health plan~~  
24 ~~or secondary payer determines that the lower than expected~~  
25 ~~utilization was due to factors unrelated to delivery system~~  
26 ~~transformation and enhancements, it may require the FQHC's site~~  
27 ~~to refund a portion of the wrap-cap payments.~~

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

31 ~~(i) The difference between the participating FQHC site's actual~~  
32 ~~utilization and 70 percent of the projected utilization shall be~~  
33 ~~multiplied by the site's per-visit rate that was determined pursuant~~  
34 ~~to Section 14132.100.~~

35 ~~(ii) The total number of member months for the APM enrollees~~  
36 ~~of the participating FQHC's site for the year shall be divided by~~  
37 ~~12.~~

38 ~~(iii) The amount in clause (i) shall be multiplied by the amount~~  
39 ~~in clause (ii), yielding the maximum amount of the refund to be~~

1 ~~made by the participating FQHC's site. The refund shall be paid~~  
2 ~~in one aggregate payment.~~

3 (A) *The actual total utilization, expressed as traditional*  
4 *encounters, for the applicable year shall be determined.*

5 (B) *The projected total utilization contained in the clinic-specific*  
6 *PMPMs for the actual APM enrollees for the applicable year shall*  
7 *be determined.*

8 (C) *The amount in subparagraph (B) shall be adjusted to reflect*  
9 *the applicable comparison utilization for the year as follows:*

10 (i) *Multiplied by 1.05 for year one.*

11 (ii) *Multiplied by 1.075 for year two.*

12 (ii) *Multiplied by 1.1 for year three.*

13 (D) *The amount in subparagraph (C) shall be subtracted from*  
14 *the amount in subparagraph (A).*

15 (E) *The amount in subparagraph (D) shall be multiplied by the*  
16 *per-visit rate that was determined pursuant to Section 14132.100*  
17 *for the participating FQHC yielding the payment adjustment for*  
18 *the participating FQHC site. The payment adjustment shall be*  
19 *paid to the participating FQHC site by the principal health plan,*  
20 *or subcontracting payer, as applicable, in one aggregate payment.*

21 (2) (A) *To incentivize care delivery in ways that may vary from*  
22 *traditional delivery of care, participating FQHCs shall have the*  
23 *flexibility to experience a lower than expected visit utilization of*  
24 *up to 30 percent of projected utilization. If an FQHC site's actual*  
25 *utilization is at a level that is more than 30 percent lower than the*  
26 *projected utilization, the department shall review, in consultation*  
27 *with the principal health plan, or subcontracting payer, as*  
28 *applicable, the FQHC site's relevant data to identify the cause or*  
29 *causes of the difference, including, but not limited to, its volume*  
30 *of alternative encounters. If the department is able to determine*  
31 *that all or part of the lower than expected utilization was due to*  
32 *objective factors developed by the department in consultation with*  
33 *the principal health plans and FQHCs that are related to delivery*  
34 *system transformation and enhancements, such as alternative*  
35 *encounters, the department shall allow the participating FQHC*  
36 *site to retain all or a portion of the payments attributable to the*  
37 *utilization decrease that exceeds 30 percent lower than the*  
38 *projected utilization. If the department is unable to determine that*  
39 *all or a portion of the utilization decrease in excess of 30 percent*  
40 *was related to delivery system transformation and enhancements*

1 according to the objective criteria developed pursuant to this  
2 subparagraph, the participating FQHC site shall be required to  
3 refund the applicable payment amount to the participating health  
4 plan or subcontracting payer pursuant to subparagraph (B).

5 (B) The total amount refunded by the participating FQHC's  
6 site to the principal health plan or subcontracting payer shall be  
7 limited to an amount calculated as follows:

8 (i) The actual total utilization, expressed as traditional  
9 encounters, for the applicable year shall be determined.

10 (ii) The projected total utilization contained in the clinic-specific  
11 PMPMs for the actual APM enrollees for the applicable year shall  
12 be determined and multiplied by 70 percent.

13 (iii) The amount in clause (i) shall be subtracted from the  
14 amount in clause (ii).

15 (iv) The amount in clause (i) shall be multiplied by the  
16 participating FQHC site's per visit rate that was determined  
17 pursuant to Section 14132.100, yielding the maximum amount of  
18 the refund to be made by the participating FQHC site. The refund  
19 shall be paid in one aggregate payment.

