

Advancing Payment Innovation within Federally Qualified Health Centers: Lessons from California

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IN BRIEF

Under the Affordable Care Act, California's Medicaid population increased by roughly 35 percent. Many of the newly enrolled childless adults are enrolled in managed care and receive primary care services through Federally Qualified Health Centers (FQHCs). To enhance the capacity of FQHCs to improve care delivery for their patients, California's Department of Health Care Services is pursuing a value-based, alternative payment methodology (APM) for its FQHCs. The proposed APM pilot is designed to give FQHCs more effective incentives to achieve the goals of the Triple Aim — better care, better health, and lower costs. This brief, made possible through support from the Blue Shield of California Foundation, describes the pilot development process and proposed payment methodology, and outlines early lessons. California's experience may help inform other states exploring alternative payment models for FQHCs.

California's Medicaid program (Medi-Cal) serves nearly 14 million beneficiaries, with approximately 75 percent of these individuals in Medi-Cal's managed care health plans. Since Medicaid expansion in January 2014 under the Affordable Care Act, Medi-Cal enrollment has grown 35 percent due to the large influx of childless adults at or below 138 percent of the federal poverty level, expanding the overall Medicaid managed care population. Much of the newly enrolled population has sought primary care services through Federally Qualified Health Centers (FQHCs), increasing the number of clinics across the state.¹ As a result, safety net providers, including FQHCs, have greatly expanded responsibilities in providing access to primary care services for Medi-Cal beneficiaries.² To support FQHCs' need for greater flexibility to improve care delivery for their patients, as well as broader trends to link payment to outcomes, California's Department of Health Care Services (DHCS) and stakeholders are pursuing a value-based payment reform pilot for their FQHCs.

This brief describes the efforts of California and its FQHC stakeholders, documents the pilot development process and proposed payment methodology, and outlines key lessons to date. California's experience in the design and planning process may provide useful insights for other states that are exploring alternative payment models for their FQHCs.

FQHC Landscape in California

Established in 1990 by Section 4161 of the Omnibus Budget Reconciliation Act, FQHCs are public or tax-exempt entities that meet the requirements to receive direct funding under the Public Health Service Act (Section 330). Federal law requires that FQHCs be reimbursed for all reasonable costs associated with the services they provide. Therefore, state Medicaid programs must pay the cost for all covered services that FQHCs provide to Medicaid beneficiaries.

In 2000, Section 702 of the Medicare, Medicaid, and Benefits Improvement and Protection Act adapted the payment methodology for FQHCs, moving from a retrospective cost-based system to prospective payment system (PPS) methodology. This created a PPS per-visit rate equal to 100 percent of costs in the previous year. States are permitted to use an alternative payment methodology (APM); however, the new payment methodology must ensure that health centers do not receive less than what they would have received under PPS and the health centers have to agree to it.

Currently, Medi-Cal managed care plans 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. DHCS directly reimburses FQHCs through a “wrap-around” payment, which 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 the federal requirements that FQHCs be reimbursed for all billable services tied to their PPS rate. A reconciliation process is in place to further ensure that payments meet PPS requirements. This payment process, however, is cumbersome and can result in delays in payments to the FQHCs.

There are currently 1,015 FQHCs in California — 282 of which are rural health centers — that serve vulnerable populations including medically underserved communities, uninsured individuals, and the Medi-Cal population.³ Thus, FQHCs are a foundation of the state’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. FQHC providers can include: physicians; physician assistants; nurse practitioners; nurse midwives; clinical psychologists; licensed clinical social workers; comprehensive perinatal practitioners; and dental hygienists.

Pilot Goals

Beginning in 2014, DHCS partnered with the California Primary Care Association (CPCA) and the California Association of Public Hospitals and Health Systems (CAPH), to pilot an APM that would provide FQHCs more effective incentives than PPS to achieve the goals of the Triple Aim — better care, better health, and lower costs. The pilot was driven in part by FQHCs looking for innovative opportunities to improve patient care. DHCS and stakeholders established the following goals to guide pilot design and implementation:

1. Transition from the volume-based PPS system to one that better aligns financing and delivery of health services;
2. Promote care delivery redesign and allow for flexibility to deliver care in the most effective ways to improve primary care access;
3. Improve the beneficiary experience;
4. Enhance collaboration and coordination between FQHCs and Medi-Cal managed care plans; and
5. Simplify the payment structure for clinics and shift the primary payer responsibility to the Medi-Cal managed care plans.

