

STATE OF CALIFORNIA  
**Budget Change Proposal - Cover Sheet**  
 DF-46 (REV 08/15)

Fiscal Year 2016-17	Business Unit 4260	Department Health Care Services	Priority No.
Budget Request Name 4260-025-BCP-DP-2016-GB		Program 3960010	Subprogram

Budget Request Description  
 Federal Qualified Health Centers Pilot (SB 147)

Budget Request Summary

The Department of Health Care Services (DHCS), Deputy Director's Office, requests three-year, limited-term expenditure authority of \$240,000, to support the implementation, administration, and evaluation of an alternative payment methodology (APM) pilot for select California Federally Qualified Health Centers (FQHCs), pursuant to the requirements of Chapter 760, Statutes of 2015 (SB 147).

Requires Legislation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Code Section(s) to be Added/Amended/Repealed	
Does this BCP contain information technology (IT) components? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If yes, departmental Chief Information Officer must sign.</i>	Department CIO	Date
For IT requests, specify the date a Special Project Report (SPR) or Feasibility Study Report (FSR) was approved by the Department of Technology, or previously by the Department of Finance. <input type="checkbox"/> FSR <input type="checkbox"/> SPR Project No. Date:		

If proposal affects another department, does other department concur with proposal?  Yes  No  
 Attach comments of affected department, signed and dated by the department director or designee.

Prepared By <i>Kyng Harrison</i>	Date 1/5/2016	Reviewed By <i>[Signature]</i>	Date 1/6/16
Department Director <i>[Signature]</i>	Date 1/6/16	Agency Secretary <i>[Signature]</i>	Date 1/7/16

**Department of Finance Use Only**

Additional Review:  Capital Outlay  ITCU  FSCU  OSAE  CALSTARS  Dept. of Technology

BCP Type:  Policy  Workload Budget per Government Code 13308.05

PPBA <i>[Signature]</i>	Date submitted to the Legislature 1-8-16
----------------------------	---

# BCP Fiscal Detail Sheet

BCP Title: Federal Qualified Health Centers Pilot (SB 147)

DP Name: 4260-025-BCP-DP-2016-GB

## Budget Request Summary

	FY16					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Salaries and Wages						
Earnings - Permanent	0	137	137	137	0	0
<b>Total Salaries and Wages</b>	<b>\$0</b>	<b>\$137</b>	<b>\$137</b>	<b>\$137</b>	<b>\$0</b>	<b>\$0</b>
Total Staff Benefits	0	66	66	66	0	0
<b>Total Personal Services</b>	<b>\$0</b>	<b>\$203</b>	<b>\$203</b>	<b>\$203</b>	<b>\$0</b>	<b>\$0</b>
Operating Expenses and Equipment						
5301 - General Expense	0	4	4	4	0	0
5302 - Printing	0	1	1	1	0	0
5304 - Communications	0	4	4	4	0	0
5320 - Travel: In-State	0	6	6	6	0	0
5322 - Training	0	2	2	2	0	0
5324 - Facilities Operation	0	18	18	18	0	0
5340 - Consulting and Professional Services - External	0	0	300	0	0	0
5344 - Consolidated Data Centers	0	2	2	2	0	0
<b>Total Operating Expenses and Equipment</b>	<b>\$0</b>	<b>\$37</b>	<b>\$337</b>	<b>\$37</b>	<b>\$0</b>	<b>\$0</b>
<b>Total Budget Request</b>	<b>\$0</b>	<b>\$240</b>	<b>\$540</b>	<b>\$240</b>	<b>\$0</b>	<b>\$0</b>

## Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	120	120	120	0	0
0890 - Federal Trust Fund	0	120	270	120	0	0
0995 - Reimbursements	0	0	150	0	0	0
<b>Total State Operations Expenditures</b>	<b>\$0</b>	<b>\$240</b>	<b>\$540</b>	<b>\$240</b>	<b>\$0</b>	<b>\$0</b>
<b>Total All Funds</b>	<b>\$0</b>	<b>\$240</b>	<b>\$540</b>	<b>\$240</b>	<b>\$0</b>	<b>\$0</b>

## Program Summary

Program Funding						
3960010 - Medical Care Services (Medi-Cal)	0	240	540	240	0	0
<b>Total All Programs</b>	<b>\$0</b>	<b>\$240</b>	<b>\$540</b>	<b>\$240</b>	<b>\$0</b>	<b>\$0</b>

