

# Spotlight on Health Center Payment Reform: California's Alternative Payment Methodology (APM) Pilot

## Introduction

Payment reform and delivery system transformation efforts have critical implications for health centers' financial performance, sustainability, and their mission of providing high-quality, patient-centered care to underserved populations. In some states, Primary Care Associations (PCAs) and health centers are focused on health center-specific reform through Medicaid alternative payment methodologies (APMs).

As PCAs and health centers navigate the growing number of payment reform efforts, many have expressed the desire to learn about the details of the payment models, including health center-specific reform through Medicaid APM. This case study provides details about California's Medicaid (called Medi-Cal) APM pilot, including the goals for the APM, relevant state context, payment methodology, quality and access indicators link to payment, patient population covered by the model, and roll-out. The information in this case study can help inform other states' payment reform efforts.

## California context

- California was an early Medicaid expansion state, and with the Affordable Care Act (ACA) increased coverage to nearly all non-elderly adults with incomes at or below 138% of the Federal Poverty Level (FPL).<sup>1</sup>
- 12.2 million Californians are covered by Medicaid<sup>2</sup> as of February 2016, up 4.4 million since 2013.<sup>3</sup>
- Almost one-third of California's 39.1 million residents are enrolled in Medicaid.<sup>4</sup>
- In 2015, 52.9% of Californians were enrolled in managed care organizations (MCOs), while 77% of Medicaid enrollees were in MCOs.<sup>5</sup>
- 3.7 million Californians (95.6% of whom are low income) are cared for by health centers, including 2.17 million Medicaid enrollees.<sup>6</sup> The health center Medicaid market share grew from 33% in 2013 to 41% in 2015, with 54% of all new Medicaid enrollees assigned to health centers.<sup>7</sup>

<sup>1</sup> Medicaid.gov website (accessed May, 9, 2016); available from <https://www.medicaid.gov/>.

<sup>2</sup> California's Medicaid program is called Medi-Cal. For consistency with language used in other states we refer to the program as Medicaid throughout this paper except where the program name is used as a proper noun.

<sup>3</sup> *Medicaid and CHIP in California* (access May, 16, 2016); available from <https://www.medicaid.gov/medicaid-chip-program-information/by-state/california.html>.

<sup>4</sup> Based on US Census Total population of 39.1 million as of July 2015, and 12.2 million covered by Medicaid in 2016.

<sup>5</sup> The Kaiser Family Foundation, *Total Medicaid MCO Enrollment* (accessed May 9, 2016); available from <http://kff.org/other/state-indicator/total-medicaid-mco-enrollment/>.

<sup>6</sup> HRSA Health Center Program Data Comparisons (accessed May 16, 2016); available from <http://bphc.hrsa.gov/uds/datacomparisons.aspx>.

<sup>7</sup> California Healthcare Foundation, *Medi-Cal Win-Win: Surging Enrollment Fosters Investment in the Safety Net*; available from <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalWinWinSurgingEnrollment.pdf>

In 2016 California began to implement a Medicaid waiver program, called Medi-Cal 2020, effective through 2020. The waiver's major elements include a Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program that builds on prior Delivery System Reform Incentive Payment (DSRIP) program efforts; a Global Payment Program (GPP); a Dental Transformation Initiative (DTI); and funding for Whole Person Care (WPC) pilots. The overarching goal of the WPC pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner to improve beneficiary health and well-being through more efficient and effective use of resources.

The waiver prioritizes the development of systems that increase value for payers and patients, including cross-system integration and coordination. The waiver incorporates incentives based on the attainment of benchmarks, and the PRIME project sets targets for moving toward alternative payment models (APM), with a goal of 60% of Medicaid payments paid through an APM by the end of the waiver.

## Background

### ***California Prospective Payment System (PPS)***

California has for many years used a managed care model for Medicaid. There is substantial MCO penetration in the Medicaid market, and California has historically funded Medicaid services at an overall rate that is one of the lowest among the fifty states.<sup>8</sup> As a result, there is less opportunity than in other states to identify cost savings that might fund or incentivize care transformation. Furthermore, in early discussions between the California Primary Care Association (CPCA) and the state Medicaid agency, the Department of Health Care Services (DHCS), the state expressed no interest in payment models that would require additional State General Fund spending. The CPCA, in partnership with health centers in the state, pursued an APM under Federally Qualified Health Centers (FQHCs) Medicaid law as a means of adding flexibility to the existing health center payment (PPS) in order to increase access to the growing number of Medicaid beneficiaries and to support patient-centered care.