Overview of Pilot Planning Efforts

State Legislation and the Proposed Pilot

California State Senate Bill (SB) 147 (Chapter 760, Statutes of 2015) authorized a three-year pilot program for county and community-based FQHCs, to begin no sooner than July 2016. As proposed under the FQHC APM pilot, the PPS payment and wrap-around would be replaced by an upfront, clinic-specific capitation rate. FQHCs would receive a comprehensive payment from health plans on a monthly basis rather than having to wait until the end of the year for a supplemental payment, which is particularly beneficial to cash-strapped health centers. This payment reform would allow FQHCs to use flexible resources to deliver care in innovative ways that would 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.

Participating FQHCs would benefit from a simplified payment process, replacing the previous billing approach and associated delays in payment. While plans and FQHCs would have additional requirements under the pilot, both are expected to benefit from better coordination of care, which would help to reduce unnecessary utilization of services and improve beneficiary experience.

Under the proposed pilot, DHCS would solicit FQHC participation in the APM pilot via a formal application process. Medi-Cal managed care plans would be required to participate if their network health centers are selected for the pilot.

Engaging Key Stakeholders and the Stakeholder Process

The active involvement of key stakeholders throughout the planning process was a critical factor in developing the FQHC APM pilot. Shortly after the introduction of SB 147, which was developed and sponsored by CPCA and CAPH, the state convened a Policy Work Group to seek stakeholder input on policy issues and obtain buy-in. Key participants included CPCA and CAPH, which were driving the legislative efforts, and the California Association of Health Plans, the Local Health Plans of California, individual health plans, and legislative staff. The Policy Work Group addressed key issues in helping the bill go through the legislative process, and, after the bill was signed into law, the group worked through the provisions in the statute to ensure federal approval and successful program implementation.

The state also convened three sub-work groups to develop recommendations for: (1) rate development; (2) contracting; and (3) alternative encounters. The Policy Work Group and the sub-work groups addressed proposed pilot design, rate development, clinic selection and readiness, and evaluation.

CPCA and CAPH collaborated extensively with the state to advance their goals of greater flexibility in care delivery and simplifying the payment structure. In addition to participating in the Policy Work Group and subgroup meetings, CPCA and CAPH supported the state by researching policy issues, soliciting input from their members on technical questions, and developing creative solutions to

policy problems. These organizations also worked with legislative staff to coordinate and advance the parallel efforts of drafting and navigating SB 147 through the legislative process and to the Governor's desk.

Engaging the Centers for Medicare & Medicaid Services

DHCS developed a pilot concept paper, incorporating details agreed upon by stakeholders across the state, and formally submitted the concept to the Centers for Medicare & Medicaid Services (CMS) in October 2016.⁴ DHCS is using the paper as the basis for discussion with federal authorities with the ideal goal of achieving buy-in on the overall concept before the state submits its official request to CMS to pursue the pilot. If approved, DHCS plans to implement the three-year pilot no sooner than January 1, 2018.

Pilot Design and Policy Issues

Following are key design elements and policy issues addressed collaboratively by the state and the stakeholders, as summarized in the FQHC APM concept paper.⁵

Populations and Covered Services

The pilot will include four categories of aid populations reflecting the majority of FQHC users: (1) children; (2) adults; (3) seniors and persons with disabilities (SPD); and (4) expansion adults. Eligible Medicaid beneficiaries must be enrolled in a managed care plan and assigned to a primary care provider who works in a participating health center. Those members who are eligible for the pilot will be referred to as "assigned pilot members."

The per-member per-month (PMPM) rate will cover all of the services that a health center includes in its current PPS rate. Services could include obstetrics and other specialty services, as well as behavioral health services for mild to moderate mental health conditions, if those services are currently offered at the health center. Under the pilot, health centers will have the flexibility to provide services that are currently not reimbursed, such as: (1) integrated primary and behavioral health visits on the same day; (2) group visits; (3) email or phone visits; (4) community health worker contacts; (5) case management; and (6) care coordination across systems.

The scope of services currently provided by health centers varies throughout the state. The Policy Work Group considered limiting the services included to physical health to promote uniformity among the pilot sites and to eliminate the concern about revisiting contracts with specialty partners, particularly for behavioral health services. The work group considered three options: (1) including behavioral health and all other services; (2) eliminating behavioral health services; or (3) a hybrid approach allowing behavioral health services to be included if behavioral health providers are already paid the same way as the other services, and not included if they are paid through other arrangements. Although the state preferred the first option, it was open to input from the stakeholders. To inform the process, CPCA and CAPH conducted an inventory of health centers that provide behavioral health services and the percentage of those services relative to their total services, as well as an inventory by site of which services were provided. The Policy Work Group

concluded — with the support of CPCA and CAPH — that the new rate should include the full scope of services contained in the current PPS rate for a health center.