20 (C) Any adjustment made pursuant to this paragraph shall be  
21 requested by a principal health plan, ~~secondary subcontracting~~  
22 payer, or FQHC, no later than 90 days after the last day of the  
23 fiscal year for which the adjustment is sought. ~~that determination~~  
24 ~~by the department pursuant to subparagraph (A).~~

25 ~~14138.18. The department, in consultation with FQHCs and~~  
26 ~~principal health plans interested in participating in the APM pilot~~  
27 ~~project, may modify the adjustment process or methodology~~  
28 ~~specified in Sections 14138.14, 14138.15, 14138.16, and 14138.17~~  
29 ~~to the extent necessary to comply with federal law and obtain~~  
30 ~~federal approval of necessary amendments to the Medi-Cal state~~  
31 ~~plan.~~

32 ~~14138.19. A participating FQHC or principal health plan or~~  
33 ~~the department may request an APM enrollee true-up to assure the~~  
34 ~~total amount of the APM supplemental capitation or wrap-cap~~  
35 ~~payments, as applicable, are adjusted to accurately reflect the~~  
36 ~~number of applicable APM enrollees.~~

37 ~~14138.18. (a) The department, in consultation with interested~~  
38 ~~FQHCs and principal health plans, may modify any methodology~~  
39 ~~or process specified in this article to the extent necessary to comply~~  
40 ~~with federal law or to obtain any necessary federal approvals.~~

1 (b) *This article shall be implemented only to the extent that*  
 2 *federal financial participation is available and any necessary*  
 3 *federal approvals have been obtained.*

4 (c) *In the event of a conflict between a provision in this article*  
 5 *and the terms of a federally approved APM, the terms of the*  
 6 *federally approved APM shall control.*

7 14138.19. *In the event of an epidemic, or similar catastrophic*  
 8 *occurrence that the department determines is likely to result in at*  
 9 *least a 40 percent increase in actual utilization per member per*  
 10 *month within the APM scope of services for one or more APM aid*  
 11 *categories at a participating FQHC site, the department may*  
 12 *adjust, or require the adjustment of, payments made pursuant to*  
 13 *this article as it deems necessary to account for the utilization*  
 14 *increase at the affected participating FQHC site.*

15 14138.20. (a) (1) *Within six months of the conclusion of pilot*  
 16 *project, an evaluation shall be completed by an independent entity.*  
 17 *This independent entity shall report its findings to the department*  
 18 *and the Legislature. The evaluation shall be contingent on the*  
 19 *availability of nonstate General Fund moneys for this—purpose—*  
 20 *purpose, and the availability of private foundation or nonprofit*  
 21 *foundation money for this purpose.*

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

25 (b) *The evaluation shall assess whether the APM pilot project*  
 26 *produced improvements in access to primary care services, care*  
 27 *quality, patient experience, and overall health outcomes for APM*  
 28 *enrollees. The evaluation shall include existing FQHC required*  
 29 *quality metrics and an assessment of how the changes in financing*  
 30 *allowed for alternative types of primary care visits and alternative*  
 31 *touches encounters between the participating FQHC and the*  
 32 *patient: patient and how those changes affected volume of same-day*  
 33 *visits for mental and physical health conditions. The evaluation*  
 34 *shall also assess whether the APM pilot project's efforts to improve*  
 35 *primary care resulted in changes to patient service utilization*  
 36 *patterns, including the reduced utilization of avoidable high-cost*  
 37 *services: services and services provided outside the FQHC.*

38 14138.21. *Notwithstanding Chapter 3.5 (commencing with*  
 39 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*  
 40 *Code, the department may implement, interpret, or make specific*

1 *this article by means of all-county letters, plan letters, plan or*  
2 *provider bulletins, or similar instructions, without taking*  
3 *regulatory action.*

4 *14138.22. For purposes of implementing this article, the*  
5 *department may enter into exclusive or nonexclusive contracts on*  
6 *a bid or negotiated basis, including contracts for the purpose of*  
7 *obtaining subject matter expertise or other technical assistance.*  
8 *Any contract entered into or amended pursuant to this section*  
9 *shall be exempt from Part 2 (commencing with Section 10100) of*  
10 *Division 2 of the Public Contract Code and Chapter 6*  
11 *(commencing with Section 14825) of Part 5.5 of Division 3 of the*  
12 *Government Code, and shall be exempt from the review or*  
13 *approval of any division of the Department of General Services.*

O