# Federally Qualified Health Center Advanced Primary Care Practice Demonstration

## Demonstration Details

DESIGN

1. What is the authority to conduct the demonstration?

   This Demonstration will be conducted in accordance with the Secretary's demonstration authority under section 1115A of The Social Security Act, which was added by section 3021 of the Patient Protection and Affordable Care Act and establishes the Center for Medicare and Medicaid Innovation (CMMI). The Act states that "The CMMI shall test payment and service delivery models … to determine the effect of applying such models under the applicable title … on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title." The statute defines "The term „applicable title" means title XVIII, title, XIX, or both.

2. What is the purpose of the demonstration?

   The demonstration is intended to determine the impact of providing financial and technical resources to Federally Qualified Health Centers (FQHCs) to make the transition into an advanced primary care practice, also known as a patient-centered medical home (PCMH). CMS is interested in determining what factors and resources would be required for FQHCs to develop the capability to become PCMHs and, thus, achieve the goals of better health for the population, better care for individuals, and lower costs.

3. How long will the demonstration last?

   This will be a 3 year demonstration beginning November 1, 2011, and continuing through October 31, 2014.

4. Where will the demonstration be conducted?

   FQHCs from across the country can participate in the demonstration provided they meet all eligibility criteria and agree to all the demonstration terms and conditions.

5. How many FQHCs can participate?

   CMS will accept up to 500 FQHCs into the demonstration.

6. What are the eligibility criteria for FQHCs?

   To participate, an FQHC must be an individual (brick and mortar) site identified by a specific Provider Transaction Access Number (PTAN) issued by CMS. In addition, the FQHC must have provided medical services to at least 200 unique, qualified Medicare beneficiaries in a previous 12-month period as determined by Medicare administrative claims data. FQHCs that provide only specialty services, such as vision or dental and those that provide medical services only to the migrant or homeless populations will not

be able to participate in the demonstration. FQHCs must agree to all demonstration Terms and Conditions and must not be under a corrective action plan for serious financial or safety issues according to the Health Resources Services Administration (HRSA).

7. Are FQHC look-alikes eligible to participate?

   Yes, all FQHCs, regardless of whether they receive grant funding under Section 330 of the Public Health Act, are eligible to apply for the demonstration, assuming they meet all the eligibility requirements. Thus, FQHC look-alikes are eligible to apply.

8. Can a group of FQHCs that are part of a larger community health center grant participate?

   No. The demonstration will only accept application from individual (brick and mortar) FQHC sites. However, individual sites that are part of larger CHC grants may apply individually as long as they meet all other eligibility criteria.

9. Can an FQHC participate in this demonstration and in other CMS demonstrations such as the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration?

   Generally speaking, FQHCs may not be receiving payments for providing the same services to a beneficiary from more than one demonstration simultaneously. In the case of the MAPCP demonstration FQHCs would have to choose which of the two demonstrations they wish to participate in. They will not be able to switch demonstrations later and will not be reimbursed by both demonstrations. Other CMS demonstration projects have different participation requirements. Therefore, it is prudent to check participation restrictions for each demonstration opportunity for which you are interested.

10. Why is participation limited to FQHCs who served 200 or more unique, qualified fee for service Medicare beneficiaries?

    CMS is interested in determining what factors and resources would be required for FQHCs to develop the capability to become PCMHs. We determined that those FQHCs serving fewer than 200 unique, qualified fee for service Medicare beneficiaries would not be able to provide enough information for making these determinations.

11. What are the demonstration Terms and Conditions?

    - The FQHC agrees to pursue Level 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) by the end of the Demonstration.
    - The FQHC agrees to remain in the Demonstration for the 3-year duration beginning November 1, 2011.
    - The FQHC agrees to submit an application to participate in the demonstration no later than 11:59pm on Friday, September 9, 2011, and an initial Patient Centered Medical Home (PCMH) readiness assessment as part of the application process by no later than 11:59pm (ET) on Friday, September 16, 2011.

