Supporting Federally Qualified Health Center Participation in Value-Based Payment to Improve Quality and Achieve Savings

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ABSTRACT

In its Innovation Center Strategy Refresh, the Centers for Medicare & Medicaid Services (CMS) included the goal of moving, by 2030, 100% of traditional Medicare beneficiaries and "the vast majority" of Medicaid beneficiaries into accountable care arrangements in which providers are paid based on quality care, health outcomes, and costs. However, federally qualified health centers (FQHCs), which provide care to 1 in 11 people in the United States, have largely been left out of value-based contracts. Medicaid managed care organizations, which operate these programs for most state Medicaid agencies, have presented several barriers to participation, and the complexity of FQHC payment policy creates additional challenges. This report outlines these barriers and highlights FQHC networks that are having success with value-based payment. The authors offer guidelines on designing successful value-based payment contracts for FQHCs and recommend action steps for CMS, state Medicaid agencies, and FQHCs that will enable more of these safety-net providers to participate in value-based care — and realize savings as well as improved quality for patients.

Policy points

- States and the federal government can do more to substantially increase health center participation in advanced value-based payment arrangements.
- State Medicaid agencies, which oversee Medicaid managed care organizations, should define minimum standards for value-based payment arrangements that ensure health centers can meaningfully participate.
- The Centers for Medicare & Medicaid Services can encourage these actions through policy clarification and guidance to state Medicaid directors.

GLOSSARY

- **Accountable care organizations (ACOs)** are groups of health care providers that work together to provide high-quality, coordinated care, improve health outcomes, and manage costs.
- **Federally qualified health centers (FQHCs)** are federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of a patient's ability to pay.
- **Fee for service** is an approach to payment in which health care providers are paid for each service performed.
- **Managed care organizations (MCOs)** are health plans or health care companies that use a managed model of care to keep quality high while limiting costs.
- **Prospective payment system (PPS)** is a method of payment in which a provider is reimbursed a predetermined, fixed amount per patient.
- **Value-based care** is an approach to designing care that focuses on quality, provider performance, and the patient experience.
- **Value-based payment (VBP) models** are a type of financial incentive that rewards health care providers based on the quality and cost of care they provide.

INTRODUCTION

Federally qualified health centers (FQHCs) are federally funded health centers that operate under the oversight of the Health Resources and Services Administration. Nationwide, more than 1,400 FQHCs serve 32.5 million patients, or 1 in 11 Americans. To be an FQHC, a health center must meet criteria showing that it provides comprehensive, integrated primary care services for a medically underserved community. FQHCs provide community-based, culturally competent care, and these organizations are a vital part of primary care access in the United States because of their mandate to provide care to all patients in their community, regardless of their ability to pay. FQHCs are a large and critical component of primary care access for the Medicaid program, serving approximately one in six Medicaid beneficiaries nationally.

How FQHCs Are Funded

FQHCs have a unique policy context for payment changes given their funding sources. In addition to insurance payments, FQHCs receive federal funding under Section 330 of the Public Health Service Act to support their ability to care for uninsured patients and address public health crises such as the COVID-19 pandemic and the opioid epidemic.[2] This funding comes from a combination of annual congressional appropriations (30%) and a multi-year Community Health Center Fund (70%).

FQHCs are paid for providing care to Medicare and Medicaid patients using a prospective payment system (PPS), which is a federal minimum payment intended to compensate FQHCs for the costs of providing care for their population. Using the PPS rate, FQHCs receive a fixed, per-visit reimbursement. To promote innovation in Medicaid, federal law allows states to choose an alternative payment methodology (APM) instead. Participating FQHCs must agree to adopt the APM, and payments made to FQHCs must be equal to what they would have received under the PPS.

Despite this attempt to provide a minimum "floor" of reimbursement, FQHCs have large numbers of uninsured patients for whom they receive no payment. FQHCs often, therefore, operate on small and unpredictable margins.

While the movement toward value-based payment (VBP) — in which insurers pay providers for quality, provider performance, and patient experience — has existed for decades, the Centers for Medicare & Medicaid Services (CMS) identified VBP as a top priority relatively recently. In its Innovation Center Strategy Refresh,[3] published in October 2021 and updated in April 2024,[4] CMS defines goals for the coming decade for the Medicare and Medicaid programs. Primary among these goals is the ambitious aim of moving 100% of traditional Medicare beneficiaries and "the vast majority" of Medicaid beneficiaries into accountable care arrangements, in which providers are paid based on quality care, health outcomes, and costs, by 2030.