**Personal Services Details**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
VR00 - Various (Eff. 07-01-2016)(LT 06-30-2019)	0	137	137	137	0	0
<b>Total Salaries and Wages</b>	<b>\$0</b>	<b>\$137</b>	<b>\$137</b>	<b>\$137</b>	<b>\$0</b>	<b>\$0</b>
<b>Staff Benefits</b>						
5150350 - Health Insurance	0	32	32	32	0	0
5150600 - Retirement - General	0	34	34	34	0	0
<b>Total Staff Benefits</b>	<b>\$0</b>	<b>\$66</b>	<b>\$66</b>	<b>\$66</b>	<b>\$0</b>	<b>\$0</b>
<b>Total Personal Services</b>	<b>\$0</b>	<b>\$203</b>	<b>\$203</b>	<b>\$203</b>	<b>\$0</b>	<b>\$0</b>

## Analysis of Problem

### A. Budget Request Summary

The Department of Health Care Services (DHCS), Deputy Director's Office, requests three-year, limited-term expenditure authority of \$240,000, to support the implementation, administration, and evaluation of an alternative payment methodology (APM) pilot for select California Federally Qualified Health Centers (FQHCs), pursuant to the requirements of Chapter 760, Statutes of 2015 (SB 147). One-time contract authority of \$300,000 is requested in FY 2017-18, to prepare an evaluation of the pilot. The contract will be funded 50 percent Federal Funds (FF) and 50 percent reimbursement from a foundation. FY 2016-17 expenditure authority requested: \$240,000 (50% General Fund (GF)/ 50% FF). FY 2017-18 expenditure authority requested: \$540,000 (\$120,000 GF/ \$270,000 FF/ \$150,000 reimbursement).

In recent years, FQHCs have been working to find new, more patient-centered and efficient ways to provide services, in order to meet the needs of a growing Medi-Cal patient population. There has been considerable interest across the health care delivery system to test payment and delivery reform that promotes value over volume and ultimately delivers better health outcomes for Medicaid beneficiaries. California is seeking this pilot to take steps toward delivery of high quality, cost effective care. The pilot would help FQHCs achieve the Triple Aim goals contained in the Affordable Care Act.

Currently, FQHCs are reimbursed through a federally mandated bundled prospective payment system (PPS) based on face-to-face visits with a limited number of health professionals. Under the pilot, the payor of FQHC services would transition from the state to Medi-Cal managed care plans. The pilot would assure clinics are reimbursed at no less than the PPS rate, as prescribed under federal regulations, while incenting delivery system and practice transformation at FQHCs through flexibilities available under a full capitation payment structure. The objective of the pilot is to transition the delivery of care at FQHCs from its current volume-based system to one that better aligns the financing and delivery of health care services.

This pilot, as well as the expenditures allocated to them, is based on an entirely new concept that has no existing DHCS resources assigned to it. By granting these resources, DHCS, will be able to perform the necessary monitoring, calculations, administration, and oversight of these new programs (and the populations affected by them) as outlined in the FQHC APM pilot.

### B. Background/History

In 1989, the U.S. Congress established FQHCs as a new provider type. FQHCs are public or tax-exempt entities which receive a direct grant from the federal government under Section 330 of the Public Health Service Act, or are determined by the federal Department of Health and Human Services to meet the requirements for receiving such grants. Federal law defines the services to be provided by FQHCs for Medicaid purposes and included special payment provisions to ensure that they would be reimbursed for 100% of their reasonable costs associated with furnishing these services. One of the legislative purposes in doing so was to ensure that federal grant funds are not used to subsidize health center or program services to Medicaid beneficiaries. State Medicaid programs must pay for covered services provided by FQHCs. There are over 820 FQHC locations (FQHCs may have more than one clinic location) in California.

**Analysis of Problem**

Federal Medicaid payments to FQHCs are governed by state (Medi-Cal in California) and federal law. In December 2000, Congress required states to change their FQHC payment methodology from a retrospective to PPS. This federal law change established (for existing FQHCs) a per-visit baseline payment rate equal to 100 percent of the center's average costs per visit incurred during 1999 and 2000 which were reasonable and related to the cost of furnishing such services. States are required to pay FQHCs a per-visit rate, which is equal to the baseline PPS payment rate, increased each year by the Medicare Economic Index (MEI), and adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC during that fiscal year. Under PPS, State Medicaid agencies are required to pay centers their PPS per-visit rate (or an APM, discussed below) for each face-to-face encounter between a Medicaid beneficiary and one of the FQHC's billable providers for a covered service.

