WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 4.1. Federally Qualified Health Center Alternative Payment Model Project [14138.1 - 14138.23] *(Heading of Article 4.1 amended by Stats. 2022, Ch. 47, Sec. 104.)*

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

(a) “Alternative encounter” means an encounter provided by the participating FQHC that is approved by the department for the APM project, but that is not recognized as a billable visit as described in subdivision (g) of Section 14132.100. The department, in consultation with participating FQHCs, shall develop a list of approved alternative encounters for the APM project, which may be updated from time to time.

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

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

(1) Adults.

(2) Children.

(3) Seniors and persons with disabilities.

(4) The adult expansion population eligible pursuant to Section 14005.60.

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

(e) “APM project” means the project authorized by this article.

(f) “APM scope of services” means the scope of services for a participating FQHC for which it is entitled to receive a per-visit rate pursuant to Section 14132.100, but only to the extent those services are covered pursuant to the contract between the department and the applicable principal health plan.

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

(h) “Clinic-specific PMPM” means the monthly, per assigned member, capitated amount the principal health plan or subcontracting payer is required to pay to the participating FQHC for the APM scope of services. The clinic-specific PMPM is exclusive of any incentive payments and shall be developed to reflect the amount the participating FQHC would have received under the prospective payment system methodology set forth in Section 14132.100.

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

(j) “Member” means a Medi-Cal beneficiary who is enrolled with a principal health plan, including those beneficiaries delegated to a subcontracting payer.

(k) “Participating FQHC” means an FQHC participating in the APM project at one or more of the FQHC’s sites. “Participating FQHC” also refers to an FQHC’s site that is participating in the APM project.

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

(m) “Principal health plan” means a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, within a county in which the APM project is implemented.

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

(o) “Traditional encounter” means an encounter that is recognized as a billable visit, as described in subdivision (g) of Section 14132.100 or the approved Medi-Cal State Plan.

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

(Amended by Stats. 2022, Ch. 47, Sec. 105. (SB 184) Effective June 30, 2022.)

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

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

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

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

(d) Today, FQHCs face certain restrictions because the current payment structure reimburses an FQHC only when there is a traditional encounter with a provider. Current law prohibits payment for both a primary care visit and mental health visit on the same day.

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

(f) A reformed payment methodology will enable FQHCs to take advantage of alternative encounters. Alternative encounters, such as group visits and email consultations, are effective care delivery methods and contribute to a patient’s overall health and well-being.

(g) An alternative payment methodology for FQHCs, designed and implemented as permitted by federal law, should do all of the following:

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

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

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

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

(5) Promote timely, accurate, complete, and systemic reporting of alternative encounters at FQHCs.

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

(Repealed and added by Stats. 2022, Ch. 47, Sec. 107. (SB 184) Effective June 30, 2022.)

14138.12. (a) (1) The department shall authorize a payment reform project for FQHCs using an APM in accordance with this article.

(2) Implementation of the APM project shall begin no sooner than January 1, 2024, subject to any necessary federal approvals.

(3) Before implementation of an APM project for a participating FQHC site, the department shall notify the FQHC site in writing of the applicable draft clinic-specific PMPM rate(s) for the participating FQHC site. A participating FQHC, with respect to one or more

sites of its choosing, may opt to withdraw its participation in the project subject to a notice requirement as determined by the department, but not less than 120 days before implementation of an APM project.

(4) At least 90 days prior to implementation of an APM project for a participating FQHC site, the department shall notify a principal health plan in writing of the principal health plan's specific APM supplemental capitation rates for the participating FQHC. The notification from the department to the principal health plan shall be based on the rates submitted by the department for federal approval. If the APM supplemental capitation rates are modified after the notification to a principal health plan, the department shall notify a principal health plan of the revised rates.

(5) At least 90 days prior to implementation of an APM project for a participating FQHC site, the department shall notify a principal health plan and the FQHC site in writing of the clinic-specific PMPM rate for the participating FQHC site.

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

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

(Amended by Stats. 2022, Ch. 47, Sec. 109. (SB 184) Effective June 30, 2022.)

14138.13. (a) The department shall notify every FQHC in the state of the APM project and shall invite any interested FQHC to apply for participation in the APM with respect to one or more of the FQHC's sites. Consistent with federal law, the state plan amendment described in subdivision (b) of Section 14138.12 shall specify that the department and each participating FQHC voluntarily agrees to the APM.

(b) (1) The department shall develop, in consultation with interested FQHCs and principal health plans and consistent with federal law, the eligibility criteria to be used in evaluating applications from interested FQHCs for participation in the project, which shall include, but need not be limited to, the following:

(A) The FQHC has the demonstrated ability to collect and submit encounter data in a form and manner that satisfies department requirements.

(B) The FQHC is in good standing with the relevant state and federal regulators.