Rate Setting and Alternative Services

For the initial year of the pilot, the PMPM payment will be determined using historical data from the individual health centers. The goal is to ensure that the capitated payment will be equivalent to the amount it would have received under PPS. Data collected for the rate-development process will include enrollment, utilization, and cost information, as well as the category of aid.

To help determine the rate-setting methodology, the state engaged its actuary, Mercer, to analyze historical data from a subset of health centers and health plans in three counties and calculate projected rates. The health centers and health plans submitted two years' worth of enrollment, utilization, and cost data for all PPS-related visits for three categories of aid (child, adult, SPD). The analysis, which included projected rates for the individual health centers and health plans, was useful in informing the rate calculation discussion among the stakeholders.

This exercise helped the actuaries develop a template for the required data elements to be used during the actual rate-setting process. Those data elements will include: (1) enrollment, utilization, and cost information by month; (2) category of aid; and (3) FQHC utilization and cost information for all assigned pilot members and their PPS-related visits. Health plans and Independent Provider Associations (IPAs) will report payment made to the FQHC for each claim and/or capitation arrangement, and FQHCs will report payment received from health plans, the PPS amount, and the wrap-around payment for each claim, as well as additional payments received as part of a capitation arrangement. DHCS will also use several years' worth of FQHC-specific reconciliation data and PPS rate information — including any prior-year requests for changes in scope or services in the rate-setting process.

The analysis helped in clarifying the challenges and the time involved in validating the data, such as verifying the completeness of the submissions and reconciling the discrepancies between the health center and health plan data. As a result of the analysis of projected rates, the state will require the participating health plans, rather than the state, to collect, validate, and reconcile the historical data from the health centers, and then submit the “clean” data to the state for the pilot rate development.

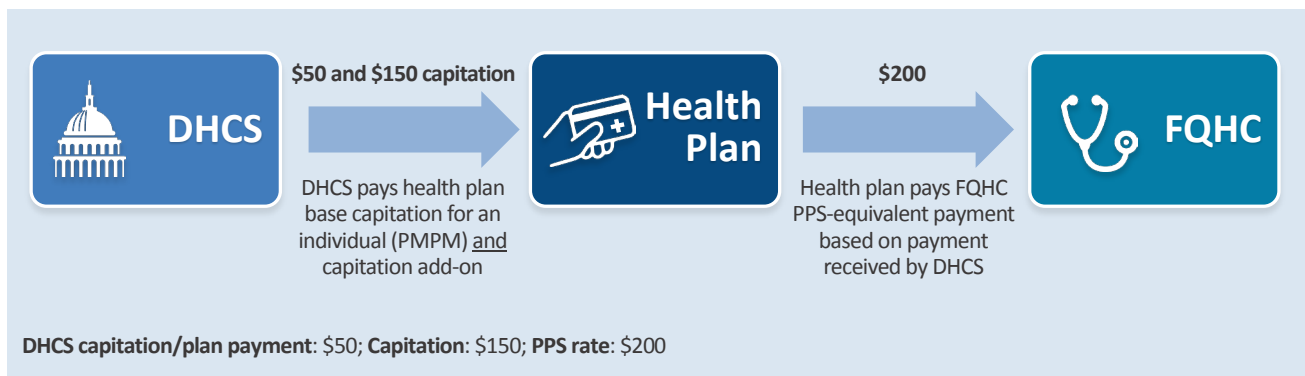
For years two and three of the pilot, DHCS will base the rates on utilization experience, which will include both traditional services as well as new, alternative encounters. Alternative encounters are services that are currently not billable under PPS, but are designed to increase patient engagement, improve patient outcomes, and generally allow better coordinated and integrated care. Examples include: (1) group visits; (2) case management; (3) wellness visits; (4) marriage and family therapist visits; (5) integrated primary and behavioral health visits; (6) pharmacist consultations; and (7) patient support groups. Giving health centers the ability to bill for alternative encounters is a key benefit for participating in the pilot. This flexibility also allows health centers to take advantage of innovative ways to deliver care, such as through electronic and mobile technology. The state convened a stakeholder work group to identify these alternative encounters and ensure that they are tracked for future rate setting.

Payment Flow

Under PPS, FQHCs must be paid a per-visit rate based on a predetermined, fixed amount. In California, FQHCs are reimbursed directly by the state for beneficiaries in the fee-for-service program or by the health plan for visits by their members. For managed care members, the FQHC bills the state for the difference between the health plan payment and the PPS rate. As described earlier, the payment that the state makes to the FQHC is known as the wrap-around payment. Additionally, there is a final reconciliation between the state and the FQHC to ensure that the payment is equivalent to the PPS rate.

