

- **May FQHCs participate in incentive programs, and exclude incentive payments from their reconciliation?**

State and federal law clearly allows that FQHCs can participate in these programs and exclude incentive payments from their PPS Managed Care annual reconciliation. Many FQHCs participate in a wide variety of P4P quality incentive programs.

- **What are the relevant sections of state and federal law?**

Federal: 42 CFR §405.2469(a)(2) states that “Any financial incentives provided to Federally Qualified Health Centers under their Medicare Advantage Contracts, such as risk pool payments, bonuses, or withholds, are prohibited from being included in the calculation of supplemental payments due to the Federally Qualified Health Center.” This has also been applied to Medi-Cal in California.

Federal: A State Medicaid Directors Letter from September 27, 2000 states that “MCOs frequently use their own funds to include financial incentives in their contracts with subcontracting providers. Financial incentives provide the subcontractor with an incentive to reduce unnecessary utilization of services or otherwise reduce patient costs. Such incentives may be negative, such as withholding a portion of the capitation payments. If utilization goals are not satisfied, the subcontractor forgoes the withhold amount in whole or part. Incentives may also be positive, such as a bonus that is paid if desired utilization outcomes are achieved....”

State: Welfare and Institutions Code 14132.100(h) says that “if FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity...the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract by contract basis and not in the aggregate, and may not include managed care incentive payments that are required by federal law to be excluded from the calculation.”

- **What is the San Mateo P4P case?**

The Department of Health Care Services (DHCS) has proposed to reconcile out the San Mateo FQHC’s total incentive payments. The FQHC appealed and the case is pending before the Sacramento Superior Court.

The issue in the case was whether the P4P incentive payments received by the FQHC from their managed care plan met the definition of ‘financial incentives’ that are required by federal law to be excluded from reconciliation. The Chief Administrative Law Judge (ALJ) disagreed with the ALJ who presided over the hearing, by finding that many of the payments made to the FQHC in San Mateo were linked to “*single instances of preventative services being provided or associated activities being performed,*” and, under the ALJ’s interpretation, this did not meet the guidelines set down in the September, 2000 Medicaid Directors letter, which states that “MCOs frequently use their own funds to include financial incentives in their own contracts with subcontracting providers” ... in order to impact “*utilization or other goals set by the MCO.*”

Based on the initial findings from the case, it’s appears that DHCS believes there is some ambiguity in the law that has led to disagreement in interpretation around what constitutes an “incentive” that may be excluded from the FQHC reconciliation.

- **How does the San Mateo case relate to my incentive arrangements?**

The San Mateo case is still being appealed, with a hearing set for April 6, 2018.

No matter the ruling in the case, however, it is not precedent setting for all FQHCs, although if DHCS prevails, it may apply the findings to other FQHCs. It does shed light on ambiguities in the law.

- **Given purported ambiguities in the law, is there a way to be sure that my incentive programs are 'safe' to exclude from reconciliation?**

FQHCs are operating under broad federal policy relating to FQHC participation in incentive programs, but do not have detailed state guidance on how to define those incentive payments that are excluded from annual reconciliation reports. Below are some 'best practices' that we believe will create the 'safest' possible incentive program for FQHCs to participate in, without fear of inclusion in reconciliation. These best practices include:

- Incentive payments should be completely separate from payments for services (cap or FFS)
- The FQHC and health plan should maintain clear documentation of P4P programs and payments
- Payments should be "at risk" – that is, an FQHC should not receive the payment unless they meet a performance target
- Incentives should be based on performance measured against a benchmark and reward improvement or meeting a performance standard
- Incentive payments should be independent of providing any individual unit of service that generates a PPS payment
- These best practices apply whether the incentives come from the managed care plan or an IPA

- **What are my next steps?**

If you have a current Incentive program in place with your managed care plan (or IPA) you should review these potential best practices with your plan partners to ensure your program falls within the purview of the guidelines.

If you do not currently have an Incentive program or partnership with your managed care plan (or IPA) you should bring these potential 'best practices' to your plan/IPA partners and discuss how to ensure any developed incentive programs are built for FQHCs.

- **Are there examples of incentive measures that I can use to facilitate discussion with my plans/IPAs?**

The Integrated Healthcare Association (IHA) is working with health plans, providers, and other stakeholders to a common measure set for all Medi-Cal Pay for Performance programs. Over time, we hope to see the whole Medi-Cal industry move toward adopting this standardized measure set. The IHA measure set meets all of the FQHC incentive 'best practices' listed above. When discussing this issue with plans, and health center may want to consider encouraging the plan to adopt the IHA measure set as an easy solution that also brings the industry closer to standardization.

- **I have additional questions, who can I speak with?**

Please contact Meaghan McCamman from CPCA at mmccamman@cpca.org

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