(C) The FQHC has the financial and administrative capacity to undertake payment reform.

(2) In addition to the criteria listed in paragraph (1), the department may take into consideration the number of APM enrollees assigned by a plan at each FQHC site as an eligibility requirement for FQHC participation.

(3) In accordance with the process and criteria developed pursuant to paragraphs (1) and (2), the department shall approve or deny an interested FQHC site application for participation in the project. The department, at its sole discretion, may limit the number of participating FQHCs in the project and the number of counties in which the project will operate.

(4) All principal health plans and applicable subcontracting payers are required to participate in the APM project pursuant to this article to the extent that one or more contracted FQHC sites located in the plan's county are selected to participate in the project.

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

(d) Payment to the participating FQHC shall continue to be governed by the provisions of Sections 14087.325 and 14132.100 for services provided with respect to a person who is a Medi-Cal beneficiary, but who is not a Medi-Cal beneficiary within a designated APM aid category.

(e) Payment to the participating FQHC for furnishing services within the scope of the APM to a Medi-Cal beneficiary within a designated APM aid category who is enrolled with a Medi-Cal managed care plan that is not contracted with the FQHC shall be at the per-visit rate determined pursuant to Section 14132.100.

(f) After implementation of an APM project, a participating FQHC, with respect to one or more sites of its choosing, may opt to discontinue its participation in the project subject to a notice requirement of no less than 180 days before the beginning of the next managed care rating period.

(Amended by Stats. 2022, Ch. 47, Sec. 110. (SB 184) Effective June 30, 2022.)

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

(b) A participating FQHC shall receive from the principal health plan or applicable subcontracting payer reimbursement for each APM enrollee in the form of a clinic-specific PMPM. The department shall determine the clinic-specific PMPM taking into account all the following factors:

(1) Historical utilization of applicable FQHC services in each APM aid category.

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

(3) The projected mix of assigned members across the APM aid categories.

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

(c) A participating FQHC and applicable principal health plan or subcontracting payer may enter into arrangements in which the clinic-specific PMPM amount required in subdivision (b) is paid in more than one capitated increment, as long as the total per-member capitation each month received by the participating FQHC is at least equal to the clinic-specific PMPM.

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

(e) The department shall adjust the amounts in subdivision (b) as necessary to account for any change to the prospective payment system rate for participating FQHCs, including changes resulting from a change in the Medicare Economic Index pursuant to subdivision (d) of Section 14132.100, any changes in the FQHC's scope of services pursuant to subdivision (e) of Section 14132.100, and changes in the projected mix of assigned members across APM aid categories.

(f) An FQHC site participating in the APM project shall not receive traditional wrap-around payments for visits within the APM scope of services it provides to its APM enrollees for any service period in which it participates in the APM project. A participating FQHC site shall not be entitled to make a reconciliation request pursuant to Section 14132.100 or 14087.325 in connection with visits within the APM scope of services provided to APM enrollees for any service period in which it participates in the APM project.

(g) A principal health plan or subcontracting payer shall not terminate a contract with a participating FQHC for the specific purpose of circumventing the payment obligations implemented pursuant to this section.

(h) FQHCs shall have the right to pursue any available remedy against Medi-Cal managed care plans or subcontracting payers, including judicial review, as appropriate in connection with the requirements of this section.

(Amended by Stats. 2022, Ch. 47, Sec. 111. (SB 184) Effective June 30, 2022.)

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

(b) For each principal health plan that contains at least one participating FQHC in its provider network, the department shall determine an APM supplemental capitation amount for each APM aid category to be paid by the department to the principal health plan, which shall be expressed as a PMPM amount. This supplemental capitation amount will be in addition to the funding for the APM scope of services already contained in the principal health plan's capitated rates paid by the department and shall be actuarially sound in accordance with Section 438.4 of Title 42 of the Code of Federal Regulations. The department shall determine the APM supplemental capitation amount for each APM aid category, taking into account all of the following factors:

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

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

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

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

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

(d) The department shall pay each principal health plan its applicable APM supplemental capitation amount for the number of APM enrollees for each APM aid category reported by the principal health plan pursuant to subdivision (c), and shall appropriately fund each principal health plan to pay the per-visit rate for unassigned Medi-Cal beneficiaries described in subdivision (e) of Section 14138.13.

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

(f) The department shall adjust the amounts in subdivision (b) as necessary to account for any change to the prospective payment system rate for participating FQHCs, including changes resulting from a change in the Medicare Economic Index pursuant to subdivision (d) of Section 14132.100, any changes in the FQHC's scope of services pursuant to subdivision (e) of Section 14132.100, and changes in the projected mix of assigned members across applicable APM aid categories.

(Amended by Stats. 2022, Ch. 47, Sec. 112. (SB 184) Effective June 30, 2022.)