For MCP patients, DHCS is required to reimburse an FQHC for the difference between its per-visit PPS rate and the payment made by the plan. This payment is known as a "wrap around" payment. The MCP wrap-around rate was established to comply with federal and state regulation to reimburse a provider for the difference between their PPS rate and their MCP reimbursement.

FQHCs and Rural Health Clinics (RHCs) are both reimbursed under the PPS system. The average (\$178.14) and median (\$157.24) PPS rate paid to an FQHC and RHC in 2014-15 is considerably higher than the most common primary care visit reimbursement rates in Medi-Cal, but it also includes additional services not included in a primary care visit. Because FQHCs are required to receive an MEI adjustment to their rates under federal law, and because of their role in providing primary care access to the Medi-Cal population, FQHCs have been exempted from the Medi-Cal rate reductions.

SB 147 calls for a pilot project using an APM where FQHCs would receive per-member per-month (PMPM) payments from the health plan, and would no longer receive a "wrap around" payment from DHCS. CMS has indicated a state may accept an FQHC's written assertion that the amount paid under the APM results in payment that at least equals the amount to which the FQHC is entitled under the PPS.

The proposed APM pilot project will comply with federal APM requirements and DHCS shall file a State Plan Amendment (SPA) and seek any federal approvals as necessary for the implementation of this article. The SPA will specify that DHCS and each participating FQHC voluntarily agrees to the APM.

**Resource History***(Dollars in thousands)***Deputy Director's Office**

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	1,188	1,188	1,789	1,926	1,985
Actual Expenditures	N/A	876	1,789	1,876	1,930
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	19.0	31.0	14.0	14.0	13.0
Filled Positions	9.7	5.4	13.7	9.9	13.0
Vacancies	9.3	25.6	0.3	4.1	0.0

Analysis of Problem

Workload History

Deputy Director's Office

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
N/A	N/A	N/A	N/A	N/A	N/A	N/A

C. State Level Considerations

It is not anticipated that any other state entities will be affected by the pilot. Support has been prevalent in the legislature as well as in plan, clinic, and public health system associations.

The primary objective of DHCS is to promote access to health care services for the uninsured and the medically under-served. As the single State agency responsible for the Medi-Cal program, DHCS is required to keep costs reasonable, maintain access to services for Medi-Cal recipients and deliver efficient health care.

FQHCs serve a significant amount of uninsured, as well as providing an ever increasing portion of outpatient services to Medi-Cal beneficiaries. In turn, Medicaid funding accounts for a large portion of these community clinics' operating revenue. The FQHC APM pilot is consistent with the Administration's goals of strengthening access to health care in California and providing members with the care they need. The pilot also targets all of the Department's three linked goals within its Quality Strategy:

- 1) Improve the health of all Californians;
- 2) Enhance quality, including the patient care experience, in all DHCS programs; and
- 3) Reduce the Department's per capita health care program costs.

D. Justification

Currently, FQHCs are reimbursed a per-visit rate or a prospective monthly capitation payment by health plans that are comparable to reimbursement for non-FQHC providers. The clinic then bills the state for a wrap-around payment and a final reconciliation is done to ensure payment is equivalent to PPS.

Under the FQHC APM pilot, health plans would make a monthly capitated payment per member assigned to the clinic. This clinic specific capitation payment per-member per-month (PMPM) would be calculated to be equivalent to the amount the clinic would have received under the visit-based PPS methodology.

The clinic specific PMPM capitation payment would be determined by utilizing visits data from historical years for members who are assigned to the clinic as the primary care provider, in the Categories of Aid (COA) selected for the pilot. This rate setting methodology, which establishes a PMPM for assigned members based on average annual visits, has precedence in its similarity to a methodology agreed upon between the plans and DHCS in establishing initial rates for Community-Based Adult Services (CBAS) centers. These clinic specific PMPM capitation rates would be set according to actuarial principles that are used to set Medi-Cal managed care rates, which means using historical base year data, and

## Analysis of Problem

applying appropriate trend rates and program changes, similar to how the FQHC component of the Medi-Cal managed care plan rates are set.

In accordance with SB 147 (Hernandez, 2015), the Department is mandated to apply for the pilot through a state plan amendment, oversee and administer the program over its 3-year (at minimum) life, and assist in conducting an evaluation. Throughout this process, DHCS and the lead division of the Deputy Director's Office will coordinate and work with health plans, clinics, stakeholders, associations, and consultants to ensure the success of the pilot. As of now, the Deputy Director's Office does not have the capacity to handle this workload.

