


 The logo features two overlapping circles: an orange one on the left and a teal one on the right. The text "Medi-Cal" is in white inside the orange circle, "Explained" is in white inside the teal circle, and "FACT SHEET" is in a large, blue, sans-serif font to the right of the circles.

Medi-Cal Explained FACT SHEET

Medi-Cal Explained: How Health Centers Are Paid

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Introduction

COMMUNITY HEALTH CENTERS and Federally Qualified Health Centers in California are an integral part of the delivery system and provide access to care for millions in vulnerable populations. This system is often referred to as the “safety net.” Federally Qualified Health Centers (FQHCs) are paid for the care they provide to Medi-Cal enrollees through a complicated structure governed by state and federal law. This issue brief examines existing community health centers (CHCs) and FQHC payment methods in Medi-Cal. It also examines the role of Alternative Payment Models (APMs) — financial incentives for the provision of high-quality and/or cost-efficient care — as one strategy health centers could use to increase access, improve care, and help modernize the payment system for FQHCs.

Overview of FQHCs/CHCs in California

Community health centers is a broad term that refers to community-based health care organizations that deliver comprehensive and culturally competent primary and preventive care services to California’s medically underserved populations without regard to a patient’s ability to pay for care. CHCs include FQHCs, FQHC Look-Alikes, rural health centers, free clinics, community clinics, and other health centers that serve special patient populations, such as people experiencing homelessness, and migratory and seasonal agricultural

workers.¹ Additionally, in California, FQHCs can also be part of a public hospital system network.

FQHCs are a specific type of CHC. They are public or tax-exempt entities that must meet certain federal requirements to receive grant funding under Section 330 of the Public Health Service Act. These requirements include serving in a designated medically underserved area, or a medically underserved population, providing services regardless of a patient’s ability to pay (i.e., a sliding fee scale), and operating under the governance of a patient-majority board of directors.

CHCs serve an ethnically and culturally diverse patient population with a range of physical, behavioral, and oral health needs in both urban and rural settings. CHCs often customize their services to fit the priorities of their communities and increasingly focus on assessing nonmedical needs and addressing social determinants of health to improve the overall health of patients. CHCs serve patients across the state of California with sites in 54 out of 58 counties.² As of 2020 data, there are more than 1,200 licensed CHCs including FQHC and FQHC Look-Alikes across California serving over seven million patients.³ FQHCs in particular

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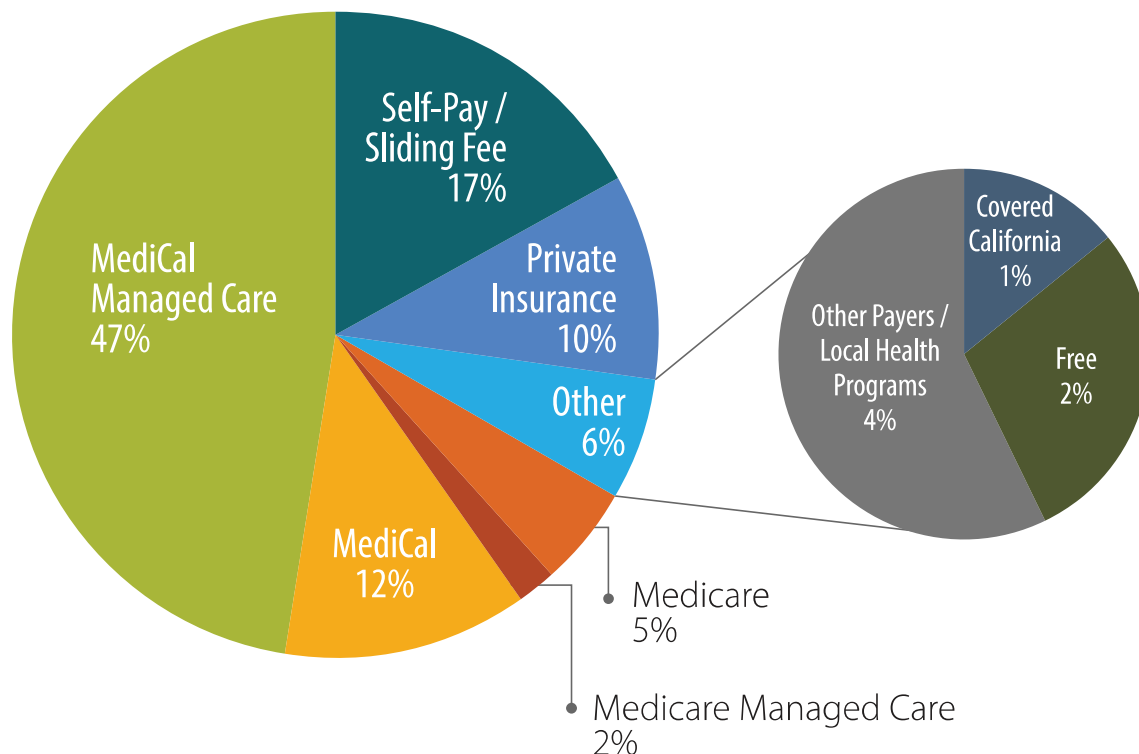
have experienced significant increases in size and number since implementation of the federal Affordable Care Act (ACA) in 2014. FQHC clinic sites have increased steadily to accommodate the increased patient load, with some regions tripling the number of patient visits during the initial implementation of the ACA.⁴ Payer mix has remained consistent since adjusting immediately following the ACA as insurance expansion increased enrollment in Medi-Cal and reduced the number of uninsured patients. Medi-Cal continues to be the largest payer for CHCs, with approximately 47% of all CHC patients enrolled in the Medi-Cal managed care system (see Figure 1).⁵