This shift to paying for value-based care is critical for future financial stewardship of the Medicaid program. Value-based care has demonstrated improved quality outcomes and financial savings for Medicare and many commercial payers since 2012.[5] This approach is now beginning to make an impact in the Medicaid environment, with states shifting toward pay-for-performance models.[6,7,8]

For the safety-net providers that care for Medicaid members, VBP reform can be particularly important as it supports predictable reimbursement that can ensure a sufficient primary care workforce, as well as investments in technology and in community health. These changes are critical to maintain health care operations and to improve the ability of safety-net providers to withstand future crises.[9]

As community-based providers, FQHCs offer high-value care with an understanding of the culture, language, and local needs of the individuals and families they serve. In addition to primary care, FQHCs bring together dental, vision, specialty care, and social services, offering an efficiency in care delivery that makes them well positioned to contribute to the goals of VBP and value-based care. Evidence consistently shows that FQHC patients have lower-cost patterns of care than non-FQHC patients. A 2016 *American Journal of Public Health* study[10] found that health center patients had lower service use and spending than did non–health center patients across all services, with 22% fewer visits and 33% lower spending on specialty care and 25% fewer admissions and 27% lower spending on inpatient care. Total spending was 24% lower for health center patients.[11]

The California Primary Care Association's Value of Community Health Centers Study[1] likewise found that adult FQHC patients had 64% lower rates of multi-day admissions, fewer inpatient hospitalization days, lower 30-day readmission rates, and fewer emergency department visits. And a Geiger Gibson/RCHN Research Collaborative study in *Pediatrics* saw lower health care costs for children who received most of their care at FQHCs compared with those who did not.[1]

Despite being well positioned for successful performance in value-based arrangements, FQHCs have historically participated in VBP contracts at disproportionately low rates. Participation in accountable care organizations (ACOs), groups of health care providers that work together to provide high-quality care focused on improving outcomes and lowering costs, can provide the support that FQHCs need to engage in VBP contracts. However, a 2019 survey from the Commonwealth Fund reported that in 2018, only 39% of FQHCs were members of an ACO.[1]

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Managed Care–Related Barriers to FQHC Participation in VBP

Today, most Medicaid funds flow through Medicaid managed care organizations (MCOs). Forty-one states have Medicaid MCO contracts, and 74% of all Medicaid enrollees are enrolled in comprehensive managed care with a Medicaid MCO for some or all of the Medicaid-covered services they receive.[1] This makes Medicaid managed care policy central to state and federal efforts to build VBP in Medicaid.

Medicaid MCOs present three major barriers to FQHC VBP adoption: (1) fragmented sources of payment for the FQHC's Medicaid patients; (2) misaligned incentives and power imbalances between the Medicaid MCOs and their FQHC partners; and (3) a lack of regulatory or contractual direction for MCOs on VBP arrangements with FQHCs.

Fragmented Medicaid Payment Sources

Across all FQHCs, approximately 50% of patients are insured through Medicaid.[1] However, most Medicaid markets have a preponderance of MCOs. KFF's managed care tracker[1] lists 287 separate plans across the country, with an average of seven MCOs per state and 26 in California.

With multiple MCOs serving Medicaid patients in each market, FQHCs' patient panels are typically fragmented across multiple MCO contracts, so clinicians are often paid differently for different patients. Researchers studying advanced primary care practice models have found that VBP approaches can only be successful when at least two-thirds of patients are included in the arrangement.[1] When providers still have a substantial portion of their patients in a traditional fee-for-service contract where payment is based on services performed, they are unable to effectively commit to operational changes required in a VBP arrangement.

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Even if two or more MCOs in an FQHC's patient panel have VBP arrangements, the plans might have different rates, terms of payment, data portals, and quality measures. Carolina Medical Home Network, which contracts with the state's five Medicaid MCOs on behalf of a group of FQHCs in North Carolina, evaluated its uncoordinated arrangements, finding that the health centers were required to track more than 3,900 data points monthly across five different data portals.

