Sustainability Considerations for the California Federally Qualified Health Center Alternative Payment Methodology

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Since 2016, health centers (HCs) and statewide clinic and managed care plan (MCP) associations have been collaborating with the Department of Health Care Services (DHCS) on building a capitated Alternative Payment Methodology (APM) to support the delivery of value-based care in California's Federally Qualified Health Centers (FQHC). The intent of the APM is to move away from volume-based and rigid billing requirements of the prospective payment system (PPS) to a population-based upfront reimbursement methodology with quality reporting that provides more flexibility to deliver comprehensive primary care services with a diverse care team. APM 1.0 stalled in 2017 when the State and HCs could not agree on the authority for federal authorization of the APM.

The work to develop the second version of the APM began again in earnest when 2020's global health crisis illuminated the need for flexibility in PPS-restrictions around care delivery and the benefits of a per-member-per-month (PMPM) payment for financial predictability and safety net stability. DHCS and HCs hoped for strong participation in the APM, including a varying representation across health center size and geography. However, APM 2.0 launched on July 1, 2024 with two health centers: one public hospital system and one small non-profit health center. Unanticipated challenges arose during the design and pre-implementation stages that inhibited widespread participation.

Most FQHCs have not opted to participate in the first wave of APM 2.0 due to financial instability, patient misassignment, and complexity in health center encounter data. These seemingly small details had a significant impact on the cost-benefit analysis for practices, especially smaller practices with less data infrastructure to analyze and participate in new requirements. The complexities of the APM pre-implementation resulted in DHCS pausing implementation of a second cohort of APM until the underlying challenges can be resolved. This brief will outline the biggest challenges in APM 2.0 design and describe mitigation efforts for future APM design.

APMs clarified:

An **alternative payment methodology** refers to the specific financial mechanism used to pay providers an alternative to traditional fee for service payment.

An **alternative payment model** is a broad framework or approach that rewards quality and cost efficiency (e.g. Accountable Care Organization or bundled payment).

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The Impact of Assignment Misalignment on APM Revenue

CMS Requirements for FQHC APMs:

1) It is voluntarily agreed to by the state and the individual FQHC.

2) It "results in payment to the center or clinic of an amount which is at least equal to the amounts otherwise required to be paid to the center or clinic" under PPS.

3) It is codified in federal approval through either a state plan amendment or waiver.

Only PPS providers – in California that includes FQHCs, FQHC Look-a-likes, and rural health centers – are eligible to participate in the APM 2.0. Most FQHCs have not opted to participate in the first wave of APM 2.0 due to the lack of confidence that they would retain at least as much revenue as under the current PPS system. This may seem ironic given that all policy discussions to develop APM 2.0 consistently started with the federal requirement that an APM must ensure that a health center will receive at least as much as they would under PPS.

When preliminary rates were released, many FQHCs realized that their revenue under APM would be less than under traditional PPS. The reason for this was rooted in site-specific member assignment and the misalignment of where patients are assigned versus where they receive care. To set an actuarially sound rate, the State's actuaries – Mercer – determined that at a minimum threshold of 70% of all historical utilization needed to come from assigned members at the participating health center site. If an FQHC's utilization from assigned

Figure 1: Unassigned Utilization Penalty:

For every percentage point the clinic is below the 70% threshold, they lose 1.4% of revenue. There is no means to recoup this lost revenue unless they do not transform care and then file for reconciliation.

	Revenue decrease relative to baseline period
Assigned Utilization	70% Threshold
100%	0%
90%	0%
80%	0%
79%	0%
78%	0%
77%	0%
76%	0%
75%	0%
74%	0%
73%	0%
72%	0%
71%	0%
70%	0%
69%	1.4%
68%	2.9%
67%	4.3%
66%	5.7%
65%	7.1%
64%	8.6%
63%	10.0%
62%	11.4%
61%	12.9%
60%	14.3%

members fell below this threshold, the actuary discarded utilization from "unassigned" members until the 70% threshold was reached. This was coined the "unassigned utilization adjustment". Utilization was considered "unassigned" even if the member who was seen at the site was assigned to another site within the same organization.