Aligned with CHCs’ mission to serve the most vulnerable populations in California, over half of their

patients have incomes that fall below the federal poverty line.⁶ The majority of CHC patients identify as Latino/x (54%)⁷ and approximately a third have a limited English proficiency.⁸ CHCs are a crucial component of California’s safety net and often serve as the entry point into the health care system for their patients and as a connection to local social services and supports needed to improving patient experience, access, and outcomes.

This issue brief focuses specifically on efforts related to APM models for FQHCs and FQHC Look-Alikes that receive prospective payment system (PPS) reimbursement for serving Medi-Cal patients. PPS is a payment method in which a predetermined fixed amount is paid to a clinic for the services provided during a patient visit and is described

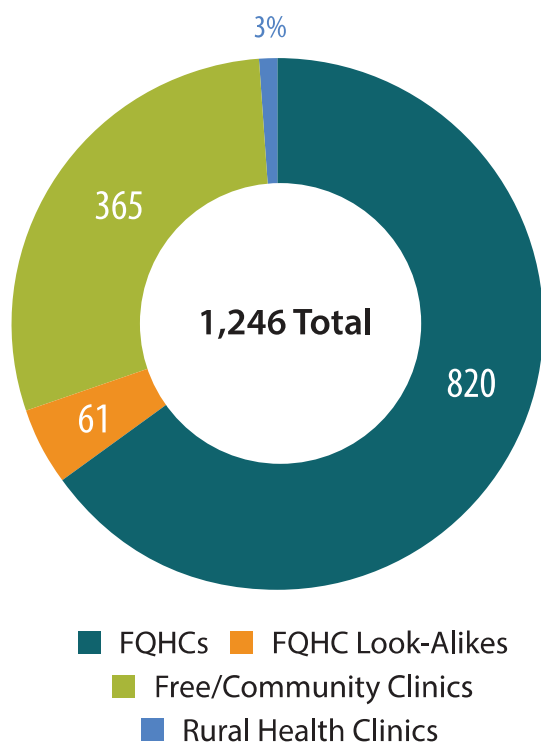
Figure 1. Community Health Centers by Patient Coverage in California, 2020



Source: “Primary Care Clinic Annual Utilization Data” (2020), Dept. of Health Care Access and Information.

in more detail below. However, the remaining community clinics also represent opportunities for exploring innovative reimbursement strategies, as they total approximately a third of all health centers in California (see Figure 2). Even if these health centers are not federally qualified providers and are not eligible to receive PPS reimbursement, they also provide care to a proportion of Medi-Cal patients. While Rural Health Clinics do receive the PPS payment, they are not a focus of this brief.

Figure 2. Community Health Centers by Category, 2020*



Source: "Primary Care Clinic Annual Utilization Data" (2020), Dept. of Health Care Access and Information.

