



Accelerating Value-Based Payment in California's Federally Qualified Health Centers: Options for Medicaid Health Plans

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I. Introduction and Overview

States, health plans, and providers, including federally qualified health centers (FQHCs), continue to move away from fee-for-service payments into value-based payment (VBP) arrangements. In California, as in other parts of the country, these arrangements give primary care providers greater flexibility and rewards for improving quality while reducing the cost of care. Primary care is the backbone of any high-functioning health care system. Research demonstrates that greater use of primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department (ED) visits, and lower mortality.¹ However, primary care providers often feel under-prepared, under-resourced, and understaffed to meet the physical, behavioral, and social service needs of their patient populations.

VBP programs seek to better coordinate care and to achieve better health outcomes for patients. They give providers flexibility to deliver care in ways that best meet the needs of their patient populations. FQHCs and health plans in California are making progress in the transition to value-based care. For example, virtually every managed care plan (MCP) and FQHC in the state participates in pay-for-performance programs (P4P) that focus on an FQHC's own quality, and in many cases, costs. These P4P programs have evolved from rewarding providers for simply reporting data to more sophisticated, multi-tiered, outcomes-based incentive programs. MCPs, provider organizations, foundations, and individual providers themselves have directed time, energy, and financial resources to learn about and develop the capacity of providers to implement new care delivery and payment models.

In order to further drive quality, improve health outcomes for their patients, and reduce costs, FQHCs need to coordinate with outside providers that serve their patients, whether that be behavioral health, dental, specialty care, pharmacy, outpatient labs, emergency departments, in-patient hospital care, nursing home or long-term care facilities. While some MCPs and FQHCs are involved in broader population-based initiatives that include incentives linked to both quality and total cost of care delivered beyond the FQHC walls, such arrangements are not the norm.

Because they are deeply embedded in the community, FQHCs are uniquely positioned to impact care across the health care system. VBP arrangements give health centers the ability to provide patient-centered care through team-based approaches that effectively address the patient's health and social needs. VBP models typically allow flexibility for FQHCs to deliver and be paid for care through services outside the traditional scope of health care services, often referred to as alternative encounters or touches. Alternative encounters may include: home visits; telemedicine encounters and telephone visits; information management; clinical follow-up and transitions; dental care coordination; transportation assistance; health education and

IN BRIEF

Leading-edge federally qualified health centers (FQHCs) and health plans in California are demonstrating interest in advanced payment models (APMs) aimed at providing greater flexibility for FQHCs to deliver care in innovative ways. Their joint goal is to improve quality and decrease the health care costs of their patients. To support uptake of such arrangements by Medi-Cal (Medicaid) health plans, this report highlights examples from around the country and in California of promising payment models that provide greater flexibility, tie payment more closely to quality, and give FQHCs the ability to reap financial rewards from improving quality and reducing utilization costs across the larger health care system. It describes how health plans and FQHCs can address challenges and adapt value-based payment (VBP) models for the FQHC setting that do not require state or federal action. It points out opportunities for health plans, FQHCs, and the state to leverage lessons from other states for accelerating the adoption of VBP in California. While the paper is oriented to the California landscape, the lessons herein can be applied in other states seeking to advance VBP models in FQHCs.

supportive counseling; support group participation; group education; exercise classes; panel outreach; and case management (see description of Oregon's Alternative Payment and Advanced Care Model on page 14).

VBP can also help FQHCs with provider retention by relieving pressure on providers to see more patients, which is inherent in the current encounter-based system. VBP programs may increase revenue predictability, provide better data for care coordination, allow predictive modeling, and create a better understanding of an FQHC's financial operations. Health centers that adopt VBP will also align with the commercial market, which is already embracing greater accountability.

Health plans can help FQHCs bolster efforts to coordinate care, use data, and fully engage the communities they serve. FQHCs are becoming increasingly important to health plans' primary care networks, allowing them to expand their reach and have a greater impact on member health. FQHCs are closely connected to and trusted by the communities that they serve and often offer a wider range of services than traditional primary care practices, thereby being more responsive to patients' health and social needs. VBP arrangements can also help health plans bring up their Healthcare Effectiveness Data and Information Set (HEDIS) scores and bend the cost curve on both acute and long-term costs, particularly with complex patients, which FQHCs serve in a greater proportion.

About this Report

This report highlights promising VBP models from California and around the country that provide greater flexibility, tie payment more closely to quality, and give FQHCs the ability to reap financial rewards from improving quality and reducing utilization costs across the larger health care system. It outlines opportunities for health plans to accelerate the adoption of VBP in California's FQHCs. These opportunities include:

1. Building on existing VBP models;
2. Considering incremental approaches to VBP;
3. Working with FQHCs to form an entity that allows multiple FQHCs, in partnership with a health plan, to come together to address accountability for total cost of care;
4. Continuing to support and bolster efforts that build the capacity of FQHCs to be successful in total cost accountable care models;
5. Participating in opportunities to share and learn about promising accountable care models and addressing factors that would lead to an acceleration of these models; and
6. Encouraging and supporting efforts by the State of California to revise the FQHC Alternative Payment Methodology (APM) pilot (for details on California's APM pilot, see the sidebar on page 6).

With support from the California Health Care Foundation and Blue Shield of California Foundation, CHCS conducted interviews with 28 stakeholders in California and around the country to inform this report. Stakeholders were asked about existing and proposed health plan and FQHC VBP arrangements and state-level APMs, including program design, methodologies, and lessons. The interviews also delved into opportunities for implementing VBP with FQHCs, as well as the challenges to implementation and ways to overcome them. Stakeholders interviewed included leaders from FQHCs, managed care plans, accountable care organizations (ACOs), state health plan and primary care associations, national associations, California Department of Health Care Services officials, and officials from other states.

II. Background

Value-Based Payment in Medi-Cal

State Medicaid programs and health plans are changing the way they pay for health care services through VBP arrangements. VBP encompasses activities that move away from the traditional fee-for-service (FFS) payment system, which rewards the volume of services provided, to APMs that reward high-quality, cost-effective care. Payments made to providers under VBP are linked to quality or demonstrate value in some way, such as choosing evidence-based clinical guidelines and protocols, or improving patient experience.

In the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, which is part of the state's Medi-Cal 2020 Section 1115 demonstration waiver, public hospitals and managed care plans are required to have 60 percent of patients attributed to APMs by 2020.² The APMs defined in the PRIME Framework align with the Health Care Payment Learning and Action Network (LAN) APM framework,³ which is the most commonly used VBP framework. Payments for all APMs are affected wholly or in part by quality performance against a benchmark (e.g., prior performance; peers; national/regional/state standard; etc.).