California's current PPS methodology pays FQHCs site-specific per-visit rates. Health centers established a per visit baseline rate using their own average per-visit costs from fiscal years 1999-2000. For a new health center, the rate is based on the health center's projected cost report or the rates for similar health centers in the area. Rates are adjusted annually based on the Medicare Economic Index (MEI) or in consideration of any defined change in scope of services provided. A change in the scope of services accounted for in a health center's PPS can be sought for a number of reasons,<sup>9</sup> provided that it is based on reasonable costs and would result in a net change in the health center's rate equal to or in excess of 1.75 percent. Yet, a state productivity screen has prevented many health centers from using a change in scope to achieve an increased PPS rates as their costs have increased.

Health centers are paid similarly to other primary care providers by managed care plans and bill the state directly for a "wrap around" payment, making up the difference between the payment made by the managed

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<sup>8</sup> The Kaiser Family Foundation, *Medicaid Spending per Enrollee (Full or Partial Benefit)*; available from <http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/>

<sup>9</sup> A change in scope can be sought due to: the addition of a new or deletion of an existing health center service; a change in service due to amended regulatory requirements, relocation or remodeling; a change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic; an increase in service intensity attributable to changes in the types of patients served; changes in the provider mix changes in operating costs attributable to capital expenditures associated with a scope modification; and indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

care plan and the health centers' PPS rate. At the end of the fiscal year, health centers and the state conduct a reconciliation to ensure that health centers received their PPS rate for all eligible visits. However, many health centers have experienced long delays in reconciliation settlements, averaging three years.

Several aspects of California's existing PPS methodology, however, limit the ability of health centers to provide patient-centered care. These include the inability to bill for both a primary care and mental health visit that occur on the same day, and a strict requirement that such visits must be provided within the four walls of the health center, limiting opportunities for innovative care models. Furthermore, the requirement that health center services be provided by the specific provider types named in the health center statute make it challenging to innovate care delivery by using non-billable providers such as marriage and family therapists, clinical pharmacists, and community health workers.

The acronym APM is used in literature to refer to both the FQHC-specific methodology available to states under the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), and to a variety of other payment methodologies. In this paper we use FQHC APM to refer to health center specific Alternative Payment Methodologies as defined in BIPA, and APM to refer to other payment methods or methodologies.

### **California APM goals**

The CPCA and health centers are interested in an FQHC APM as a way to:

- Substantively test payment and delivery reforms that promote value over volume by, for example, using the whole care team with all individuals practicing to the full extent of their education and training, providing care outside of the face-to-face visit with specific providers, and addressing workforce challenges such as shortages of certain provider types and burnout;
- Better coordinate and unify incentives across managed care plans and health centers;
- Secure a more predictable cash flow than currently exists with the annual payment reconciliation process with the state;
- Provide care options that patients want, such as phone encounters;
- Improve capacity of health centers to deliver high-quality care to a population growing in number and in complexity of needs;
- Engage in incremental reform that provides flexibility to employ new care delivery models while limiting financial instability that could lead to reduced access to care for vulnerable populations; and
- Establish experience valuable in future payment reform efforts, including those with more risk.

The California DHCS's interest in implementing an APM for health centers underscores the desire to "transition away from a payment system that rewards volume."<sup>10</sup> Furthermore, the APM provides a mechanism for greater alignment between health centers and the managed care financing and delivery systems. In addition, the state is interested in reducing the need to manage its own claims and administration systems and rely more on the efforts of MCOs, which have parallel systems that the state itself oversees.

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<sup>10</sup> Hernandez, E. (2015). SB 147 Medi-Cal – Pilot program on Federally Qualified Health Center alternative payment methodology. Retrieved from [http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201520160SB147](http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB147)

## California APM overview

California's APM pilot translates a pilot site's current PPS visit rate into four aid category specific PPS-equivalent, per member per month (PMPM) capitation payments for all Medi-Cal managed care patients assigned to the site.<sup>11</sup> Key elements of the APM determined to date (with others still in development) are listed below. The three-year pilot is anticipated to begin in 2017.

### ***Payment definition and flow:***

Health centers will receive a site-specific PMPM payment that is equivalent to the site's historic PPS rate.