* There were 82 community health centers that did not submit a 2020 report to HCAI

FQHCs across the state vary in size, structure, and scope of service offerings. While regional differences factor into organizational affiliation, FQHCs have increasingly broadened their network structure through participation in independent practice associations, private practice acquisitions, and hospital partnerships. FQHCs have also launched efforts to integrate and expand behavioral health

services, often contracting with provider networks to offer services for nonspecialty mental health conditions, also referred to as mild-to-moderate conditions. An analysis of FQHCs by region indicates that while FQHCs have experienced significant growth since the 2014 implementation of the ACA, the extent of that growth has varied widely across the state due to several factors such as market penetration, access to care, and patient choice. During 2014–19, while the number of patient encounters among FQHCs increased statewide by 45%, regions such as Humboldt/Del Norte, the Bay Area, and Los Angeles grew at a slower pace comparatively. Over this same period, the Inland Empire region saw the number of FQHC patient visits triple, with growth estimated at 206%.⁹

While the median California FQHC has generated positive operating margins overall, these margins have been trending downward, with operating losses of 1.1% found among FQHCs in the lowest 25th percentile in 2019.¹⁰ California FQHCs operating in the top 75th percentile had positive operating margins of 6.6%, above the state benchmark of 3%, while the FQHCs operating in the 50th percentile had margins below 2.5%.¹¹ While the declines in operating margins have been attributed to expenses outpacing revenues, the recent financial impact of the COVID-19 pandemic further highlighted significant risk to the future viability of FQHCs absent additional funding support, particularly among those FQHCs that sustained large losses.¹² Overall, the financial health of FQHCs underscores the variability and diversity among health centers in California, and across urban and rural regions, that will require a nuanced approach when considering participation in APMs.

Prospective Payment System Overview

Under federal law, FQHCs are subject to special cost-related payment structures. Established in 2000, Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act shifted the FQHC payment method from a retrospective cost-based system to PPS. The intent was to offset the costs that FQHCs incur for providing care to uninsured and underinsured patients while ensuring FQHCs are paid appropriately and can provide covered services to Medicaid enrollees.

Under PPS, FQHCs are paid a predetermined rate that encompasses reimbursement for all services provided during a single visit, and it is adjusted annually for inflation. In California, these rates are in a publicly available fee schedule on the California Department of Health Care Services (DHCS) website.¹³ Defined under federal law, FQHCs must either directly provide, or contract for access to, preventive and primary health care services such as family and internal medicine, pediatrics, obstetrics and gynecology, diagnostic laboratory and radiology services, emergency services, preventive dental services, and pharmacy services (in certain centers).¹⁴ FQHCs may also provide other outpatient services such as vision services, behavioral health services, and other ambulatory care services included in the state's Medicaid plan. FQHCs may offer some nonmedical services to their patients, such as language interpretation services and health education.¹⁵

States have some flexibility in the scope of services considered in the PPS rate development calculation and must have a process to adjust PPS rates to reflect changes to the scope of services provided by the FQHC, such as when a new covered benefit is added to the Medicaid program. States also have strategies to ensure that FQHCs are reimbursed for services that are not included in the PPS rate but can improve outcomes for patients.

For example, some states use a higher annual inflation rate when setting PPS rates, and others use an "enhanced" PPS rate whose supplemental payments incentivize FQHCs to provide specified services, such as case management.

Encounters and Visits

The PPS rate structure is designed to provide financial certainty to FQHCs and to reduce the incentive to deliver unnecessary health care services, which can occur in a volume-based fee-for-service (FFS) system that reimburses and rewards providers for each individual service. However, PPS is restrictive and encounter-based, and an FQHC will receive PPS only if the following criteria are met:

- The service is provided within the four walls of a clinic
- The service is defined as an allowable encounter / set of services as defined under PPS
- Only one billable service is provided to a patient per day (with the exception that a medical visit and a dental visit can be provided on the same day)
- The service is rendered by a billable provider type

COVID-19 Reimbursement Flexibilities

The COVID-19 pandemic and public health emergency has resulted in additional, temporary flexibilities that allow FQHCs to be reimbursed for telehealth and phone visits and reimbursement for care provided outside of the health center. It is unclear what the long-term policy under PPS will be around virtual visits and how that may vary state by state.

However, it is anticipated that the implementation of the new APM initiative described in the appendix provides a pathway to include telehealth services and other modalities into a global rate even after the public health emergency has ended.