Medi-Cal 2020 builds on payment innovations that have been in place for years in California, including: (a) pay-for-performance; and (b) sub-capitated arrangements, which involve an MCP delegating a portion of its capitation to another entity as a capitated payment designed to cover a specified set of services. Medi-Cal has been monitoring the performance of its MCPs and supporting their efforts to reward providers for quality outcomes through the use of programmatic tools and mechanisms including: the Medi-Cal Managed Care Performance Dashboard;⁴ the External Accountability Set;⁵ and the Auto-Assignment Incentive program.⁶ The Auto-Assignment Incentive Program also rewards MCPs with a greater percentage of default enrollments based upon specific performance measures. MCPs are increasingly implementing programs that reward providers for improved quality, and many MCPs are aligning the measures in their own incentive programs with the ones used by the State of California in the External Accountability Set.

The FQHC Payment Landscape

FQHCs are an essential part of California's health care safety net, providing primary care (family medicine, internal medicine, pediatrics, obstetrics and gynecology), as well as diagnostic lab services, radiologic services, preventive health services, cancer screening, family planning services, dental services, and patient case management. There are currently more than 1,500 FQHC sites in California that serve vulnerable populations, including the Medi-Cal population, medically underserved communities, and the uninsured.⁷ FQHCs have been especially critical in meeting the health care needs of the Medi-Cal population, which grew significantly as a result of Medicaid expansion under the Affordable Care Act.

Federal law requires that FQHCs be reimbursed for all reasonable costs associated with the services they provide through a Prospective Payment System (PPS) or Alternative Payment Methodology, based on a health center's historical costs of providing comprehensive care to Medicaid patients. Each FQHC has its own PPS or APM rate, which is updated annually for inflation. States are also required to have a Change in Scope policy in place, to update a health center's rate if there is a change in the type or intensity of services that are available to health center patients. If a state has chosen to reimburse health centers via an APM, two statutory requirements must be met: (1) that each health center agrees to the APM; and (2) that any payment be no less than what a health center would have received via the PPS rate. The latter provision has historically limited the types of VBP arrangements that states and plans can enter into with FQHCs, such as those involving downside risk, as direct payments to FQHCs cannot decrease under VBP arrangements.

Medi-Cal MCPs have the authority to set their own rates for FQHC payments, and are required to reimburse FQHCs at a rate equal to those paid to similarly contracted non-FQHC providers. If the MCP rate is lower than PPS, the state directly

reimburses an FQHC through a “wrap-around” payment that is the difference between its per-visit PPS rate and the payment made by the managed care plan. The wrap-around rate was established to comply with federal requirements that FQHCs be reimbursed for all billable services tied to their PPS rate. The state requires a reconciliation process to further ensure that payments meet PPS requirements. The reconciliation process, however, is cumbersome and time-consuming, resulting in significant delays between the time when services are provided and when FQHCs receive payment.

California's FQHC Alternative Payment Model Pilot

In 2015, FQHCs, MCPs and the state came together to design an Alternative Payment Methodology pilot to allow greater flexibility in delivering care, improving quality, reducing costs, and simplifying the burdensome payment system. Under the proposed pilot, the PPS payment and wrap-around payments would be replaced by an upfront, clinic-specific capitation rate. FQHCs would have received a comprehensive payment from health plans on a monthly basis rather than waiting until year-end for a supplemental payment. This more frequent payment would have been particularly beneficial to cash-strapped health centers.

The pilot would have helped FQHCs transition from the volume-based PPS system to one that better aligns the financing and delivery of health services and allowed FQHCs to use flexible resources in innovative ways to expand primary and specialty care access. For example, FQHCs could provide non-traditional services not currently reimbursed under traditional volume-based PPS, including but not limited to: integrated primary and behavioral health visits on the same day; group visits; email and phone “visits”; community health worker contacts; case management; and care coordination across systems. Other benefits of the pilot included a simplified payment process and flexibility to coordinate care in innovative ways.

Review of the pilot design by the Centers for Medicare & Medicaid Services (CMS) was largely positive. This was the case even though the model would have established a threshold for reconciliation that deviated from the PPS equivalency provisions under federal law, putting health center payments at risk. Although this mechanism was agreed upon by both the state and the health center associations early on in the process, CMS would not allow this approach unless the state formally requested that CMS waive the PPS equivalency provision through an amendment to the state's Section 1115 waiver. Because waiving PPS would have required a change of state law, and set a national precedent for waiving PPS equivalency, the state and other stakeholders decided not to pursue the pilot further. Although the pilot ultimately did not move forward, stakeholder planning efforts helped foster interest among health plans and providers to build capacity for implementing new payment models in the future.

III. Promising Payment Models for FQHCs

This section presents promising models for California health plans and providers to consider for building upon existing programs or launching new payment strategies that move along the VBP continuum toward greater FQHC integration and accountability. These proposed models can be designed to meet federal PPS equivalency requirements and do not require state or federal action to implement. In addition to the description of how the models could work, Exhibit 1 (*see page 8*) highlights pros and cons, key ingredients for success, and examples of each model in practice.

VBP Models Aimed at Care Delivered within the FQHC

These models provide FQHCs with more flexibility, but require greater responsibility for improving quality and managing their own costs.

- Pay-for-Performance:** FQHCs are financially rewarded for meeting pre-defined performance benchmarks on quality measures for patient satisfaction, resource use, health outcomes, or health care costs. FQHCs receive an incentive payment outside of the PPS rate from the health plan and/or the independent physician associations (IPA). Pay-for-performance (P4P) programs include metrics tied to patient engagement and population-focused measures (e.g., comprehensive diabetes care). These metrics, measured by health plans from claims data, help establish greater accountability.
- Risk-Based Capitation:** Providers receive a prospective per-member, per-month (PMPM) payment to cover a range of services (e.g., primary care), with payment contractually linked to quality metrics. This model typically applies to large provider organizations with patient panels large enough to bear the medical risk. FQHCs throughout California receive sub-capitated payment from health plans or IPAs, although these arrangements often are not contingent on meeting quality metrics. FQHCs do not bear downside risk because of the state reconciliation process to PPS equivalency. This model can serve as an entry point to greater accountability, as it requires FQHCs to manage a population, though for these arrangements to truly be value-based, quality must be tied to payments.