Misaligned Incentives for MCOs and Lack of Leverage for FQHCs

On top of this fragmentation, MCOs have fundamentally misaligned incentives, as well as the majority of the power in setting contracts. Half of all Medicaid enrollment in the country is with one of five for-profit insurance companies: Centene, Elevance, UnitedHealth Group, Molina, and CVS Health.[1] These MCOs have structural incentives to direct substantial savings to shareholders, rather than reinvesting the majority of savings in FQHCs, other providers, or the community.

Additionally, an FQHC is in a weak position when negotiating independently with an MCO. As nonprofit, independent organizations with boards of directors predominantly comprising local community members, FQHCs generally lack the market leverage, sophisticated contract negotiation teams, and resources of their larger competitors or MCO counterparts. As a result, MCOs pay FHQCs much lower rates. Massachusetts's Center for Health Information and Analysis found that the top quartile of providers in the state received 57% of all physician provider payments, while the bottom quartile received only 10%.[20] The top five provider groups in the state across all payers are large multi-hospital systems.

This inequality in reimbursement, which is created by insurers distributing health care resources based on market-negotiated contracts, can compound racial and economic disparities in the health care system. Large and powerful health care provider systems negotiate high payment rates that direct funds away from FQHCs and community providers that disproportionately serve lower-income communities of color and those with non-English language preferences.

Lack of Regulatory or Contractual Guidance

To address these inequities, policy leaders at Medicaid agencies, state departments of insurance, and CMS should realize the opportunity to address the power imbalance and align incentives to bring more FQHCs into VBP arrangements. They can do so by issuing guidance to explicitly communicate a preference for VBP arrangements, incentivize VBP contracting, or even require VBP in the procurement process.

Network Collaboration for VBP Contracting

While reliance on contracting through MCOs represents a substantial barrier to VBP adoption for FQHCs in Medicaid, other barriers exist as well. Most notably, payment policy for FQHCs is complex, which may lead state Medicaid agencies to hesitate to attempt reforms that would impact the prospective payment system (PPS) methodology described above.

However, FQHCs can participate in VBP programs without jeopardizing the PPS rules by making sure the VBP arrangements are voluntary and pay more than the PPS rate. Additionally, multiple FQHCs can form a network that is a unique legal entity. Under such an arrangement, contracts can be structured to hold the FQHC network accountable for the total cost of care (TCOC) for their attributed patients. These FQHC-led networks exist in several states (see case studies) and are sometimes called ACOs or clinically integrated networks.

Under these FQHC-led network structures, FQHCs can participate in advanced VBP arrangements, including CMS's Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model Framework category 4. Contracts can be negotiated to allow the network of FQHCs to retain some of the savings realized if the actual TCOC is less than the contracted rate ("shared savings" or "upside risk"). More sophisticated contracts might provide FQHC networks with the potential to share in more of the savings if they agree to pay back any incurred financial losses.[21] FQHC-led networks have proven successful at taking on this kind of downside risk — saving payers, Medicaid agencies, and CMS significant money. FQHC networks can use the surplus earned in these arrangements to fund joint investments in shared infrastructure, create reserves to take on additional risk in more advanced or expanded contracts in future years, purchase reinsurance and actuarial and financial services, and otherwise advance on the VBP learning curve.

Case Studies

A growing number of FQHCs are forming networks, participating in advanced VBP arrangements, and achieving financial success for their practices and their Medicaid program while providing quality care to their members. These examples illustrate two core principles for successful FQHC VBP adoption: (1) Medicaid programs with MCOs must standardize and prescribe specific elements of VBP arrangements, and (2) these elements must specifically address certain unique needs of FQHCs.

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Missouri Health Plus

Founded in 2013, Missouri Health Plus (MHP) was formed as a network of FQHCs in Missouri to support success in value-based care. MHP now has 22 FQHCs and 19 community mental health centers participating in value-based care contracts with payers. MHP negotiates contracts with the state's three Medicaid MCOs for over 200,000 Medicaid members attributed to the network. The network has additional contracts with Medicare Advantage payers and created its own Medicare ACO in January 2024.