Managed Care Plan Payments to FQHCs Under PPS

As a result of the PPS rate and requirements, FQHCs represent a unique provider reimbursement structure. Under federal Medicaid law, managed care plans (MCPs) have the flexibility to set their own rates for FQHC payments but must pay them no less than they would other contracted providers for similar services.¹⁶ If the total MCP payment to an FQHC is less than the PPS amount, the state must pay the difference quarterly through a reconciliation process and supplemental payment commonly referred to as a wraparound payment. This supplemental payment is disbursed in two stages: an interim payment paid on a per visit basis each time a claim is filed, and if necessary, a final payment once the reconciliation process is complete between the state and the FQHC.¹⁷

Challenges with PPS Payment Structure

Under the PPS model, FQHCs can bill Medi-Cal and receive reimbursement only for in-person visits with billable providers. Additionally, PPS prevents FQHCs from billing for more than one visit per day, which results in patients having to visit the health center on separate days if they have more than one billable medical, dental, or behavioral health need. These requirements are disruptive for the patient and may result in unnecessary delays in care that can result in poor health outcomes. This can be demonstrated most clearly when a patient presents inside a health center for a physical health appointment but has a clear behavioral health need. For the FQHC to receive the PPS rate to address the patient's behavioral health needs, the patient must return on another day despite significant evidence that delays in accessing behavioral health care has negative consequences on overall mental and physical health.

Not only does this result in delayed care for these patients, but it also creates capacity issues that may impact other patients, such as those with complex needs who may require in-person care from a

clinician. The “within the four walls of the clinic” requirement that patients be in a specific location for visits when the services could be safely and appropriately delivered in another setting unnecessarily limits access for patients that would prefer and can benefit from these alternative sites and provider types. For example, the PPS rate does not allow FQHCs to bill directly for services provided by clinic staff that are social workers or community health workers. The costs for services provided by these provider types must be built into the PPS rate through the delivery of services that are incident to a medical service provided by a physician, and are not separately accounted for or billable in the PPS rate. This structure does not adequately recognize the payment FQHCs would have to make to these providers and can be a barrier to the use of this culturally concordant, lower-cost workforce to address social determinants of health by providing services such as housing navigation and assistance with access to medically tailored meals. Similarly, it does not recognize home or community-based services, which are particularly important for many of the vulnerable populations that FQHCs serve.

The adjudication and timing of the PPS reconciliation process can impact health center operational cash flow because it is a retroactive payment for services already provided, which may affect the capacity of a health center to serve patients. Additionally, it is an administrative burden on both the FQHCs and the states to engage in the reconciliation process, which can be complex, time consuming, and result in delayed payments. This process can be especially hard for a newly established FQHC site engaging in its first PPS rate-setting process, as it creates financial risk while the reconciliation process is completed. States have the option to streamline the administration of the PPS wraparound payment by requiring that the MCP calculate and make the payments directly to the FQHC, but this option requires oversight to ensure that payments are accurate and reflect what the state would have otherwise paid. California has not implemented this option to date.

Alternative Payment Models for FQHCs

To alleviate several of the limitations that accompany PPS and incentivize person-centered care and health home models, states are authorized under federal law to reimburse FQHCs using APMs. APMs are payment arrangements that reward providers for efficiently delivering care that improves outcomes, meets certain quality targets, or both. APMs can be applied to a clinical condition, a specific episode of care, or a defined population.

APMs as defined broadly in the health care system include a continuum of value-based payment (VBP) options. APM and VBP are often used interchangeably. VBP models are an approach used by a state or other payer to align financial incentives and to reduce overutilization and inefficiencies in the health care system. APMs are the specific mechanism by which those approaches are implemented, which range from FFS payments that include quality or bonus payments for improving outcomes or quality scores or both, to full risk-based capitation payments in which a provider is responsible for offering an agreed-upon set of covered services to a patient for a single monthly payment (known as capitation). For the purposes of this issue brief series, when talking broadly about APMs, it is considered inclusive of the various VBP approaches. However, it is important to note that for FQHCs, APMs can be used to pay the PPS rate or to engage in more typical VBP arrangements as explained above.

Under federal law, payment to an FQHC under an APM must be equal to, or higher than, what the clinic would have received under the PPS. Following are several options for FQHC APM design, including the benefits and potential limitations of each model.¹⁸

Shared Savings

Reimbursement structure:

- FQHCs can garner a percentage of savings achieved using predefined benchmarks for quality performance and remaining under a total cost of care.
- There is no penalty if the benchmarks are not achieved — there is no downside risk to the FQHC.
- Shared savings payments are made after benchmarks in quality and cost are achieved.