Key Definitions of Accountable Care

Accountable Care Organization:

There is no single, precise definition of an accountable care organization (ACO), but generally, a mature ACO is financially responsible for the total cost of care and quality of care delivered to an attributed population. ACOs shift more accountability for health outcomes to providers, typically through a shared savings model, and many have shown positive results for improving care and reducing costs. States have significant flexibility in designing Medicaid ACO programs.⁸

Virtual ACO:

In the absence of a formal state Medicaid ACO program, a virtual ACO is an organization of smaller providers, such as FQHCs, that work together to help coordinate care for the participating member organizations.

Total Cost of Care (TCOC):

The TCOC benchmark in Medicaid typically reflects average spending under a wide range of inpatient and outpatient settings. Services may include laboratory, radiology, pharmaceuticals, behavioral health, and dental.⁹

Exhibit 1: Promising Payment FQHC – Health Plan Payment Models

Model	Pros/Cons	Ingredients for Success	Example
CENTER ONLY			
Pay-for-Performance	<p><i>Pros:</i></p> <ul style="list-style-type: none"> Helps FQHCs to build quality improvement infrastructure P4P programs with measures related to patient engagement and population-focused activities may help providers ramp-up to more accountable models <p><i>Cons:</i></p> <ul style="list-style-type: none"> Limited evidence base on effectiveness 	<ul style="list-style-type: none"> Collegiality among providers Team-based care Changes incorporated in work flow Clinically integrated guidelines Electronic health record (EHR) Quality reporting and monitoring Data analytics Accurate coding 	<ul style="list-style-type: none"> Most California MCPs, IPAs, FQHCs
Risk-based Capitation	<p><i>Pros:</i></p> <ul style="list-style-type: none"> FQHCs develop capacity to manage and impact care for an attributed population of patients Arrangements that link payment to quality drive health outcomes 	<ul style="list-style-type: none"> Capitation rate must allow sufficient room for managing care 	<ul style="list-style-type: none"> Various California MCPs, IPAs, FQHCs
TOTAL HEALTH CARE SYSTEM			
Shared Savings (Upside-Only)	<p><i>Pros:</i></p> <ul style="list-style-type: none"> Reduced inpatient and avoidable ED utilization Incentives to address SDOH <p><i>Cons:</i></p> <ul style="list-style-type: none"> Savings realized retrospectively, which means FQHCs must be able to allocate upfront resources to invest in staff or IT systems to coordinate care and manage costs 	<ul style="list-style-type: none"> Sufficient patient population Consumers and providers involved in governance structure Patients are attributed correctly Infrastructure in place to share data between health plan and FQHCs Linkages between external providers, e.g., specialists, hospitals, behavioral health providers Care coordination embedded on-site Ability of FQHC to manage transitions of care Clearly defined savings distribution methodology Accurate projections 	<ul style="list-style-type: none"> Inland Empire Health Plan Rocky Mountain Health Plan
Virtual ACO with Shared Savings	<p><i>Pros:</i></p> <ul style="list-style-type: none"> Better clinical outcomes Reduced inpatient and avoidable ED utilization Incentives to address SDOH <p><i>Cons:</i></p> <ul style="list-style-type: none"> Requires upfront capital investments 	<ul style="list-style-type: none"> Sufficient patient population Consumers and providers involved in governance structure Patients are attributed correctly Attention to risk adjustment Infrastructure in place to share data between health plan, FQHCs, and external providers Linkages between external providers, e.g., specialists, hospitals, and behavioral health providers Care coordination embedded on-site Ability of FQHC to manage transitions of care Clearly defined savings distribution methodology 	<ul style="list-style-type: none"> Accountable Health Care Alliance of Rural Oahu Medical Home Network ACO AltaMed Health Services
Bundled Payments (Upside Only)	<p><i>Pros:</i></p> <ul style="list-style-type: none"> Addresses challenging problem faced by both health plans and FQHCs Incentivizes coordination across physicians, hospitals, etc. to provide care at or below the payment level 	<ul style="list-style-type: none"> Clearly defined bundles Linkages between external providers, e.g. specialists, hospitals, behavioral health providers Infrastructure in place to share data between health plan and FQHCs 	<p>None at this time</p>

FQHC VBP Models Aimed at Care Delivered Across the Health Care System

As with VBP models aimed at care delivered within the FQHC, the following payment models give FQHCs greater flexibility in care delivery. They go further to reward FQHCs for managing the total cost of care of their patients, and coordinating care beyond primary care and across all providers.

- **Shared Savings (Upside-Only):** Providers that succeed in keeping costs below a total cost of care benchmark keep a percentage of the savings. The shared savings payment is made retrospectively, contingent upon quality performance. As an upside-only model, the payer — which could be the state or health plan — shoulders the full amount of any losses, while the FQHC is not responsible for any loss. This model incentivizes activities like coordination and effective care management across all services in order to lower the total cost of care. Shared savings models require a sufficient patient population, accurate patient attribution, and accurate cost projections. Because payments are received retrospectively, FQHCs do not receive upfront resources to invest in staff or information technology (IT) systems to coordinate care and manage costs.
- **Virtual ACO with Shared Savings:** Health plans and FQHCs can come together to build a virtual ACO that would address total cost of care (*see sidebar on page 7 for definition of ACO, virtual ACO, and total cost of care*). This model typically includes a retrospective shared savings component and sometimes a prospective PMPM payment for investments in staff and IT systems that better coordinate care and manage costs. The Medical Home Network (MHN) ACO in Chicago, which is profiled in Section IV, is an example of a successful model. A virtual ACO could be an egalitarian model with equal partners, as with MHN, or could include a partner (e.g., a hospital) that takes a larger portion or all of the financial risk. Success would require strong partnerships among FQHCs, specialty partners, and hospitals.
- **Bundled Payments (Upside-Only):** FQHCs would receive an all-inclusive payment for a specific scope of services to treat an “episode of care” with a defined start and end point. Bundles can be for acute or chronic events. FQHCs would continue to receive payments for the individual services included in the bundle based on the rates under the existing claims-based system. At the end of the predetermined time, all of the paid claims for the set of services provided to an individual are aggregated and compared to a predetermined cost benchmark. If the actual spending falls within an agreed-upon range below the benchmark amount, the FQHC would receive a percentage of the savings achieved. If actual spending exceeds the benchmark, the FQHC would not be at risk for that amount. This model incentivizes coordination across FQHCs, hospitals, and others to provide care at or below the payment level. Payment is also contingent on quality performance.

