PHM INITIATIVE

# California FQHC Revenue Streams

## Implications for PHMI

**Population Health Management Initiative (PHMI), a California collaboration of the Department of Health Care Services, Kaiser Permanente, and community health centers.**

# California FQHC Revenue Streams

- Fee-for-service Prospective Payment System (PPS)
- Proposed Capitation alternative payment model (APM)
- Enhanced Care Management (ECM) fees
- IPA sub-capitation for professional services and ambulatory diagnostics
- Pay-for-performance with Medicaid MCOs for quality HEDIS metrics
- 340B replacement program
- Section 330 and other federal funding
- County funding for care of medically uninsured (some regions)
- Kaiser Permanente funded Population Health Management Initiative (PHMI)
- Philanthropic funded projects

# FQHC Medicaid Payment for Direct Services

- The Medicaid FQHC PPS is a fixed, per-visit rate based on the historical costs of providing Medicaid services in fiscal years 1999 and 2000, inflated annually by the Medicare Economic Index (MEI).
- California FQHCs have unique PPS rates for different sites.
- PPS rates are inflated using MEI which lags the Consumer Price Index, especially in the last three years.

| From | To | U.S Annual Inflation Rate* | MEI | MEI vs. CPI |
|---|---|---|---|---|
| 2022 | 2023 | est 7.1% | 3.8% | |
| 2021 | 2022 | 7.9% | 2.1% | **-5.8%** |
| 2020 | 2021 | 4.7% | 1.7% | **-3.0%** |
| 2019 | 2020 | 1.2% | 1.9% | 0.7% |
| 2018 | 2019 | 1.8% | 1.5% | -0.3% |
| 2017 | 2018 | 2.4% | 1.2% | -1.2% |
| 2016 | 2017 | 2.1% | 1.4% | -0.7% |
| 2015 | 2016 | 1.3% | 1.1% | -0.2% |
| 2014 | 2015 | 0.1% | 0.8% | 0.7% |
| 2013 | 2014 | 1.6% | 0.8% | -0.8% |
| 2012 | 2013 | 1.5% | 0.8% | -0.7% |
| 2011 | 2012 | 2.1% | 0.6% | -1.5% |
| 2010 | 2011 | 3.2% | 0.4% | -2.8% |
| 2009 | 2010 | 1.6% | 1.2% | -0.4% |

# California FQHC Medicaid Change in Scope

- FQHCs have expanded services over time.
- Medicaid state plans must adjust the per-visit rate "to take into account any increase or decrease in the scope of such services furnished by the center."
- Each state has its own rules defining:
  - Process for determining if FQHC if there was a change in scope of services
  - How long a FQHC must provide those change in services before it may apply for change in scope
  - Medicaid cost report to calculate cost per visit
  - Inclusion of costs covered by another party as qualifying
  - The threshold for percent increase in their cost before qualifying as a significant change in cost and the allowed time span that cost increases may occur and still be counted in that change in scope
  - When the change in PPS rate goes into effect
- California Welfare and Institutions Code Section 14132.100(e)(2) defines a scope-of-service change as:
  - "The addition of a new FQHC/RHC service that is not incorporated in the baseline prospective payment system (PPS) rate."
  - "A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic."

# FQHC Alternative Payment Methodologies

**An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care.**

- The Biometric Information Privacy Act requires states to pay FQHC's using PPS methodology and to also offer an option to propose an alternative payment model (APM).
- An APM must:
- Pay participating health centers at least what they would have been paid under the PPS; and
- Be agreed to by the health center(s) receiving the APM; and
- Be approved by the State and CMS.
- An APM option gives states and FQHC's some (albeit limited) flexibility to adapt to state needs and preferences.
- Not all health centers in the state must participate and may opt-in and opt-out of the APM.
- Several types of APMs exist.

# California Proposed Capitated FQHC APM

$$\frac{\text{(Fee-for-service PPS derived revenue for included services for Medicaid MCO members in the Baseline Year)}}{\text{\# of assigned Medicaid Member Months in Baseline Year}} = \text{Per Member Per Month APM Rate*}$$

*__Note__ that the rate is inflated annually by MEI, not reset as practice redesign reduces “billable visits,” and quality component puts some of the incremental practice revenue at risk.