Many health centers interested in pursuing APM 2.0 recognized through the rate setting process that there was a high level of misalignment of the sites where patients are assigned versus the sites where they receive care. Health centers hired their own actuaries to study the Mercer rate setting. The actuary's analysis of how the unassigned utilization adjustment impacted rate setting in the APM are displayed in Figure 1. Ultimately, the health center actuaries determined that if a health center rate was subject to the unassigned utilization adjustment, there is no way for the health center to both transform care and make up this lost revenue. For this reason, health center actuaries recommended that health centers not participate in the APM if their rates included the unassigned utilization adjustment. This was the case for the large majority of health centers that had expressed interest in the model.

This issue was not anticipated based on other states' experience with setting FQHC APM rates for health centers. In almost all other states, including Oregon, Washington, and Colorado that have implemented FQHC APMs, HCs have PPS rates that are specific to the organization, not the site. Thus, members are assigned to an organization in other states and would be considered assigned members even if they sought care at different sites within the organization. Actuaries noted that if California PPS rates were organization specific rather than site specific, the issue of unassigned utilization adjustment would not have arisen.

California is very interested in ensuring that there is high continuity of care between Medi-Cal enrollees and their assigned primary care providers (PCP). Having an unassigned utilization adjustment is a way of incentivizing plans and FQHCs to ensure that members are seeking primary care with their assigned PCP and maintain this continuity of care. CPCA voiced questions regarding whether some of the unassigned utilization came from specialty care services, urgent care, behavioral health services or telehealth that would not have been expected to be at the assigned site or with the PCP. Ongoing data analysis is underway to investigate these questions.

CPCA is committed to two distinct steps to address the challenges encountered in APM 2.0.

1) In future iterations of the APM, DHCS and CPCA will continue to investigate whether it is appropriate to expect that specialty care, urgent care, behavioral health services, and telehealth services to be counted in the 70% utilization threshold, given that many of these services are not rendered at a member's assigned site.

2) DHCS is also committed to addressing assignment and utilization misalignment through a mandatory assignment reconciliation process using primary care utilization as a proxy for member choice. Starting in 2027, DHCS will require MCPs to reassign patients to primary care providers where they had the majority of their visits. The details of this are still being

determined through a stakeholder engagement process. However, the State anticipates releasing guidance to plans regarding periodic reassignment of members based on utilization in 2026.

The Importance of Accurate Encounter Data in APM

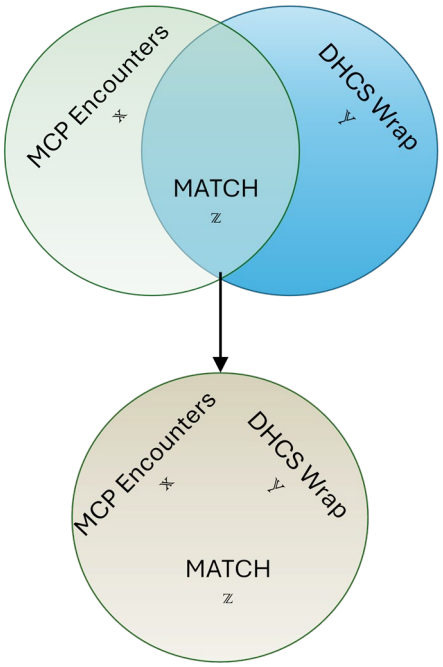
Encounter and Wrap Data Matching

Accurate encounter data is a cornerstone of the CA FQHC APM. Under the APM, MCP encounter data serves as the single source of truth for two critical functions: calculating total PPS-equivalent visits (for the purpose of PPS-reconciliation) and assessing performance on quality measures. Because payment and accountability both depend on the accuracy of this data, ensuring data integrity is essential to the health center's sustainability.