To adequately oversee the pilot, the Deputy Director's Office of Health Care Financing requests three-year limited-term resources to assist in the implementation and administration of the APM pilot.

The workload supported by these resources will include:

- Drafting and filing the State Plan Amendment (SPA) and seek any federal approvals as necessary for the implementation of the APM pilot; draft and prepare any follow-up legislative documents related to the pilot.
- Establishing the APM pilot application and readiness process, prepare for deputy review, and send out application to potential clinic sites and plans.
- Reviewing FQHC site applications and readiness submissions and provide detailed analysis and determination of qualification for pilot.
- Participating in and prepare materials for APM pilot stakeholder workgroup meetings that concern but are not limited to policy, data, rate setting, alternative encounters, and contracting.
- Notifying viable FQHC sites and plans of candidacy and coordinate their acceptance into the program, as well as any associated administrative needs.
- Coordinating with pilot plans, clinics, and consultants to receive and assist in analyzing data for purposes of rate development and any other aspects of the APM pilot.
- Working with the Department's Capitated Rates Development Division and Health Care Financing section to prepare and submit rates to the Centers for Medicare and Medicaid Services (CMS); send notifications to plans and clinics of the rate when approved by CMS.
- Assisting in any APM pilot payment adjustments that may occur, as well as adjustments to the PPS rate for participating FQHCs, including changes resulting from a change in the MEI or any change in the FQHC's scope of services.
- Assisting in obtaining contracting for the evaluation of the pilot and conduct research on transitioning the FQHC APM methodology from a pilot to a statewide program.
- Providing and assisting in any other Department oversight and administration of the pilot as outlined in the SB 147 (2015, Hernandez).
- If needed, post information regarding the pilot on the DHCS website.

The request includes one-time funding of \$300,000 (\$150,000 reimbursement authority and \$150,000 Federal Funds) for an evaluation of the FQHC APM pilot. The evaluation will be funded by foundation funds; a foundation has already expressed an expectation in writing that they will continue to provide financial support to the state for this APM pilot project effort.

**Analysis of Problem**

The evaluation by the independent entity shall assess and report on 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 encounters between the participating FQHC and the patient and how those changes affected volume of same-day visits for mental and physical health conditions. 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 and services provided outside the FQHC. The evaluation shall also identify any administrative and financial implementation issues for FQHCs that may arise if subsequent legislation makes the pilot program operative statewide.

**E. Outcomes and Accountability**

The objective of the pilot is to transition the delivery of care at FQHCs from its current volume-based system to one that better aligns the financing and delivery of health care services. Projected outcomes of the supported workload would be timely SPA submission, implementation, and oversight of the program and create a pilot where FQHCs to find new, more patient-centered and efficient ways to provide services.

Specific projected outcomes are below:

**Projected Outcomes**

<b>Workload Measure</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>	<b>2020-21</b>
Draft and file the State Plan Amendment (SPA) and any follow-up legislative documents	5	5	5	0	0
Draft the APM pilot application and readiness process	2	2	2	0	0
Review FQHC site applications and readiness submissions	100	100	100	0	0
Participate in and prepare materials for APM pilot stakeholder workgroup meetings	50	50	50	0	0
Notify viable FQHC sites and plans of candidacy and coordinate their acceptance into the program	50	50	50	0	0
Analyze data for purposes of rate development	50	50	50	0	0
Submit rates to CMS	50	50	50	0	0
Assist in any APM pilot payment adjustments or PPS adjustments	15	15	15	0	0

**Analysis of Problem**

<b>Workload Measure</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>	<b>2020-21</b>
Obtain contracting for the evaluation of the pilot	0	0	1	0	0
Conduct research and provide proposals for transitioning the FQHC APM methodology from a pilot to a statewide program.	5	5	5	0	0

**F. Analysis of All Feasible Alternatives**

**Alternative 1:** Approve 3-year, limited term expenditure authority, including one-time contract authority, to complete/implement the FQHC APM pilot as outlined in SB 147. FY 2016-17 expenditure authority is \$240,000 (50% GF/ 50% FF). FY 2017-18 expenditure authority is \$540,000 (\$120,000 GF/ \$270,000 FF/ \$150,000 reimbursement) that includes an one-time contract to prepare an evaluation of the pilot. The \$300,000 one-time contract will be funded with \$150,000 federal funds and \$150,000 reimbursed from foundation funds.

**Pros:**

- SPA will be completed and submitted to CMS in a timely manner.
- Applications and notifications with pilot clinics and plans will be processed on schedule
- Comply with state legislation.
- Provides necessary oversight of payment reform pilot and increases probability that goals of program, including state savings and better health outcomes, are met.