- The PMPM rate applies to all Medicaid beneficiaries assigned to the clinic site by a health plan. Rates will be calculated per one of four aid categories: child, adult, seniors and persons with disabilities, and adult Medi-Cal expansion (collectively called "APM aid categories"). Dual-eligibles and Medicare beneficiaries not assigned to a health center will continue to be paid for under the traditional PPS.
- The PMPM rate includes all health center services (as defined in the statute) provided to assigned APM members, with the exception of dental services. All health center services for which a health center receives PPS will be included in the PMPM rate, even if they are currently reimbursed by MCOs on a fee-for-service basis (such as specialty care, pharmacy, lab, behavioral health, prenatal care, family planning, and immunizations). The site-specific rate, rather than a health center organization rate, ensures that the site will receive at minimum the amount it would have been paid under PPS.
- A PMPM will be established for each aid category due to different utilization patterns of each APM aid category. This helps reduce risk for the state and health centers should a pilot's population mix change.
- The PMPM will incorporate the annual MEI rate increases that occur today, and health centers will still be able to conduct change of scope adjustments to their base PPS rate, which would then be converted back to a PMPM.
- Any costs incurred by the state or the plans for administration of the payment will not decrease PMPM payments to pilot sites.

The PMPM will flow to health centers through health plans and subcontracting payers.

- Health plans will be responsible for ensuring that pilot sites receive their PPS-equivalent PMPM for all assigned APM members. Payers can provide these payments as a single PMPM or in a manner that is better suited to their companies' process so long as ultimately the health center receives capitation that is equal to the PPS-equivalent PMPM.
- Health plans will receive a "supplemental wrap cap" by APM aid category for assigned pilot members in addition to their capitation rate from the state. The supplemental wrap cap will be an actuarially sound rate that accounts for the difference between the amount that health plans already receive for health center services in their capitated rates and the amount of the PPS-equivalent PMPMs for all APM participating pilot sites.
- Monthly, each plan will report to the state the number of Medicaid members assigned to the pilot sites, and will receive supplemental wrap cap payments for these members.

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<sup>11</sup> Ibid.

- The pilot establishes a risk corridor under which the state and health plans share limited profit or loss relative to the plans' wrap cap payments. Plans are responsible for costs/profits up to 0.5 percent of the supplemental wrap cap payment, the State and MCO share (in equal parts) costs/profits for the following 0.5 percent, and any costs/profits greater than one percent are borne fully by the state.
- Due to the payments being supplemental only for assigned pilot members and the small risk corridor helps to eliminate any financial incentive for MCOs to divert members to other providers.

A mechanism was established to help ensure participating health centers are incentivized to manage visits and costs, while allowing for flexibility in delivering quality care in an efficient manner. Rather than a traditional reconciliation process, the APM identifies utilization parameters that, if exceeded, trigger a rate adjustment.

- If traditional utilization (PPS visits) plus non-traditional services is determined to be less than 70% of the utilization used to determine the health center capitation rates, the health center may be required to pay back the health plan and state for the drop below 70%. To determine whether the health center will be required to pay back, DHCS, in consultation with the health plan, will review the health center's data to identify whether the utilization decrease was due to delivery system transformation and enhancements and if not, the health center will be required to refund the health plan the difference between the decrease in utilization and 70%
- The methodology for valuing non-traditional services is still under development.
- In an instance where a health center's traditional utilization is higher than the utilization projected during rate setting, a health center will receive additional payments. These rate adjustments shall be triggered only when utilization exceeds projections by more than 5 percent for the first year, 7.5 percent for the second year, and 10 percent for the third year. For differences below the trigger percentages in a given year, the health center is responsible for the costs of the increased utilization.

***Measures tracked:***

The state, the CPCA, and health centers are in the process of defining measures that will be tracked and quantified as part of the pilot. As of now:

- Only utilization of health center services (PPS visits) is used to determine the PMPM rate for pilot sites;
- Stakeholders (including the state, the CPCA, and health centers) are working to determine which non-traditional services may be counted and valued as part of a reconciliation process, should the triggers be reached, and for use in future rate setting;
- Quality, access, primary care utilization (both traditional and non-traditional services), broader health system utilization (e.g., emergency department visits) and customer satisfaction measures will all be used in evaluating the APM pilot; and
- Pilot sites will begin collecting data on non-traditional services in anticipation that future rate-setting will incorporate these factors as a way of accounting for the intensity and type of care and enabling services needed to achieve health outcomes for low-income populations served by health centers.