In acknowledgment of the critical functions of MCP encounter data, to participate in APM the state requires that at least two-thirds (66%) of the health center's base period wrap claims submitted to DHCS must have a corresponding MCP encounter record. This benchmark ensures that encounters are properly reflected across both systems and that the data used to calculate payment is complete and reliable. By establishing encounter data accuracy as a core participation criterion, DHCS ensures a strong data exchange processes between health centers and plans for all participating health centers.

Matching Percentage Methodology

- x = MCP Encounter Records (MCP 837 files) with no match in DHCS Wrap records
- y = DHCS Wrap records with no match in Encounter records
- z = Records match in both MCP Encounter and DHCS Wrap



Mismatched or missing encounter records – whether from incomplete submissions, system errors, or inconsistent coding – can lead to undercounted visits and inaccurate quality performance results. These discrepancies risk not only financial shortfalls for health centers but also undermine the credibility of the APM model as a tool for advancing value-based care.

The encounter data threshold was one key inhibitor to sites participating in the inaugural cohort. According to DHCS data sent to CPCA, 94 sites applied for Cohort 1 of the APM, and 71 sites were selected by DHCS. The sites not selected did not meet the minimum data matching criteria. CPCA elevated that applying for the APM should not be the first time that

health centers and their payers learn about a data mismatch. DHCS responded by producing a public facing dashboard that allows FQHCs to input their National Provider Identifier (NPI) and see the match percentage. Health centers can now review this dashboard to understand their matching level with payers. This is the springboard clinics need to begin planning data quality and validation efforts with the MCPs.

Intermittent Site Data

Site-level billing accuracy and transparency are crucial under the APM. Utilization at intermittent sites must be separately identifiable so that future structural changes between parent and intermittent sites can be attributed accurately and reflected in capitated rates, should the health center decide to change its parent/intermittent structure. If utilization from an intermittent site is billed under the parent clinic's National Provider Identifier (NPI), it becomes impossible for DHCS to distinguish between locations, undermining the ability to set actuarially sound site-specific APM rates.

To address this, DHCS has outlined clear requirements:

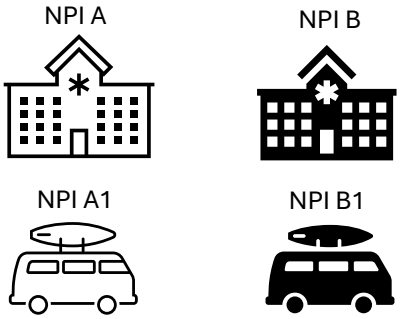
- Intermittent sites must bill using their own site-level NPIs, rather than the parent site's NPI.
- FQHCs cannot move intermittent sites between parent entities during the participation year.
- Structural or billing changes may only be made with 180 days' notice before the next participation year.
- All intermittent sites linked to a parent site must participate in APM together.

Currently, there is no regulation or guidance prohibiting intermittent sites using the parent or intermittent site NPI. Absent DHCS requirements or guidelines, it would be best practice, but not policy, to bill from the intermittent site NPI.

The following page is a graphic depiction of why DHCS needs to pull the intermittent data by site.

APM Participation Year 1

Intermittent clinics billing under intermittent site NPI:

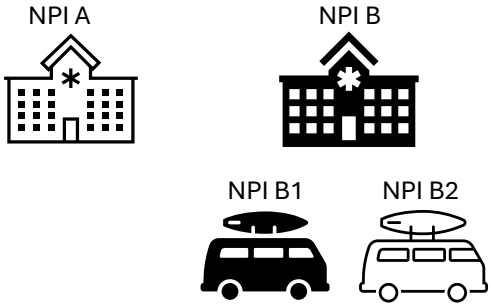


Two parent sites each with its own intermittent clinic. **Each intermittent clinic bills using its INTERMITTENT site NPI.**

- FQHC A NPI parent bills 5,000 units. The intermittent clinic A1 bills an additional 5,000 units.
- FQHC B NPI bills 8,000 units. The intermittent clinic B1 bills 7,000 additional units

Future APM Participation Years:

The intermittent data can be removed from FQHC A and moved to FQHC B.