**Cons:**

- Requires resources to fund salary and associated costs.

**Alternative 2:** Approve one (1.0) 2-year limited-term position.

**Pros:**

- Lower personnel costs to DHCS.

**Cons:**

- This approach does not ensure continuity of program operations and maintenance.
- May cause SPA or rates to be delayed, in effect delaying the entire pilot.
- Restricts Department's ability to oversee and administer program, reducing chance of pilot succeeding.

**Alternative 3:** Do not approve new State resources or expenditure authority.

**Pros:**

- No growth in state government and no long-term effect on the State General Fund.

**Cons:**

- Current workloads may be abandoned or delayed in order handle new APM workload.
- Puts entire implementation of pilot into jeopardy.
- Severely restricts Department's ability to oversee and administer the pilot program.

## Analysis of Problem

### G. Implementation Plan

Stakeholder workgroups for the APM pilot are currently being held by DHCS and will continue until early 2016. After the conclusion of the workgroups, the first round of invitations will go out to clinics to participate in the pilot. Applications for the clinics will be reviewed by DHCS; once the Department completes a review of the applications, those found in good standing will be selected and notified (along with their corresponding plan partner) of their ability to participate by June of 2016. The pilot clinics and plans will then submit data to be reviewed by DHCS and Mercer for the purposes of rate setting for the pilot. After Mercer calculates the rates during late 2016 / early 2017, the rates will be submitted to CMS and provided to participating clinics and plans. After the rates have been approved by CMS, the pilot will start the first day of the month following the month in which the department received federal approval. As of this current timeline, the first rollout of the pilot is expected to be as soon as April 1, 2017.

### H. Supplemental Information

***Total Contractual Services: \$300,000 (\$150,000 Reimbursement/\$150,000 FF)***

*Deputy Director's Office – \$300,000 (one-time effective July 1, 2017)*

The Deputy Director's Office requests \$300,000 (\$150,000 reimbursement and \$150,000 Federal Funds) for an evaluation of the FQHC APM pilot. The evaluation shall be completed and provided to the appropriate fiscal and policy committees of the Legislature within six months of the conclusion of the pilot project in those counties that are included in the initial pilot project implementation. The evaluation will be funded by foundation funds; a foundation has already expressed an expectation in writing that they will continue to provide financial support to the state for this APM pilot project effort.

### I. Recommendation: Alternative 1

Approve 3-year limited-term expenditure authority and one-time contract authority. The resources are necessary to implement the FQHC APM pilot and assist in the transformation of the health care delivery system and payment reform in order to help ensure the continued success and viability of the Medi-Cal program. These resources are critical to the timely and orderly implementation and administration of the pilot.

**WORKLOAD STANDARDS**

Director's Office

Office of the Deputy Director for Health Care Financing  
3-Year Limited-Term Expenditure Authority (7/1/16 – 6/30/19)

<b>Activities</b>	<b>Number of Items - Annual</b>	<b>Hours per Item</b>	<b>Total Hours</b>
Draft and file the SPA and seek any federal approvals as necessary for the implementation of the APM pilot; draft and prepare any follow-up legislative documents related to the pilot.	2	100	200
Establish the APM pilot application and readiness process, prepare for deputy review, and send out application to potential clinic sites and plans.	2	100	200
Review FQHC site applications and readiness submissions and provide detailed analysis and determination of qualification for pilot.	100	10	1000
Participate in and prepare materials for APM pilot stakeholder workgroup meetings that concern but are not limited to policy, data, rate setting, alternative encounters, and contracting.	50	5	250
Notify viable FQHC sites and plans of candidacy and coordinate their acceptance into the program, as well as any associated administrative needs.	50	10	500
Coordinate with pilot plans, clinics, and consultants to receive and assist in analyzing data for purposes of rate development and any other aspects of the APM pilot.	50	20	1000
Work with the Department's Capitated Rates Development Division and Health Care Financing section to prepare and submit rates to the CMS; send notifications to plans and clinics of the rate when approved by CMS.	50	5	250
Assist in any APM pilot payment adjustments that may occur, as well as adjustments to the PPS rate for participating FQHCs, including changes resulting from a change in the Medicare Economic Index or any change in the FQHC's scope of services.	15	10	150
Assist in obtaining contracting for the evaluation of the pilot and conduct research on transitioning the FQHC APM methodology from a pilot to a statewide program.	2	40	80
<b>Total hours worked</b>			<b>3,630</b>