Health Plan Perspective: Keys Ingredients for Successful Shared Savings Models with FQHCs

Health plan leaders interviewed for this report pointed to the following key ingredients to implementing successful shared savings models with FQHCs:

- **Population size:** Attributed populations must be of sufficient size (most successful shared savings models have at least 5,000 patients) to reduce random variation and accurately account for costs and savings.
- **Buy-in of front-line providers and staff:** Agreements made between health plans and FQHCs about implementing new payment models must be clearly communicated by health center leadership to the providers who are responsible for delivering the care. Providers need to know how they are being held accountable.
- **Using timely data to provide better care:** Providers need to be able to act on data to deliver better care. For example, an FQHC that receives a notification that one of its patients is being discharged from the hospital must have a process in place and staff available to effectively manage that transition.
- **Linkages to other providers and hospitals:** FQHCs need to be connected to other providers and hospitals to be able to coordinate care outside of the FQHC's walls.
- **Access to care:** Patients must have access to after-hours care to avoid unnecessary emergency department utilization.

IV. Health Plan - FQHC Accountable Care Arrangements: Local and Regional Examples

This section includes examples of VBP arrangements between health plans and FQHCs at a local or regional level in states across the country. In a number of states, FQHCs or groups of FQHCs have contracted with payers to establish VBP arrangements that are not part of statewide policy initiatives. Plans and FQHCs have drawn on local expertise and established roles in the communities they serve to create VBP arrangements that grant them flexibility to provide services to their patients outside of the encounter-based framework. These examples provide lessons that may be useful for health plans and FQHCs in California that are designing and implementing new VBP models independent from state-based programs or activities.

Colorado: Rocky Mountain Health Plans and Mountain Family Health Centers

Rocky Mountain Health Plan (RMHP) is one of seven Regional Accountable Entities that provide care coordination services and managed behavioral and physical health delivery for Medicaid beneficiaries under Colorado's Accountable Care Collaborative delivery system. RMHP is also one of two entities that are permitted under state law to operate as a managed care organization for Medicaid beneficiaries, covering the Western Slope region of the state.¹⁰ In 2014, RMHP launched a payment reform pilot, the Payment Reform Initiative for Medicaid Expansion (PRIME), as part of the state's efforts to implement Medicaid expansion.

Under this program, the state pays RMHP a monthly fee to provide a comprehensive set of physical health services to its members.¹¹ RMHP pays participating primary care providers, including FQHCs, a single, risk-adjusted, PMPM payment to cover primary care for each practice's attributed members. These practices have both upside and downside financial risk, as is typical for a full-risk capitated model, although PPS equivalency is not at risk for FQHCs. Practices are also able to earn additional shared savings payments for meeting cost and quality targets. These incentives are also shared with community mental health centers in the region that contract with RMHP to support the coordination of physical and behavioral health care.¹² Quality measures include: body mass index assessment for adults; HbA1c control for patients with diabetes; antidepressant medication management; and implementation of a patient activation measure. Under the program, RMHP can also use additional contracting levers and provide support to its providers to advance quality and practice transformation.

Mountain Family Health Centers (MFHC), a FQHC with four sites in this region, participates in Colorado's PRIME program in a contractual arrangement with RMHP for 20,000 of its attributed Medicaid members. The capitation payment, which provides cash flow, revenue certainty, and predictability, has allowed the health center to add staff across the spectrum of care to provide more services and better care coordination. The incentive payments also allow MFHC to make capital investments.

RMHP and MFHC are aligned in their shared goals of meeting the needs of the whole person, and RMHP views MFHC as essential to this vision.¹³ Both RMHP and MFHC recognize that this effort requires actionable data, care coordination, and community engagement. To that end, RMHP is investing in the practice transformation of MFHC by providing tools for data integration, care management, and financial management, and shares clinical and cost data on attributed patients. A number of community engagement strategies, such as coordination with hospitals and community mental health centers, have also led to better overall outcomes for patients. Future metrics will emphasize increased coordination and greater accountability.

Hawaii: Accountable Health Care Alliance of Rural Oahu

Accountable Health Care Alliance of Rural Oahu (AHARO) is a network of four FQHCs in Oahu, Hawaii, whose mission is to promote “access, quality, and cost effectiveness in health care by empowering consumers to evaluate the performance of health care agencies that serve them.”¹⁴ One of AHARO’s key goals is to develop value-based health care systems, and the organization serves as the single point of contracting for the network’s performance-based arrangements with four Medicaid health plans collectively serving a total of 40,000 Medicaid patients.

AHARO developed a “virtual accountable care” payment model (*see page 7 for accountable care definitions*) where each health center receives a prospective PMPM payment from each plan to be used for supporting capital investments, enhancing care coordination, and addressing social determinants of health (SDOH).¹⁵ A portion of that payment is paid to AHARO to support clinical integration activities, such as developing a common dashboard to track quality and performance across all health centers.¹⁶ AHARO views this model as an equal, and mutually beneficial, partnership between the health plans and the health centers based on three key elements: (1) trust; (2) correctly aligned incentives for all participants; and (3) the transparent exchange of data.¹⁷ FQHCs are responsible for participating in joint quality initiatives, offering expanded office hours for greater patient access, providing care-enabling services, addressing SDOH, and reporting on quality and performance measures focused on reducing avoidable costs. Measures include managing inpatient care transitions, decreasing unnecessary ED utilization, managing complex patients, and increasing access to care.¹⁸ Receiving an upfront payment allows health centers to invest in critical infrastructure and staffing to deliver better care and meet quality and performance targets.

In this model, the health center is accountable for the total cost of care for the patients attributed to them, and shares in any savings with the respective health plan. Savings are distributed through a predetermined formula between AHARO and the FQHCs.

Illinois: Medical Home Network Accountable Care Organization

Established in 2014, the Medical Home Network (MHN) ACO includes nine FQHCs, three hospital systems, and their physician practices that came together to “improve health care delivery in the safety net, enhance quality of care, and reduce medical costs” in Chicago’s south and southwest neighborhoods.¹⁹ The ACO is operated by Medical Home Network, a not-for-profit health care organization founded in 2009 by the Comer Family Foundation.