***APM authorization:***

- The APM pilot was authorized by Senate Bill 147, signed into law in 2015. This bill includes a fair amount of detail about the pilot program, including the duration, the aid categories to be included, the overall flow of the payments, and the thresholds detailed above. It also requires that an independent entity perform an evaluation of the APM pilot project.

- The state recognizes that it will need to submit a State Plan Amendment (SPA) as required by the Centers for Medicare & Medicaid Services (CMS). It is working with stakeholders to finalize additional details in preparation for SPA submission.

***Strategies to ensure APM is equal to what PPS would have been:***

- The rate setting process and annual rate adjustment process will ensure PPS equivalency, and will be triggered only when the thresholds described above are met.
- The ability to adjust rates based on scope changes and annual rate increases based on the MEI is preserved.
- The use of category of aid-specific PMPMs also provides risk protection from instances in which a pilot site's patient population mix changes substantively.
- Should a Medi-Cal patient that is not assigned to the pilot site visit and receive care, the health center may bill and receive the PPS rate for the non-assigned Medi-Cal patient.

***Timing of reconciliation process and wrap payments:***

- As described above, health centers will receive their entire PPS-equivalent revenue through the health plans. It is anticipated that this system will reduce payment delays associated with the current system of reconciliation. DHCS has agreed it will remain responsible for an annual reconciliation/rate adjustment process if triggered.

## **APM overview roll-out**

The California APM Pilot is targeted to begin in October 2017. There is no pre-established number of health centers that can participate in the pilot. Health center participation is voluntary, and health centers can choose to have one or more of their sites participate. However, the authorizing legislation permits the state to limit the number of participating health centers, and the number of counties in which the pilot operates.

The enabling legislation enumerates criteria for participation, and authorizes the use of additional criteria. The legislated criteria are that the health center:

- Has demonstrated ability to collect and submit encounter data in a form and manner that satisfies department requirements;
- Is in good standing with the relevant state and federal regulators; and
- Has the financial and administrative capacity to undertake payment reform.

The legislation also permits the state to consider the number of APM enrollees assigned by a plan at each health center site. At the health plans' request and initiation, the CPCA, along with other key partners and consultants, negotiated further detail for these criteria,<sup>12</sup> and shared them with the state. The criteria (described in Table 1) are under consideration by the state and have not been finalized.

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<sup>12</sup> FQHC Readiness Criteria, March 9, 2016. Shared by CPCA in May 2016.

**Table 1: Proposed Criteria for Participation**

Forty-five days of financial reserves at the organizational level
Demonstrated ability to adopt the APM based on most recent audited financial statement and other relevant external audits
Ability to transmit data to plans/Independent Practice Associations (IPAs) in agreed-upon electronic format
Demonstrated ability to measure and track “alternative encounters” once the pilot begins
Ability to meet the minimum performance level (25th percentile of national Medicaid) for all applicable Healthcare Effectiveness Data and Information Set (HEDIS) metrics required under Medi-Cal managed care
Ability to pass systems testing for any new data collection requirements
Demonstrated ability to collect and submit encounter data in a form and manner that satisfies the department requirements
Absence of an active corrective action plan from the MCO regarding encounter data submission, or ability to demonstrate progress if a plan exists
Good standing with the relevant state and federal regulators
Demonstrated compliance with the state’s Timely Access to Care regulations and other state/federal requirements during the pilot
Demonstrated capacity and commitment for transformation
Description of a strategy to move to the APM
The appropriate level of staffing as evidenced by documentation of the health center's care team model, including numbers of staff by type/function

If the health center is unable to meet one of the above criteria and can document how the limitation will not adversely impact its participation in the pilot, the California DHCS has the discretion to include the health center in the pilot.

## Results and Future Plans

As mentioned above, the enabling legislation requires that third-party evaluation of the pilot be conducted. The CPCA, health centers, and other stakeholders are conversing with the state about the conceptual focus and scope of the evaluation. There is a shared interest in including quality and other such measures in the evaluation.



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**National Association of Community Health Centers**

1400 I Street, NW, Suite 910

Washington, DC 20005

[www.nachc.org/states](http://www.nachc.org/states)

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**Prepared by John Snow, Inc.**

JSI contributors to this paper include Elena Thomas Faulkner, MA, Stacey Moody, MSW, and Morgan Anderson, MPA.

For more information about this publication, please contact:

Kersten Burns Lausch

Deputy Director, State Affairs

[klausch@nachc.org](mailto:klausch@nachc.org)

202.331.4606

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