On average, MHP contracts reduced the medical loss ratio by more than 8 percentage points across payers. The resulting reduction in total spending saved an estimated $191 million over the last several years. Those shared savings have been invested in the FQHCs and community mental health centers. In addition to negotiating and managing value-based care contracts, MHP offers centralized support, including delegated provider credentialing and enrollment, data analytics and reporting, and support for payment denials and claims resolution. MHP has also invested in efforts to align clinical quality measures across contracts, as well as supporting staff capacity and operational workflows.

While the MHP VBP contracts were initiated as "upside-only" arrangements, MHP is now engaged in downside risk arrangements.

Community Care Cooperative

Community Care Cooperative (C3) was founded in 2016 to unite a group of Massachusetts FQHCs and leverage the strength of that network to improve primary care and advance health equity. C3 has become Massachusetts' largest Medicaid ACO and has expanded to include a Medicare presence in Massachusetts as well as six other locations (California, Connecticut, Louisiana, North Carolina, Oregon, and Washington, DC). C3 now has ACO contracts for Medicaid, Medicare, and commercial lines of business, and is responsible for the TCOC for approximately 250,000 patients attributed to its FQHCs.

C3's VBP arrangements include advanced components such as two-sided risk and prospective capitation in Medicaid and in Medicare through the federal Realizing Equity, Access, and Community Health (REACH) model. In addition, C3 participates in the Massachusetts Medicaid demonstration in which ACOs are exposed to up to 100% of the first 5% of losses, after which a series of "risk corridors" moderate the downside risk to the ACO. C3 has beaten the market average performance and earned incentive payments of more than $40 million in its first four years of operation. As a nonprofit, FQHC-led ACO, C3 saw 98% of its savings paid out directly to its FQHCs to reinvest in their mission. C3's success has allowed it to branch out into other areas to further support FQHCs, including building capacity to support pharmacy operations and investing in Epic electronic health records.

Community Health Network of Washington / Community Health Plan of Washington

In 1992, community health centers across Washington State affiliated as Community Health Network of Washington (CHNW). With the advent of Medicaid managed care in the state, CHNW created Community Health Plan of Washington (CHPW). Today CHNW comprises 21 community health centers serving more than a million patients annually. CHPW is Washington's only nonprofit Medicaid MCO, serving nearly 270,000 Medicaid members, most of whom receive their primary care via CHNW. CHPW serves an additional 40,000 members via Medicare Advantage and Washington's exchange-based public health insurance option.

CHNW and CHPW have been engaged in payment arrangements centered on primary care providers managing their patients' TCOC for more than 30 years. Today, over 90% of CHPW's total expenses fall under HCP-LAN Alternative Payment Model Framework categories 3A or higher, with payments tied to quality performance. These arrangements have fostered the community health centers' ability to develop infrastructure related to care coordination, health equity, and social determinants of health. CHPW offers centralized support to the community health centers to ensure success in VBP and support better patient outcomes. These functions include data analytics and reporting through multiple tools including CHPW's Clinical Integration Solution, which combines the health centers' electronic health record data and CHPW's claims data.

Recommendations for VBP Model Design to Support FQHC Participation

Medicaid policymakers looking to advance the adoption of value-based arrangements by FQHCs should follow several principles that align with the HCP-LAN Alternative Payment Model Framework.[22] The following recommendations for payment models draw from this framework to address the needs of FQHCs.

1. Return Shared Savings to FQHCs

- Participating FQHC networks should be eligible to share in a substantial portion (50% or more) of the savings realized when the actual total costs incurred for their attributed population are below the benchmark or goal set for average TCOC.
- The definition of TCOC should encompass a reasonably representative and comprehensive set of services with some nuance, such as excluding costs that are rare, extreme, and difficult to modify like organ transplants or certain high-cost drugs.

2. Adjust Payment Model for the FQHC Patient Population

- The benchmark costs used to set rates should be based on the average TCOC in the market, or the average amount the MCO gets paid per enrollee, rather than using the FQHC networks' own historical low reimbursement as a starting point.
- Upfront investment funding should be available to support FQHC networks in building the infrastructure needed to participate alongside providers that have better access to capital.
- TCOC performance calculations should incorporate risk adjustment strategies that consider social needs and demographic characteristics. Proven models exist, with excellent predictive value; an example is Massachusetts Medicaid's social determinants of health model, which has been in use since 2018.[23]
- Quality incentives should include credit for improvement, not just attainment.