- The FQHC agrees to submit an updated readiness assessment every 6 months for the duration of the Demonstration.
- The FQHC agrees to cooperate with the organization CMS engages to evaluate the Demonstration. This may include providing additional information or data.
- The FQHC agrees to comply with all monitoring requirements. This includes updating the readiness assessment every 6 months throughout the Demonstration.
- The FQHC must attest that it is not currently under a corrective action plan from HRSA for serious safety or financial issues.
- The FQHC acknowledges that CMS can terminate participation in the Demonstration for failure to progress toward PCMH recognition based on periodic readiness assessment scores.
- The FQHC acknowledges that CMS can terminate participation in the Demonstration by any FQHC that has committed Medicare fraud.
- By applying to participate the FQHC agrees to participate in learning cooperatives and other technical assistance that is offered by CMS and HRSA.
- The FQHC acknowledges that failure to comply with all terms and conditions may result in disqualification from the Demonstration.
- These terms and conditions are subject to change in the interest of improving results under the demonstration. Such changes would require the consent/approval of both parties and at least 30 days advance notice to facilitate their implementation.

12. What are participating FQHCs expected to do in the demonstration?

    Participating FQHCs are expected to become a recognized Level 3 Patient-Centered Medical Home as determined by meeting NCQA 2011 standards by the end of the demonstration in October 2014. This means that participating FQHCs will make whatever practice changes and/or improvements necessary to document, to the satisfaction of the NCQA 2011 PCMH standards, that the FQHC is capable of providing comprehensive, coordinated, patient-centered primary care as would be the case in any patient-centered medical home. CMS expects participating FQHCs to channel the care management fees received from the demonstration into the transformation of the practice to offset any additional costs associated with becoming a recognized PCMH medical home. CMS further expects that participating FQHCs will actively participate in the technical assistance that is offered to assist in the transformation, comply with the requirement to update the PCMH readiness assessment every 6 months to determine progress, and to cooperate with the CMS evaluation contractor to provide additional data and information as will be needed to measure the results of the demonstration.

13. What is the Care Management Fee?

    The Care Management Fee is a fee paid to each participating FQHC prospectively on a quarterly basis for each eligible Medicare beneficiary that is attributed by CMS to the FQHC. CMS uses administrative claims data to identify Medicare beneficiaries that have received medical services from an FQHC within the previous 12 month period (look-back period). A fee of $18 per beneficiary per quarter ($6 per beneficiary per month) will be paid electronically to the FQHC directly without the need to submit a claim. The care

management fee is in addition to and exclusive of the usual all inclusive payment that is paid to FQHCs for covered services through claims submission. However, care management fees should not be included in annual cost reporting or be used to calculate all inclusive payment amounts.

14. Will quarterly fee payments be adjusted for any disenrollment that occurs during the quarter?

    No. Adjustments will only be made quarterly for any disenrollment identified during the quarterly eligibility review. Fee payments will not be adjusted retroactively.

15. How are Medicare beneficiaries "attributed" for payment purposes?

    CMS uses administrative claims data to identify beneficiaries that have received medical services from a participating FQHC. Claims data is examined to identify Medicare beneficiaries that are covered by Medicare Part A and fee-for-service Part B, are not participating in a Medicare Advantage (MA) plan, are not currently in hospice care, and are not being treated for end stage renal disease (ESRD). Beneficiaries are attributed to the FQHC from which they have received the plurality of their care within the previous 12 month (look-back) period. In cases where a beneficiary has visited more than one FQHC equally the one with the most recent visit will be assigned the beneficiary. A roster of attributed beneficiaries will be provided to participating FQHCs along with quarterly payments.

    Beneficiary eligibility may change over the course of the demonstration for many reasons (death, change in coverage, etc.). Therefore, beneficiary eligibility will be verified each quarter prior to payment being made and attribution rosters will be adjusted accordingly. A new beneficiary roster will be sent quarterly along with an explanation of changes in roster status.

    Participating FQHCs will not be permitted to challenge attribution.

16. Can a disqualified beneficiary whose status changes later in the demonstration (i.e. leaves Medicare Advantage for fee for service) be re-attributed?

    Yes. If a beneficiary appears eligible during a quarterly eligibility review they can be attributed to the FQHC that has provided the most services or was visited by the beneficiary most recently.