# California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM)

**ECM Populations of Focus**

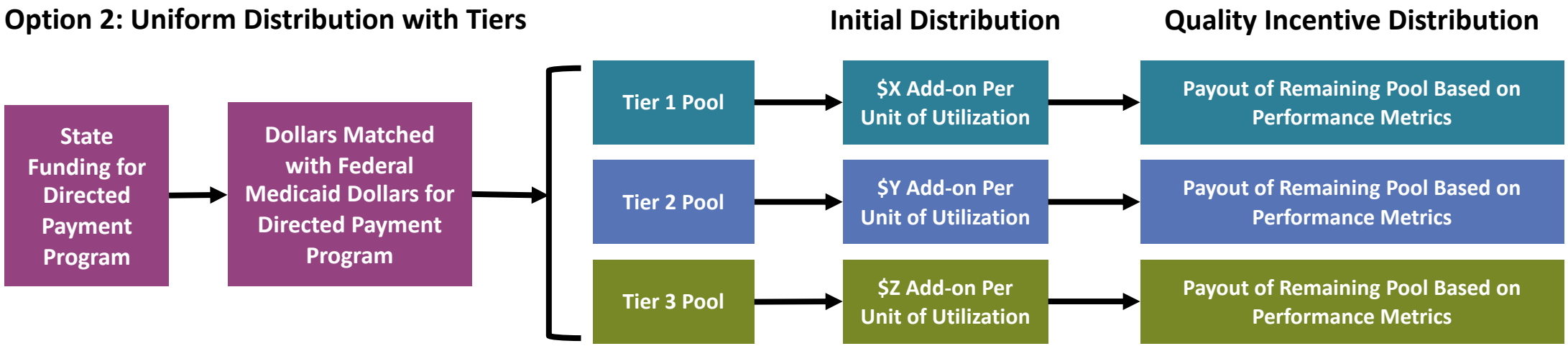
- Individuals and families experiencing homelessness
- Adults, youth, and children who are high utilizers of avoidable emergency department, hospital, or short-term skilled nursing facility services
- Adults with serious mental illness or substance use disorder
- Children and youth with serious emotional disturbance, identified to be at clinical high risk for psychosis or experiencing a first episode of psychosis
- Adults and youth who are incarcerated and transitioning to the community
- Adults at risk of institutionalization and eligible for long-term care
- Adult nursing facility residents transitioning to the community
- Children and youth enrolled in California Children's Services (CCS) with additional needs beyond CCS
- Children and youth involved in child welfare (including those with a history of involvement in welfare, and foster care up to age 26)

# Medicaid Managed Care Value-based Payment Opportunities

- FQHCs are often paid a primary care capitation from Medicaid MCOs with a wrap payment from Medi-Cal that equates to PPS equivalency. In effect, this is fee-for-service reimbursement.
- FQHCs often have a pay-for-performance program opportunity with Medicaid MCOs based on HEDIS quality metrics. Some programs also include hospital utilization metrics.
- FQHCs may participate in an independent practice association (IPA) that takes capitated risk for professional services and outpatient diagnostics.

# 340B Revenue Replacement Program for California FQHCs

- $105 million annual funding
- Currently paid as a fee-for-service add-on payment to PPS
- CPCA, FQHCs, and Medi-Cal are considering transitioning to a Directed Payment Program; some aspects are still under discussion such as whether to offer the same incentive to all FQHCs or adjust for FQHC size (Option 2).
- Approximately $7.50 per visit add-on payment
- Approximately 10% of the funding placed in an incentive fund
- Currently proposed metrics: blood pressure and diabetes control



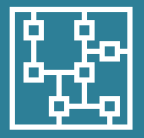
# FQHC Governmental Funding

- Each FQHC has its own unique Section 330 annual funding amount from HRSA. It is not directly proportional to the number of medically uninsured and underinsured visits.
- Under the Federal Public Health Emergency declared in early 2020, states agreed to put a hold on Medicaid eligibility redetermination in exchange for the Federal Government becoming financially responsible for a higher proportion of the cost of Medicaid. Medicaid disenrollment can be effective as early as June 1, 2023.
- FQHC ARPA funding must be spent by March 31, 2023. Some FQHC patients insured by Medicaid will become medically uninsured or transition to marketplace high deductible plans that will place them on the sliding fee scale for visits other than for preventive care.
- California is giving full scope Medi-Cal to adults 50 years of age or older and immigration status does not matter. All other Medi-Cal eligibility rules, including income limits still apply.
- Some FQHCs receive funding from County Government for the medically uninsured.

# Grant Funding for Participation in the PHMI

## Implementation Grants 2023 - 2025

Best-practice workflows and care team redesign supported by practice coaching, training, and tools/resources



## Technology Grants 2023 - 2025

PHM platform that will enhance care delivery through meaningful bidirectional data exchange and analytics to enable whole patient view and population level management

## Grants

Supports staffing for delivery model and technology implementation and training

# FQHC Medicaid Strategy

**Strategy for a California FQHC interested in adopting the capitated FQHC APM**

1. Outreach and engage assigned members into primary care and behavioral health services to build baseline PMPM rate.
2. Redesign model of care to trigger change in scope and to be ready to adopt to a capitated model that makes better use of the care team independent of whether it results in a “billable” visit but don’t turn it on until the CHC is ready to pivot to capitation.
3. Be careful in accepting third party revenue streams that would prevent practice transformation costs from being included in a cost report to determine the new PPS rate as a result of change in scope.
4. Reduce low value care costs for professional services and outpatient diagnostics versus primary focus on managing total cost of care.
5. Optimize quality pay-for-performance programs.

**Strategy for a California FQHC planning to stay with FFS PPS**

1. Outreach and engage assigned members into primary care and behavioral health services to build baseline PMPM rate.
2. Reduce low value care costs for professional services and outpatient diagnostics versus primary focus on managing total cost of care.
3. Optimize quality pay-for-performance programs.