3. Use Administrative Funds to Support Staff Capacity and Additional Services Needed for Patients with Complex Care Needs

- The payment model should support staffing of an integrated care team and clinical programs that prioritize and engage the members with the most complex needs.

- Adequate funding should be provided for the administrative work and community partnerships required to engage members and to identify and address health-related social needs.

4. Make Contract Mechanics Transparent and Timely

- All methodology (including TCOC, quality measures, risk adjustment, and attribution) should be replicable and fully transparent to participating provider networks.
- Providers should have regular access (e.g., via monthly feeds) to data on their attributed population, claims history, and risk data.
- Benchmarking and settlements should be timely, providing FQHCs access to the shared savings revenue within months of the conclusion of the performance year.

5. Standardize Requirements Across MCOs

- Perhaps most importantly, the payment model should be substantially standardized across all Medicaid MCO payers in each market.
- This standardization should include quality measures, reimbursement rates, and aligned contract terms that incentivize FQHCs to enter into VBP arrangements.

The Roadmap to VBP: Recommendations for Action

Recommendations for FQHCs and Primary Care Associations

To succeed in VBP in Medicaid, FQHC leaders must be willing to make operational changes in partnership with the primary care association and other FQHCs in their region or state. This will enable them to negotiate contracts that support successful transitions to VBP. Suggested actions include:

- Join or form a network to provide the legal entity needed for contracting.
- Adopt network-level population health analytics for understanding and forecasting cost and quality performance across the network and at each FQHC.
- Align on contract terms that are important for network and individual FQHC success.
- If needed, reduce the number of MCOs with which the FQHCs are contracting. This can be achieved by releasing a request for proposals that defines minimum standards for a network-level MCO contract and declaring an intention to work with a select few. The state Medicaid agency can assist with auto-assignment rules ensuring that beneficiaries' primary care relationships are preserved to the greatest extent possible.

Recommendations to State Medicaid Agencies and Managed Care Organizations

State Medicaid agencies bear primary responsibility for advancing VBP in Medicaid, as well as for contracting with MCOs and overseeing MCOs' performance. State Medicaid agencies should therefore provide more prescriptive direction and a state contracting landscape that promotes VBP standardization across MCOs in each market. State Medicaid agencies have substantial authority to direct their MCOs through procurement, contract, and sub-regulatory

processes (e.g., bulletins and guidance letters), without the need for policy levers that require CMS authority. Examples include:

- Draft a bulletin, guidance letter, or publicly posted value-based roadmap document to communicate that the MCOs in the market must offer aligned VBP terms to provider networks in Medicaid, and outline a process (e.g., a series of meetings with all the MCOs and key provider stakeholders led by the Medicaid agency) to define these terms. This communication creates a permissible legal framework for MCOs to coordinate with one another, avoiding antitrust considerations that might otherwise be concerning for health plans.
- Create a framework or simple checklist of model contract terms to streamline negotiations and encourage standardization. This framework could be impactful even if the checklist were nonbinding, allowing MCOs and providers to deviate from the list to create other contract terms by mutual agreement.
- Incorporate requirements into the procurement process or through MCO contract amendments to designate a minimum amount of VBP. The state Medicaid agency could require a percentage of VBP arrangements to be HCP-LAN category 4 TCOC arrangements and require MCOs to meet benchmark levels not only for their overall population but also for patients attributed to safety-net providers or FQHCs.
- Issue a bulletin or contract amendment to clarify expectations for good-faith contract negotiations, if a state Medicaid agency has VBP requirements in its MCO contracts. For example, the state Medicaid agency could define standards for timelines for initiation and completion of formal contract negotiations, as well as timeliness in provision of requested data.

In addition to these mechanisms to direct MCOs on VBP, state Medicaid agencies also have an enormous opportunity to reduce the power imbalance between MCOs and safety-net providers through the MCO procurement process. For example, a state Medicaid agency could structure its MCO procurement to allow the state's primary care association to be part of the review process. Such a structure would give FQHCs a significant voice in determining which MCOs win the state's Medicaid business and create accountability for the MCOs.