Benefits:

- The FQHC is not responsible for any losses and experiences only the benefits of meeting benchmarks.
- Incentivizes the use of patient-centered activities such as care coordination across medical and social services.

Limitations:

- Successful arrangements require an FQHC to have enough of a patient base to spread the benchmarks across to reduce the impact of outliers and increase the potential shared savings sufficiently to drive care transformation investments by the FQHC.
- If the shared savings arrangements are spread across too many benchmarks, there may not be enough of an impact on each one to meet the goals of the payer.
- This model does not provide FQHCs up-front funding to invest in staff and resources that would increase the FQHCs' ability to meet the benchmarks and make other improvements to patient care.

Pay for Performance

Reimbursement structure:

- FQHCs receive a payment for meeting agreed-upon quality and performance benchmarks.
- The payments are in addition to the PPS rate.

Benefits:

- Creates an incentive for accountability on key quality metrics and other patient outreach and engagement activities.
- Builds capacity for FQHC quality improvement efforts.

Limitations:

- Requires sophisticated data exchange and updates to workflows for tracking and reporting that may require investments by FQHCs to effectively participate.
- There is limited evidence demonstrating sustained quality and system improvements.
- If there are multiple pay-for-performance arrangements with varying measures, there may be reduced value because resources will not support improvements across a broad scope.

Risk-Based Capitation Under Federal FQHC APM Rules

Reimbursement structure:

- The FQHC receives a capitation payment (also referred to as a per-member per-month) to cover a defined set of services (such as primary care).
- The capitation payment can be tied to meeting certain quality metrics.
- The FQHC does not have downside risk due to the PPS reconciliation process, and the state has the option to pay PPS or PPS plus some additional funds.

Benefits:

- FQHCs get the flexibility to manage care more effectively for patients.
- It can help drive improved quality outcomes and metrics.

Limitations:

- There must be agreed-upon quality metrics and benchmarks to make these arrangements truly value-based, and the arrangement must

be designed with enough upside risk that it is attractive to the FQHCs to participate because it is a voluntary model.

- The capitation payments must be negotiated to be robust enough to allow for effectively managed care and to give the FQHC enough flexibility to invest in system transformation and quality improvement while still remaining economical to achieve desired cost savings.
- If FQHC utilization/patient volume at a site is low, an FQHC will be less able to make this arrangement effective.

Virtual Accountable Care Organization with Shared Savings

Reimbursement structure:

- FQHCs and MCPs work collectively to build a virtual accountable care organization (ACO).
- Established when a group of small providers work together to coordinate care across all the organizing members to achieve goals related to total cost of care.
- Can include a shared saving arrangement with a payment received after benchmarks are achieved.
- Can include an up-front payment from MCPs to the FQHCs to allow for investments in staff and resources to help achieve goals and improve patient care.

Benefits:

- Incentivizes investment in activities that address social determinants of health and coordination across the system.
- FQHCs can leverage a larger population base and collective resources to make a larger impact than when done in isolation.

Limitations:

- Requires infrastructure investments to be effective and to create the necessary data exchanges and capabilities, as ACOs rely on well-established coding practices to realize the margins that make these arrangements successful.
- Strong partnerships across the system of care, including hospitals and other providers and not just with the MCP, are necessary, and building those strategic relationships and aligning incentives may take time.

Bundled Payments (upside only)

Reimbursement structure:

- FQHCs receive a predetermined, all-inclusive payment that includes total allowable expenditures, or “target price,” for an episode of care. “Episode of care” refers to the entire care continuum for a single condition or medical event during a fixed period of time.
- FQHCs would receive reimbursement for the individual services provided in the bundle based upon established rates, and at the conclusion of the fixed period of time or episode of care, all the paid claims are aggregated and compared to the predetermined target price.
- If the total cost of the episode of care is lower than the target price, the FQHC would not be at risk for that amount and would receive a percentage of the savings achieved.

Benefits:

- Bundled payments can include acute or chronic events and incentivize coordination of care across various medical providers and settings, including FQHCs, hospitals, specialty groups, and other participating providers.
- Payment is contingent on quality performance, which may increase care quality while lowering health care costs.

Limitations:

- Technical infrastructure and internal data systems must be robust enough to support data sharing across care teams and throughout the span of time for an episode of care.
- For FQHCs the specific challenge to this approach is that the services would have to be separate from the current PPS rate to avoid the site being paid twice for the same service and violating federal financing rules.