The MHN ACO partners with CountyCare, a Medicaid health plan run by Cook County Health and Hospitals System. CountyCare makes a PMPM payment to MHN’s ACO providers to deliver care coordination to their patients.²⁰ To support care coordination activities, the ACO created MHNConnect, a data-sharing portal that integrates data from the ACO providers, area hospitals from within and outside of the ACO, and claims and pharmacy data. This system allows providers access to real-time, actionable data to support care coordination activities and transitions of care.²¹

The MHN ACO also receives a quarterly shared savings payment from CountyCare. In turn, the ACO distributes a portion of the savings to its member organizations based on each one’s total cost of care and its performance on quality measures, including those related to care coordination, data management, and care transitions. The ACO keeps a portion of the savings from the health plan for capital investments, clinical support, and building reserves in anticipation of developing future models with downside risk. In Year 1 (July 2014-July 2015), the ACO earned \$17.7 million in shared savings.²²

VI. Health Plan - FQHC Accountable Care Arrangements: California Examples

Following are examples of accountable care arrangements between health plans and FQHCs in California.

AltaMed Health Services: Virtual ACO

AltaMed is the largest FQHC in the United States, with 35 sites in Los Angeles and Orange counties.²³ AltaMed operates as both an FQHC and an IPA. As an FQHC, AltaMed employs providers and staff who function in a traditional FQHC structure. The IPA allows AltaMed to supplement the FQHC staff and expand its network with additional providers from the community who work on a contract basis.²⁴ AltaMed's operations are paid on a partially capitated basis (the health center accepts Medicaid, Medicare, commercial, and dually eligible Medicare-Medicaid enrollees), and the IPA has a fully capitated arrangement for the Program for All-inclusive Care for the Elderly (PACE) enrollees.²⁵ AltaMed's size and revenue structure allow it to function as an integrated health system and a virtual ACO with the ability to provide coordinated care and impact costs across its total population of patients.

Inland Empire Health Plan: Shared Savings Program

Inland Empire Health Plan is launching a shared savings program in 2019 for medical groups in order to create accountability for cost and quality of services beyond primary care.²⁶ Providers are eligible to earn shared savings payments when actual spending for enrolled members is below a pre-defined target. The program is upside only, with no risk to the providers for losses if spending is greater than the target. In order to receive their share of savings, medical groups must meet defined targets tied to managing the total cost of care and improving quality for Medi-Cal members.

While this program is not specifically designed for FQHCs, three participating groups include FQHCs: SAC Health System; Arrowhead Regional Medical Center and its associated health centers; and Riverside University Health System and its associated county FQHCs. These groups have strong relationships with hospital and specialty partners that can help with effective data sharing, and care coordination to bolster their capacity to meet the program's quality targets and to manage costs.

VII. State-Led Payment Models

This section highlights examples of state-led VBP models, which include: (1) capitated APMs; (2) APMs with a rate adjustment for quality; and (3) shared savings as part of an ACO model. The APMs were designed specifically for FQHCs, while the ACOs are part of a larger Medicaid program in which FQHCs have decided to participate. All of these models provide a framework for FQHCs to participate in VBP initiatives, allowing them flexibility to deliver coordinated, quality care. While California is not currently pursuing a state-based model, health plans and FQHCs can apply lessons from these state-led initiatives to help guide VBP arrangements with FQHCs.

Capitated Alternative Payment Models

Capitated FQHC APMs uncouple payment from the face-to-face patient visit, converting the existing FQHC PPS rate to a capitated PMPM payment. Capitated FQHC APMs are designed to give states and health centers more flexibility in how they deliver care, and include incentives for improving quality. These arrangements allow FQHCs to offer services, such as group visits and care management, which are not paid for under the existing per-visit payment system. Capitated FQHC APMs are currently being implemented in two states, Oregon and Washington State, which both secured approval through a State Plan Amendment. Colorado also developed a model, proposed as a State Plan Amendment, which is currently under consideration by CMS. These models are profiled in Exhibit 2 and descriptions that follow.

Exhibit 2: Overview of State-Led Capitated Payment Models

State	Start Date	Model Type	Methodology	Lessons and Possible Application for CA
Colorado	2018	Value-Based APM	FQHCs select 11 quality measures and earn points for meeting those measures. Measures were developed by the state using elements from other programs, including Uniform Data System. ²⁷ If the FQHC earns enough points, it continues to receive the full encounter rate. If not, its rate will be reduced for future encounters. The maximum reduction is 4%, keeping the reduced rate above PPS equivalency.	State pays higher rates to FQHCs and puts the amount above PPS at risk. The higher rates provide additional resources for innovative care and QI efforts, while holding FQHCs accountable. Higher rates also reduce the need for reconciliation to PPS.
	Proposed 2018 ²⁸	Capitated APM	The state will pay FQHCs a population-based PMPM payment for a set of primary care services to replace the current per-visit payment. The PMPM payment would be tied to quality and performance.	See above.
Oregon	2013	Capitated APM	The health plan pays the base encounter rate and the state pays an upfront, supplemental capitated PMPM wrap payment to the FQHC. Clinics submit reconciliation reports quarterly, with settlements paid on an annual basis. Starting in January 2019, a portion of payment is tied to meeting five quality benchmarks.	Giving FQHCs flexibility to provide alternative services may influence quality and cost. Efforts are currently underway by the Oregon Primary Care Association to analyze outcomes data. ²⁹
Washington State	2017	Capitated APM	FQHCs receive a PMPM payment from the health plan as well as a monthly “enhancement payment.” The rate is then prospectively adjusted annually by the state to reflect the FQHC’s performance on seven quality targets. FQHCs continue annual reconciliation to ensure PPS equivalency. In lieu of a settlement process, adjustments are made prospectively to future rates.	FQHCs have the flexibility to use payments above PPS to influence patient care. Meeting quality goals ensures the availability of these resources and reduces the burden of reconciliation.

Colorado: FQHC Value-Based APM and Proposed FQHC APM

FQHCs in Colorado are currently able to choose between two methodologies for reimbursement by the state: (1) the traditional FFS PPS rate; and (2) a value-based APM rate that is cost-based and tied to quality and performance metrics.³⁰ The value-based APM methodology for FQHC providers aligns with the payment model for primary care providers (PCPs) under Colorado's Accountable Care Collaborative (ACC) delivery system. Colorado is not a Medicaid managed care state. Medicaid providers contract with a geographically exclusive Regional Accountable Entity that provides PCPs with care management and data services, and is responsible for meeting the behavioral health needs of their attributed Medicaid beneficiaries, though it is not at financial risk. (One exception is Rocky Mountain Health Plan, which is accountable for both physical and behavioral health for its beneficiaries; its relationship with some FQHCs is detailed in a previous section). Under the ACC model, PCPs are eligible for an enhanced FFS rate that is adjusted based on meeting quality and performance benchmarks. The differential, which will increase over time, is designed to be roughly equivalent to the amount that PCPs received under the Affordable Care Act's primary care physician rate increase (Section 1202) that the state has effectively extended since it expired in 2014.