17. What will happen if an FQHC's beneficiary population falls below 200?

    If the beneficiary population falls below 200 in a participating FQHC it will not result in disqualification of the FQHC. Patient panels will fluctuate from quarter to quarter so the population may increase in subsequent months.

APPLICATION

18. How can an interested FQHC apply to participate?

    Eligible FQHCs will be identified through Medicare administrative claims data. Those that meet initial eligibility criteria (served at least 200 unique, qualified Medicare beneficiaries in previous 12 months, not specialty FQHCs, not exclusively migrant or homeless FQHCs) will be sent a letter inviting them to participate. They will be directed to the demonstration application web site where they will have access to all of the necessary information for making an informed decision and submitting an application to participate. The application period will be open from June 6, 2011 through September 9, 2011. Also, all initial readiness assessments must be submitted by September 16, 2011 for an application to be considered complete. Applications or readiness assessments will not be accepted after this time unless CMS decides to extend the submission period.

19. What is required to apply?

    The application is web-based and has multiple sections. An applicant must complete all application questions and agree to all Terms and Conditions. Once this is completed the applicant will be directed to complete the baseline readiness assessment. The application process will generate a user ID and password to access the readiness assessment which will be sent to the applicant's E-Mail address only after all application questions have been answered. With access to the readiness assessment the applicant can answer the survey questions and submit. This will complete the application process.

20. How will FQHCs be selected to participate?

    In the event that more than 500 FQHCs apply to participate a selection methodology will be used to identify participants.

    It will be important for CMS to create a balanced distribution of FQHCs to obtain the most meaningful results from the demonstration. Therefore, FQHCs will be selected to participate based on several parameters including geographic location/region/State, urban vs. rural, practice size, electronic health record, readiness assessment score, and current recognition status. These parameters are not exclusionary. CMS is interested in have a balance of FQHCs that are large and small, urban and rural, with and without EHR, various readiness levels, and with and without formal recognition or PCMH accreditation.

21. How will I know if I am selected to participate?

    All applicants will be notified by mail as to the disposition of their application by October 10, 2011.

MONITORING

22. How will CMS monitor FQHC progress in meeting demonstration goals?

    CMS will monitor each participating FQHC's transformation progress by comparing readiness assessment scores at baseline with readiness assessment scores updated every 6 months. In addition, CMS will conduct random site audits to assure that assessment responses are accurate and true.

23. What will happen if FQHCs are not progressing?

    Each participating FQHC has agreed to pursue Level 3 PCMH recognition. If noticeable progress is not being made CMS will analyze the circumstances and recommend the FQHC use additional technical assistance resources to overcome barriers. If no progress is being made CMS may disqualify the FQHC for failure to comply with all terms and conditions as stated in the Terms and conditions.

TECHNICAL ASSISTANCE

24. Is technical assistance available for participating FQHCs?

    CMS and HRSA will make technical assistance available to participating FQHCs to support their transformation and achieve NCQA recognition as a PCMH at no cost to participating FQHCs.

    HRSA has developed a series of technical assistance and training resources that highlight successful strategies for obtaining and maintaining PCMH recognition status. These training opportunities include educational and training sessions, and Webinars focusing on understanding NCQA standards, and mock surveys to gain experience with the NCQA PCMH recognition process and documentation requirements. In addition, CMS is developing transformational learning systems to assist participating FQHCs to successfully transform their practice into a recognized patient-centered medical home.

25. Is other technical assistance for helping FQHCs through the transformation process available?

    CMS is in the process of developing a learning system specifically for assisting FHQCs through the process of PCMH transformation. The learning system is expected to be available sometime in 2012, and will focus on teaching practices how to transform their current practice culture to one that supports a patient-centered, coordinated health care model such as the patient-centered medical home.

EVALUATION

26. What measures will CMS use to evaluate the impact of the demonstration?

CMS will evaluate the results of the Demonstration by analyzing practice change over time. A baseline status will be established using a supplemental survey questionnaire which is administered as part of the application process and initial Readiness Assessment responses. Changes in Readiness Re-Assessments every 6 months and changes in practice characteristics from baseline will constitute evaluation measurements over time.