14138.16. (a) For the duration of the APM project, the department shall establish a risk corridor structure for the principal health plans relating only to the APM supplemental capitation payments pursuant to Section 14138.15, to the extent consistent with principles of actuarial soundness and in accordance with Section 438.6(b)(1) of Title 42 of the Code of Federal Regulations.

(b) The risk sharing of the costs under this section shall be constructed by the department with input from affected stakeholders so that it is symmetrical with respect to risk and profit. The department shall develop and specify the terms of the risk corridor in a form and manner specified by the department through all-plan letters or other technical guidance that shall be deemed incorporated into the contracts between each affected principal health plan and the department.

(Amended by Stats. 2022, Ch. 47, Sec. 113. (SB 184) Effective June 30, 2022.)

14138.17. (a) In order to ensure participating FQHCs have an incentive to manage visits and costs, while at the same time exercising a reasonable amount of flexibility to deliver care in the most efficient and quality driven manner, for the duration of the APM project the department shall, in accordance with this subdivision, establish a payment adjustment structure. The payment adjustment structure shall be developed with stakeholder input and shall meet the requirements of Section 1396a(bb)(6) of Title 42 of the United States Code and Part 438 (commencing with Section 438.1) of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations.

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

(c) The payment adjustment structure shall permit an aggregate adjustment to the payments received when actual utilization of services for a participating FQHC's site exceeds or falls below expectations that were reflected within the calculation of the rates developed pursuant to Sections 14138.14 and 14138.15. For purposes of this payment adjustment structure, both actual and expected utilization shall be expressed as the total number of traditional encounters that would be recognized pursuant to subdivision (h) of Section 14132.100 for the APM enrollees of the participating FQHC's site across all APM aid categories and averaged on a per member per year basis.

(d) An adjustment pursuant to this section shall occur no more than once per year per participating FQHC's site during the APM project, and shall be requested within 90 days of the close of the rating period, except when additional time is permitted by the department. All adjustments shall be subject to approval by the department.

(1) An adjustment to payments in the case of higher than expected utilization shall be triggered when utilization exceeds projections in any year. If an adjustment is required in a given year, the participating FQHC site shall receive an aggregate payment adjustment from the principal health plan or applicable subcontracting payer that is based upon the difference between its actual utilization for the year and the projected utilization for the year. The payment adjustment in each instance shall be calculated as follows:

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

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

(C) The amount in subparagraph (B) shall be subtracted from the amount in subparagraph (A).

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

(2) To incentivize care delivery in ways that may vary from traditional delivery of care, participating FQHCs shall have the flexibility to experience a lower than expected visit utilization of up to 30 percent of projected utilization. The department shall develop, with input from affected stakeholders, objective criteria to ensure minimum standards for access and quality. If an FQHC site does not meet those established quality and access standards, the participating FQHC shall be required to return a portion of PMPM revenue based on a formula developed by the department with input from affected stakeholders. A participating FQHC shall not receive revenue lower than the amount calculated as follows:

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

(B) The amount in subparagraph (A) shall be multiplied by the per-visit rate that was determined pursuant to Section 14132.100 for the participating FQHC site yielding the payment adjustment for the participating FQHC site.

(e) Any adjustment made pursuant to this section may only be requested by a principal health plan, subcontracting payer, participating FQHC, or the department.

(Amended by Stats. 2022, Ch. 47, Sec. 114. (SB 184) Effective June 30, 2022.)

14138.18. (a) This article shall be implemented only to the extent that any necessary federal approvals have been obtained and federal financial participation is available and not otherwise jeopardized.

(b) (1) The department may modify any methodology or other provision specified in this article to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, if the modification does not violate the spirit, purposes, and intent of this article.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with interested FQHCs and principal health plans to the extent practicable.

(3) In the event of a modification made pursuant to this subdivision, the department shall notify affected FQHCs, principal health plans, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of the modification.

(Repealed and added by Stats. 2022, Ch. 47, Sec. 116. (SB 184) Effective June 30, 2022.)

14138.21. This article shall not be deemed to affect the amounts paid or the reimbursement methodology applicable to FQHCs for dental services and for services that are provided outside the scope of a contract between the department and an applicable principal health plan that is in effect as of January 1, 2024, or for any other amounts for which the FQHC may be eligible outside of the prospective payment rate, including, but not limited to, incentives or supplemental payments.

(Repealed and added by Stats. 2022, Ch. 47, Sec. 119. (SB 184) Effective June 30, 2022.)

14138.22. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

(Repealed and added by Stats. 2022, Ch. 47, Sec. 121. (SB 184) Effective June 30, 2022.)

14138.23. For purposes of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including, but not limited to, contracts for the purpose of obtaining subject matter expertise or other technical assistance. Any contract entered into or amended pursuant to this section shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(Amended by Stats. 2022, Ch. 47, Sec. 122. (SB 184) Effective June 30, 2022.)