FQHCs that choose to be reimbursed under the value-based APM methodology select 11 quality measures, which align with the Uniform Data System³¹ measures that FQHCs report to the Health Resources and Services Administration (HRSA), and earn points for meeting those measures. These measures include five structural measures related to practice transformation, and six performance measures focused on clinical outcomes. National Committee for Quality Assurance Patient-Centered Medical Home recognition counts as meeting all of the structural measures.³² If the FQHC performs well enough on the quality measures, it continues to receive the full reimbursement rate; if not, its rate will be reduced for future encounters. The maximum reduction is four percent, which keeps the reduced rate above PPS equivalency.³³

The state, in close coordination with the Colorado Community Health Network, has also developed a pilot similar to the Oregon and Washington State models. Under the pilot, the state would pay FQHCs a population-based PMPM payment for a set of primary care services to replace the current per-visit payment. Similar to the current value-based APM, the PMPM payment would be tied to quality and performance, but only the amount above PPS equivalency would be at risk. With a predictable revenue stream designed for population-based care, FQHCs will have the flexibility to better meet the needs of their patients, including SDOH, by providing services outside of the current scope of services. The state submitted a State Plan Amendment for the pilot to CMS, which is currently reviewing the proposal.³⁴

Oregon: Alternative Payment and Advanced Care Model

Oregon's statewide Medicaid delivery system is structured as a Coordinated Care Organization (CCO) model, a type of ACO. A CCO is a network of health care provider organizations that have agreed to work together in their local communities to serve enrollees in Oregon's Medicaid program.³⁵ CCOs have the flexibility and financial incentives to support new models of care and pay for services that improve quality and reduce cost. Each of Oregon's 16 CCOs receives a global payment for coordinating and providing health care for a geographically defined population and is held accountable for health outcomes.

The Oregon Primary Care Association worked with the state to develop the Alternative Payment and Advanced Care Model (APCM), which was launched in 2013, shortly after the CCO model was in place. Under the APCM, participating FQHCs receive a capitated or partially capitated payment for physical health services, based on historical utilization. For Medicaid beneficiaries, FQHCs receive their regular encounter-based payment from the health plan and a capitated PMPM supplemental wrap payment from the state. Effective January 2019, a portion of the payment is at risk depending on the FQHC's performance on quality metrics chosen to align with the incentive metrics to which Medicaid CCOs are subject; however, downside losses cannot go below the PPS rate. Participating FQHCs are required to submit quarterly reports on the selected quality measures.³⁶ Each FQHC also submits a "Touches" report on a quarterly basis to track non-traditional services. Touches may include: home visits; telemedicine encounters and telephone visits; information management; clinical follow-up

and transitions; dental care coordination; transportation assistance; health education and supportive counseling; support group participation; group education; exercise classes; panel outreach; and case management.³⁷

Payments are made on an annual basis, based on reconciliation reports submitted quarterly by the FQHC. Thirteen of the state’s 32 health centers participate in the pilot.³⁸

Washington State: APM4

This initiative, launched in July 2017, expands Washington State’s previous APM3 model that allowed FQHCs to choose between being reimbursed under the traditional encounter-based PPS system or receiving an APM rate. Under APM3, implemented in 2011, clinics received a PMPM payment from the health plan as well as a monthly “enhancement payment” that was passed through the health plan from the state. Under APM3, a time-consuming retrospective reconciliation was done annually. In the case of underpayments, clinics would receive a recoupment payment annually.

Under the new APM4, the payment flow remains the same and does not affect existing health plan contracts. However, the PMPM rate is calculated differently to include: (1) incentives for meeting quality goals; and (2) a mechanism for resolving underpayments and overpayments in lieu of the traditional reconciliation process. The baseline year rate is calculated using the prior APM3 methodology, and draws on historical utilization. This rate is then prospectively adjusted annually by the state to reflect each individual clinic’s quality improvement performance. Clinics that meet quality targets against their quality baseline will continue to receive their full PMPM rate; the higher rate serves as an incentive to meet quality targets. Clinics that do not meet quality targets will be subject to downward adjustment of their PMPM rate in future years. After being adjusted downward, clinics can earn back the full benefit of the baseline PMPM rate upon meeting quality targets. Seven quality process and outcomes measures are tracked, and represent a subset of the state’s common measure set. In total dollars, downward adjustment of the PMPM rate never falls below PPS equivalent payment amounts used under APM3.

Clinics will continue to perform annual reconciliation to ensure PPS equivalency. However, instead of resolving underpayments or overpayments through a settlement process, adjustments are made prospectively in future rates.

To date, 16 of the state’s 27 clinics are participating in the voluntary APM4 initiative.³⁹ The Washington Association of Community and Migrant Health Centers aims to eventually to have all clinics participate.⁴⁰

Alternative Payment Methodology with Rate Adjustment Based on Quality

Arizona: Rate Adjustment for Quality

Arizona is proposing an alternative payment methodology with a rate adjustment for quality, which is profiled in Exhibit 3 and the below description.

Exhibit 3: Overview of State-Led Alternative Payment Methodology with Rate Adjustment

State	Start Date	Model Type	Methodology	Lessons and Possible Application for CA
Arizona	Proposed 2018	Alternative Payment Methodology with Rate Adjustment	FQHC to earn a 0.5% increase of the PPS rate for each clinical quality measure that it meets. FQHCs can earn a total increase of 1.5% by meeting all three measures.	Rate adjustment provides access to retrospective resources for FQHCs, which incentivizes quality improvement.