Two NPIs, but only one has intermittent clinics now. **Each intermittent clinic bills using its own INTERMITTENT NPI.**

- FQHC A NPI parent bills 5,000 units. FQHC B NPI bills 8,000 units. One intermittent clinic B1 bills 7,000 additional units and the other B2 (formerly A1) bills 5,000 units.

What is Next for Value-Based Payment Arrangements?

DHCS and CPCA have agreed to prioritize redesign considerations for an APM 3.0. However, given the numerous competing priorities, it is unclear when DHCS will have capacity to dedicate time and resources to this effort.

Anticipated State Guidance

In 2027, DHCS intends to release an All-Plan Letter (APL) to align DHCS requirements with the Office of Health Care Affordability (OHCA) requirements on both primary care spend and value-based payment adoption. The APL is intended to ensure all Medi-Cal MCPs are subject to OCHA requirements. OHCA recommends two related benchmarks for increasing primary care investment:

1. Annual improvement benchmark for each payer: 0.5 percentage points to 1 percentage point per year increase in primary care spending as a percentage of total medical expense for performance year 2025 through 2033; and
2. Statewide investment benchmark: 15 percent of total medical expense allocated to primary care for all payers by performance year 2034.

In terms of value-based payments (VBP), OHCA has also set some aggressive targets for APM adoption goals for percent of members attributed to HCP-LAN[1] Categories 3 and 4: 55% of Medi-Cal members in 2026 to 75% in 2034. Categories 3 and 4 range include:

- 3A: APMs with Shared Savings
- 3B: APMs with Shared Savings and Downside Risk
- 4A: Condition-Specific Population-Based Payment
- 4B: Comprehensive Population-Based Payment
- 4C: Integrated Finance and Delivery System

Note that how OHCA is defining APM may not be the same definition as the California FQHC capitated APM. Once an APM 3.0 details are determined, it would be necessary to assess whether the California FQHC APM 3.0 would fit squarely into one of the HCP-LAN categories.

[1] Health Care Payment Learning Action Network, APM Framework: https://hcp-lan.org/

Health Center VBP

Health centers in California still have other value-based payment arrangements in which they are participating, including:

- Pay-for-performance arrangements with managed care plans and/or Independent Practice Associations (IPAs) (most FQHCs);
- Supplemental payments for services not included in the PPS scope (e.g. screening for Adverse Childhood Experiences, developmental screenings, certified wellness coach services, enhanced care management, and community supports).
- Community Clinic Directed Payments (CCDP). Starting in 2025, the CCDP program is designed to provide supplemental payments to eligible clinics for providing pharmacy services or other patient support services (such as case management, care coordination, health education, specialty services, etc.). These payments are processed through the managed care plan delivery system based on utilization and performance on a determined quality measure;
- Payments for meeting milestones within the Equity and Practice Transformation (EPT) Payments Program (select FQHCs within the EPT program);
- Shared savings, such as participating in Medicare ACOs (small number of CA FQHCs); and/or

Additional Resources:

For a full list of reimbursement mechanisms supplemental to PPS, review the resources on the Finance and Billing Page of CPCA's website, here.

For more information and considerations on value-based payment arrangements, we recommend reviewing the Equity and Practice Transformation materials on VBP 101.

Risk-bearing arrangements, including participating in professional-risk through IPAs (many FQHCs) and PACE programs (small number of FQHCs)Shared-risk arrangements Despite the variety of VBP arrangements available to health centers in California, small health centers are often challenged to participate successfully in such arrangements due to lack of data and data systems to rigorously track and improve quality outcomes, sufficient size to bear risk safely, and/or scale to add new services like care management and coordination.

To move the aspirations of value-based pay from theory to practice, it is important to maximize contracting terms and support infrastructure (like data systems and reporting for real-time management). Payers also must recognize that even the largest and most robust primary care providers will not be able to or want to participate in VBP if it means doing more with less revenue.

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