While there are varying degrees of risk and benefits to MCPs and FQHCs, APMs offer the potential to improve care for patients served by FQHCs and bring additional stability to the safety-net delivery system. Additionally, APMs offer an incentive for FQHCs to invest in practice transformation that should create additional efficiencies and reduce the administrative burden on FQHCs over time. While there may be some initial work and cost to

implement the APM, it should ultimately result in systematic changes that will streamline the administration of benefits and financing. Some of these potential benefits are explored in the appendix.

Conclusion

California and other states have prioritized value-based payment arrangements that align clinical and financial incentives and risk arrangements among providers, plans, and purchasers to improve health outcomes, enrich the patient experience, and reduce health care costs and inefficiencies in care delivery. Over the years, state policymakers have signaled interest and intent in moving the Medi-Cal system away from episodic FFS payment and toward health care payment and delivery reform innovations such as APMs. The FQHC APM 2.0 initiative currently under consideration builds on this long history and has the potential to create transformation in FQHCs, the backbone of California’s primary care safety net.

Acknowledgments

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Appendix. Federally Qualified Health Center Alternative Payment Model 2.0 Initiative

As of spring 2022, California's Department of Health Care Services is preparing to submit a State Plan Amendment to the Centers for Medicare & Medicaid Services for federal approval of an alternative payment model structure for the state's FQHCs and FQHC Look-Alike sites that receive PPS reimbursement. The initiative is known as FQHC APM 2.0. It builds off previous state efforts to design an APM pilot program for FQHCs and health plans serving Medicaid patients.

Under federal law, participation in an APM must be voluntary. Additionally, the APM payment to the health center must be at least equal to the amount they would otherwise receive under the prospective payment system. As permitted under federal law, FQHCs participating in the APM may receive a practice transformation payment above PPS rates, provided that FQHCs meet certain quality benchmarks.

Basic Design Structure

While several key design considerations and decisions are still under development, the following elements are similar to the previous APM proposal:

- Managed care plans must pay participating FQHCs a capitated, per-member per-month (PMPM) rate for all assigned Medi-Cal patients.
- The PMPM will be MCP-specific and cover all Medi-Cal services within the FQHC's scope except for services specifically excluded from the APM (excluded services will be forthcoming from DHCS).
- The PMPM payment will include total PPS, which considers MCP historic utilization data specific to the participating FQHC, and is inclusive of payments for all MCP patients that received care at the FQHC over a specified period.

Potential FQHC APM 2.0 Benefits

According to stakeholders interviewed for this brief, the potential benefits of the FQHC APM 2.0 initiative include that it would:

- Align FQHC payments with broader Medi-Cal financing and policy goals
- Incentivize person-centered care and flexibility in services to increase access through a broader range of providers, eliminate single-visit-per-day requirements, and include options to provide care outside of the clinic walls (e.g., telehealth and alternative locations in the community)
- Increase alignment of quality goals and pay-for-performance initiatives across Medi-Cal to increase the impact of population health management strategies
- Promote data exchange between MCPs and FQHCs, which over time will result in more informed decisions and improved care coordination across the system
- Support the integration and coordination of physical, behavioral, oral, and long-term services to address the needs of the whole person
- Recognize the role that FQHCs have in early intervention and primary care interventions to reduce overall costs to the system and improve outcomes
- Provide FQHCs more flexibility to address patient needs, which will lessen disparities and help address social determinants of health
- Reduce administrative burdens and provides more stable revenue streams for FQHCs

Timeline and Next Steps for FQHC APM 2.0 Initiative

Following additional stakeholder engagement, a formal State Plan Amendment request is anticipated in July 2022 for federal approval by December 2022, with FQHC site selection and enrollment in the APM program launching in advance of the amendment submission. The APM PMPM payment is expected to begin January 1, 2024.

Endnotes

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19. "Health and Human Services" (PDF) in *Governor's Budget Summary — 2012-13*, State of California, 8.
20. S.B. 147, Reg. Sess. (Cal. 2015); and *Federally Qualified Health Centers (FQHC) Alternative Payment Methodology (APM) Pilot: California Concept Paper* (PDF), DHCS, October 13, 2016. Originally slated to launch in October 2017, the FQHC APM Pilot Program sought to establish a capitated model between FQHCs and Medi-Cal managed care plans, but ultimately was not pursued due to federal approvals associated with the prospective payment system equivalency provision.