Arizona has submitted a State Plan Amendment that would allow an FQHC to earn a 0.5% increase of its PPS rate for each of the three clinical quality measures that it met in the previous years. The measures, determined by the state, include colorectal cancer screening, control of hemoglobin A1c in patients with diabetes, and weight assessment and nutrition counseling for

children and adolescents. FQHCs can earn a total increase of 1.5 percent by meeting all three measures, as demonstrated by Uniform Data Set reports.⁴¹

Exhibit 4: Quality Measures for State-Led APMs

State	Quality Measures	Tie to Payment
Arizona	<ul style="list-style-type: none"> ■ Colorectal cancer screening ■ Control of hemoglobin A1c in patients with diabetes ■ Weight assessment and nutrition counseling for children and adolescents 	FQHC receives 0.5% increase in PPS rate for each quality target it meets.
Colorado	<ul style="list-style-type: none"> ■ FQHCs select six performance (clinical processes and outcomes) and five structural (practice characteristics, such as integrating behavioral health care or providing alternative types of encounters) measures from a list determined by the state. Measures were developed by the state using elements from other programs including UDS.⁴² 	FQHC maintains increased PPS rate for meeting quality targets.
Oregon	<ul style="list-style-type: none"> ■ FQHCs report on five measures, which are aligned with the CCO measures. 	Effective January 2019, up to 3.5% of payment is at risk for meeting quality benchmarks. FQHCs are required to exceed statewide CCO performance averages. ⁴³
Washington State	<ul style="list-style-type: none"> ■ Antidepressant medication management ■ Childhood immunization status ■ Medication management for people with asthma ■ Well-child visits ■ Controlling high blood pressure ■ Comprehensive diabetes care including blood pressure control and hemoglobin A1c >9%. 	FQHC receives an enhancement payment for meeting quality targets.

Shared Savings with a Medicaid ACO Model

Since 2011, 12 state Medicaid agencies have developed ACO or ACO-like programs (*see sidebar on page 7 for description of the ACO model*). In four states with Medicaid ACO programs -- Maine, Massachusetts, Minnesota, and Rhode Island -- FQHCs have joined together to leverage this delivery model and provide a shared savings incentive. The approaches for two of these states, Massachusetts and Minnesota, are profiled in Exhibit 5 and the descriptions on page 17.

Exhibit 5: Overview of FQHC Organizations Participating in State-Based ACO Models

Model	Start Date	Model Type	Methodology	Lessons and Possible Application for CA
Community Care Cooperative (C3) (Massachusetts)	2018	Shared savings with a Medicaid ACO	After an initial period of reporting data and meeting performance and quality goals, FQHCs will receive a shared savings payment based on total cost of care (TCOC) and meeting quality measures.	An overarching, coordinating organization like C3, which is able to focus on developing data and shared business resources for health centers, with an incremental approach, prepares health centers for success in VBP.
FQHC Urban Health Network (Minnesota)	2013	Shared savings with a Medicaid ACO	The state calculates shared savings payments for participating organizations, and instructs Medicaid health plans to make payments to FQHCs based on a TCOC calculation for a core set of Medicaid services, and for achieving quality targets based on 32 quality measures, scored as nine aggregate measures.	A partnership of a group of FQHCs can collaborate and leverage resources to improve quality and reduce costs.

Massachusetts: Community Care Cooperative

In 2018, under the authority of a Section 1115 waiver, Massachusetts launched a new Medicaid ACO program with three models that provide a range of options for how health plans and providers can work together. The Community Care Cooperative (C3), a nonprofit comprised of 17 FQHCs that cover 123,000 attributed members across the Commonwealth, was formed to operate under the Primary Care ACO model. This model involves an ACO provider organization contracting directly with MassHealth, the state Medicaid agency, which remains the payer.⁴⁴ C3 is governed by a board of directors that includes representatives of each of the participating FQHCs, consumers, and providers.

C3 is taking an incremental approach that will ultimately lead to a shared saving program for its participating FQHCs. In Year 1 (2018), FQHCs will receive payments for reporting data and C3 will establish a performance baseline. Payments in Year 2 will be based on meeting quality and utilization metrics. In Year 3, FQHCs will be eligible for shared savings based on TCOC (methodology is currently under development). There is tremendous diversity in the capacity of the FQHCs in Massachusetts to participate in value-based reforms. In response, C3 offers FQHCs a choice of financial arrangements, with small, medium, and large amounts of "risk" above PPS, according to an "internal financial architecture" developed by the organization.⁴⁵ The arrangements are subject to quality performance, with measures aligned with the Commonwealth's Medicaid ACO program.

In addition to the opportunity for upside financial rewards, FQHCs benefit from administrative efficiencies associated with the collective functions that C3 is taking on, including: (1) shared billing and employee health insurance; (2) standardized clinical guidelines; and (3) defined quality measures. C3 is also investing in the readiness of the FQHCs by building a robust IT infrastructure with data-sharing capabilities, and enhancing the FQHCs' capacity for financial management, population-based care, and data analytics.⁴⁶ C3, along with MassLeague, the state's primary care association, is also running a learning collaborative to help FQHCs advance payment reform. The collaborative is covering topics such as change management, care coordination, transition of care, and quality measures.⁴⁷

Minnesota: Federally Qualified Health Center Urban Health Network

In 2013, Minnesota launched its Medicaid ACO program, now known as Integrated Health Partnerships. Under this program, 10 FQHCs with 40 sites in the Minneapolis-St. Paul area came together to form the Federally Qualified Health Center Urban Health Network (FUHN) to enhance the health care of its Medicaid patients and improve primary care access for vulnerable populations.⁴⁸ Participating health centers saw this program as an opportunity to be part of health care transformation already occurring in other health care systems, particularly as health care reforms were increasingly focusing on primary care as the best way to address SDOH in populations that FQHCs were serving. These health centers also recognized the value of leveraging resources and collaborating in a competitive and rapidly changing health care environment.⁴⁹

In order to be successful in this new program, FUHN invested almost \$1.5 million through state and federal grants to build the data analytics infrastructure and capability needed to manage VBP arrangements. That infrastructure included a data warehouse that receives real-time clinical data from the FQHCs' electronic medical records, payer claims data, and admission and transfer data from hospital partners. On-site care coordinators and other health care staff are able to use these data to deliver quality care and manage costs.

There are over 32,000 patients currently attributed to FUHN. Under this model, providers receive their per-visit PPS payments, as well as a shared savings payment based on a TCOC calculation for a core set of Medicaid services, and for achieving quality targets based on 32 quality measures, scored as nine aggregate measures.⁵⁰ Between 2013 and 2016, FUHN saw a 14 percent reduction in inpatient admissions and a 23 percent reduction in emergency department visits.⁵¹ Participating health centers have earned \$20M in shared savings to date.⁵²

VIII. From Idea to Implementation: Overcoming VBP Challenges

Many of the models described in this report are familiar to health plans. The challenge lies in having the technical capacity, financial and staffing resources, internal and external support, and motivation to move forward. Some of these challenges are present in any new program, including: competing priorities; getting buy-in from leadership and staff; limited financial resources; and workforce retention. However, some challenges are specifically related to implementing VBP, including: sharing data; mapping care transitions; developing new work flows; and developing new contracts and business systems.