Additionally, a state Medicaid agency could explicitly encourage new bidders, especially nonprofit, provider-led, locally based organizations. Creating more competition (especially nonprofit competition) to reduce the massive market concentration will make Medicaid MCOs more accountable to the needs of the Medicaid program and its beneficiaries — and less accountable to shareholders. There is even precedent for states banning for-profit MCOs from their programs.[24]

Recommendations for CMS

CMS has an important role to play in encouraging MCOs to engage FQHCs in VBP contracts. We recommend three opportunities for consideration:

- At a minimum, CMS can issue a state Medicaid director letter explicitly encouraging VBP advances such as providing data transparency and adoption of recommended and standardized contract terms.

- CMS can utilize the demonstration program to incentivize VBP arrangements. For example, CMS can inform states that successful Section 1115 demonstration waiver proposals should include:
    - A commitment to advancing VBP with FQHCs, including formal comment from the primary care association, and
    - A plan for transparent requirements for reporting from MCOs to FQHCs that will support successful VBP arrangements.
- CMS can require or encourage VBP contracts as part of the Managed Care Rule. The current rule has requirements for data reporting, fiscal and program integrity, and newly finalized standards regarding timeliness of access to routine appointments. However, the rule does not require MCOs to specifically report on their VBP arrangements with FQHCs or commit to advancing such arrangements.

CONCLUSION

As CMS has indicated, advanced VBP arrangements that allow networks of providers to share in savings on TCOC for attributed populations are the future of sustainable and equitable Medicaid payment.

Medicaid programs will succeed or fail at achieving VBP at scale by bringing their FQHCs and other safety-net providers into these arrangements with the supports they need to succeed. FQHCs are too important to be left behind. CMS's and state Medicaid agencies' ability to bring FQHCs into VBP arrangements will in turn substantially determine whether CMS is able to meet its VBP targets, address health equity, and ensure adequate access to primary care.

FQHC networks have demonstrated that they can take on VBP arrangements. These networks deliver savings to government and payers while providing quality care for their populations. They have also been shown to be mutually beneficial, allowing the clinics to reinvest in expanding access to care in their communities and growing their operations — a virtuous cycle that addresses inequities in the current fee-for-service state of Medicaid health care financing.

However, market conditions are such that these changes have not — and will not — happen without policy changes. Medicaid policymakers should proactively work to include FQHC-led networks in VBP programs using the tools and recommendations cited in this report, such as directing MCOs to standardize VBP arrangements and incorporating key design elements into contracts to support FQHC participation.

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Aditya Mahalingam-Dhingra is a mission-driven, innovation-minded health care executive with a decade of experience on the cutting edge of state and national Medicaid policy and delivery system reform. Aditya joined Community Care Cooperative (C3) in 2022 as the chief business officer and has led the organization's expansion from Massachusetts to supporting federally qualified health centers in eight states. Aditya joined C3 from MassHealth (Massachusetts' Medicaid and CHIP program), a $20B agency that provides health coverage for two million (or roughly one in every four) people in Massachusetts. Aditya served on the agency's executive team as its chief of payment and care delivery Innovation, overseeing $6B across its accountable and managed care contracts, and leading a team of 60+ FTE as well as the agency's policy innovation and health equity efforts. In his nearly 10-year career with the state, he successfully led the design, federal negotiation, implementation, and management of large parts of the largest re-structuring of the Medicaid program in 20 years, including the agency's first program for accountable care organizations.

Vikki Wachino has spent her career leading and inspiring organizations that make a difference to people most in need. She founded and is executive director of the Health and Reentry Project, a major initiative to promote public health and public safety by expanding access to health care for people who are returning to communities from prison and jail. Vikki served as deputy administrator of the Centers for Medicare & Medicaid Services from 2015-2017, where she oversaw implementation of Affordable Care Act coverage expansions and groundbreaking policies to strengthen mental health parity, delivery system reform, and Medicaid managed care. She also chairs the Strategic Advisory Council of the Community Care Cooperative.

Kim Prendergast is vice president for policy for Community Care Cooperative (C3). In this role, she leads strategic and policy initiatives, working toward a landscape that adequately supports federally qualified health centers to advance primary care, leverage value-based payments and address social drivers of health to improve health equity and health outcomes. Kim joined the organization in 2019 and has been the architect of C3's work to identify and address health-related social needs through partnerships across the health care and social services sectors. She designed and implemented the organization's $27M Medicaid-funded Flexible Services program that has served as a national model for health care-community collaboration.

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