Exhibit 6 highlights some commonly identified challenges for launching new VBP models, for both health plans and FQHCs, and includes ideas for addressing them. The two columns on the far right differentiate challenges that are more typically encountered in center-focused models versus those challenges more typically found in models that focus on total cost of care.

Exhibit 6: Overcoming Challenges of Implementing VBP

CHALLENGE	HOW TO BE SUCCESSFUL		APPLIES TO	
	What Can an FQHC Do?	What Can a Health Plan Do?	Center-Only Models	Total Care Models
Buy-in				
Hesitation by health center leadership and staff	Engage internal leadership and staff; clearly communicate changes to staff	Work collaboratively with FQHCs to engage members and community leaders	✓	✓
Governance	Engage external stakeholders: patients and community leaders; develop clear roles and processes	Participate as a partner in the planning process	✓	✓
Model Design				
Program Goals	Identify common problems and win-win opportunities; consider incremental options	Identify common problems and win-win opportunities; consider incremental options	✓	✓
Rates and Contracts	Understand your health center’s financial costs; communicate your value proposition; understand contracting and rate-setting process; build relationships with plan leaders	Build relationship with FQHC leaders; be transparent; communicate expectations clearly	✓	✓
Incentives	Ensure incentive payments are sufficiently tied to performance and able to be counted outside of PPS	Design incentives that are tied to quality and demonstrate value	✓	✓
Population size	Partner with other FQHCs to increase the pool of attributed patients	Work with FQHCs to identify other FQHCs to increase the pool of attributed patients		✓
Finances and Payment				
Patient attribution	Develop clear attribution methodology upfront; share and reconcile data	Develop clear attribution methodology upfront; share and reconcile data	✓	✓
Financial health	Shore-up accounting systems, coding practices; develop business intelligence capacity	Provide support for financial management	✓	✓

(Exhibit 6 continues on page 19)

(Exhibit 6 continued from previous page)

CHALLENGE	HOW TO BE SUCCESSFUL		APPLIES TO	
	What Can an FQHC Do?	What Can a Health Plan Do?	Center-Only Models	Total Care Models
Data				
Data infrastructure	Build EHR capacity; access data from external entities	Provide resources to build IT infrastructure; provide tools for managing care in real time; develop predictive modeling; help FQHCs access data from external entities	✓	✓
Data analytics	Participate in training opportunities for staff: coding, data analytics, etc.	Share data in a timely and actionable format		✓
Care Coordination				
Knowing where patients are getting care outside of the FQHC	Develop partnerships with external providers; leverage health plan data to track patients	Share data and work with external partners to identify gaps		✓
Managing care transitions	Know how to use data to manage care transitions	Share data and develop relationships with center-based care coordinators	✓	✓
Setting-up effective care coordination models	Design and implement new care models; embed care coordinator on-site; integrate clinical guidelines across sites; incorporate changes in work flow; implement team-based care	Provide upfront resources for hiring care coordinators; establish communication channels between the health plan and FQHC	✓	✓
Quality				
Measures	Start with narrow set of measures; align measures with other programs	Start with narrow set of measures; align measures with other programs	✓	✓
Monitoring and reporting	Train staff to monitor quality data; monitor individual providers	Provide resources for staff training	✓	✓

IX. Recommendations for California's Health Plans to Advance VBP in FQHCs

Drawing from lessons from VBP initiatives across the country discussed in this paper, following are recommendations for California-based health plans to accelerate VBP in FQHCs:

1. *Build on existing VBP models.*

There are a small but growing number of existing initiatives that address accountable care at the health plan and FQHC level, both nationally and in California. The examples highlighted in this report offer a starting point for health plans to work with FQHCs to design models that fit the unique strengths of the participating entities and their environment, and also address the challenges commonly faced in launching these models. Leveraging these existing models, and learning from their experiences, may enable more rapid adoption of and innovation with VBP models.

2. *Consider incremental approaches to VBP.*

Similarly, successful models that increase accountability often take an incremental approach and allow for flexibility in implementation. Health plans can work with FQHCs to build on existing VBP efforts (e.g., P4P, care coordination) and move toward more accountable models as all entities become more comfortable and successful in these efforts. This is similar, for example, to the approach of C3 in Massachusetts. Evaluating progress along the way, as well as good communication and transparency among all partners, helps participants identify challenges, make changes as necessary, and collaboratively implement solutions.

3. *Work with FQHCs to form an entity that allows multiple FQHCs, in partnership with a health plan, to come together to address accountability for total cost of care.*

FQHCs could come together to build a virtual ACO that addresses total cost of care. This model could be an egalitarian model with equal partners, as with Chicago's Medical Home Network described earlier, or could include a partner (e.g., a hospital) that takes on downside risk. Success would require strong partnerships among FQHCs, specialty partners, and hospitals.

4. *Continue to support and bolster efforts that build the capacity of FQHCs to be successful in total cost accountable care models.*

There are various training and technical support activities underway throughout California that support the readiness and capacity of FQHCs to succeed in accountable care models. These efforts recognize that changes in the payment model do not immediately lead to changes in care delivery and outcomes. Capacities not directly related to payment, such as care delivery systems, information systems, and financial accounting, must be developed to achieve success in new payment models. The implementation ideas outlined in the prior Section VIII offer a starting point for understanding the capabilities required for MCPs and FQHCs interested in launching VBP arrangements. Health plans could support FQHCs in building capacity by providing training and technical assistance, as well as providing resources to develop IT infrastructure and data analytics, and to hire on-site staff for care coordination.

5. *Participate in opportunities to share and learn about promising accountable care models and address factors that would lead to an acceleration of these models.*

Recognizing the interest of health plans in engaging FQHCs to address the quality and total cost of care for their patients, health plans could participate in efforts that bring together health plans to share lessons and learn about promising efforts to advance accountable care.

6. Encourage and support efforts by the State of California to revise the APM pilot.

California's FQHC APM pilot (described earlier) brought together health plans and FQHCs to advance payment reform. Revisiting the pilot represents an opportunity to build on the interest, goodwill, and policy development as a result of the pilot design process. The state-led examples in this report provide ideas for California and its stakeholders to develop a model that gives FQHCs greater flexibility for delivering care and impacting quality and costs. A state-level model provides the structure and incentives for moving all entities toward greater accountability. Updates to the proposed pilot could include: (1) eliminating the downside risk by removing the reconciliation threshold, therefore making it potentially more palatable to CMS; (2) keeping the single capitation payment to plans for base payment and wrap payment, with an additional amount tied to quality; and (3) developing quality measures that align with state and HRSA goals.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center committed to improving health care quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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