Under the pilot, FQHC payment will transition from the state to Medi-Cal managed care plans. The state will make a PMPM clinic-specific payment to the health plan for members assigned to the participating health center. The participating FQHCs in turn will receive, for each of their assigned pilot members, an actuarially sound, clinic-specific capitated payment from the Medi-Cal managed care plan. This clinic-specific capitated payment will eliminate the existing plan payment, wrap-around payment, and reconciliation payment, and replace it with one capitation payment equivalent to what they would have received under the previous payment system, making the reimbursement and workflow administratively simpler. Under the new payment model, the health center will be responsible for providing all of the services for the member that falls under its scope of services, including physical health services, as well as behavioral health services, obstetrics, and pharmacy if provided.

Figure 1: Example of Proposed FQHC APM Pilot Payment Flow



SOURCE: California Department of Health Care Services

Reconciliation and Risk Mitigation

California’s proposed rate-setting methodology aims to keep clinic payments equivalent to PPS, but shift the payment frequency to a single upfront monthly payment. This eliminates the traditional reconciliation process, which is administratively burdensome and expensive for both the FQHCs and Medi-Cal. The state worked with FQHCs to jointly develop a new process whereby reconciliation would be triggered when actual traditional utilization for the health center falls outside of the expected traditional utilization levels. The reconciliation triggers for greater-than-expected traditional utilization will start at five percent in the first year of the pilot, move to 7.5 percent in year two, and 10 percent in year three. For example, the state will initiate a reconciliation process when

the actual number of traditional visits at a health center is five percent above the number of projected visits used when developing the health center's rate. For less-than-expected utilization, the trigger is set at 30 percent for each of the three years of the pilot.

Establishing a threshold for reconciliation deviates from the reconciliation process required under the PPS equivalency provisions of Section 1902(bb)(6)(B). The decision to modify this process was the most significant obstacle in the pilot development. The state proposed the new reconciliation approach, in combination with the permissible clinic attestation method communicated in CMS' 2010 State Health Official letter,⁶ to align with the pilot's overarching goal of transitioning from a volume-based system to a payment methodology that rewarded value. The state viewed the rate-setting methodology, which would incorporate each FQHC's utilization rates into the capitation payment annually, coupled with the proposed reconciliation triggers, as mitigating the levels of financial risk that otherwise necessitated the traditional reconciliation process. While the health centers preferred maintaining the traditional reconciliation process, given the uncertainty with the new methodology, they were able to support the proposal with the upside possibility of the 30 percent less-than-expected utilization threshold.

Recognizing its importance, the state and the health center associations addressed this issue at the beginning of the pilot development process. Over a period of months, CPCA and CAPH and the state reached an agreement on the percentages for the phased-in triggers, which allowed the pilot development process to move forward. The state and the health center associations agreed to include this new process in the pilot design, recognizing that participation in the pilot would be voluntary and that there would be sufficient protections, including the ability of a health center to opt out of the pilot with a 120-day notice, and various overall advantages to participating. While the state believes that the proposed pilot (with a prospective clinic attestation to the sufficiency of PPS) demonstrates compliance with the federal APM statute, it continues to have discussions with CMS to explore the viability of this approach.

Managed Care Contracting

Several elements were built into the pilot to mitigate health plan risk for unanticipated costs, such as a health center changing its scope of services or a fluctuation in the number of assigned members. These protective elements include: (1) health plan capitation rates will be adjusted annually to reflect any changes to the health center's PPS rate or scope of services; (2) capitation payments from the state to the health plan will be adjusted monthly to reflect changes to the health plan's assigned members; and (3) a risk corridor will be established to protect the health plans from the averaging nature of the capitation, as rates for different FQHCs vary and the capitation could potentially be too high or too low, based on the actual member assignment to each clinic.

Existing contracts between the state and the health plans, as well as contracts between the health plans and the FQHCs, will need to be modified prior to the start of the pilot to reflect the new payment model. For contracts between the state and the health plans, modifications will include making the health plan the primary payer for the pilot health centers in the health plan's county, requiring the health plan to report on the number of assigned pilot members, and detailing the risk corridor structure. For contracts between the health plan and the health center, changes would

address the new role of the health plans, new timelines, rate methodologies, scope of services, and reporting requirements. The state will be drafting standardized language for its new contracts with the health plans, and issuing guidance for contracts between the health plans and health centers.

Pilot Size, Health Center Selection, and Roll-out

While SB 147 requires the state to invite all FQHCs to submit an application to participate in the pilot, not all health centers will be selected. Ideally, the pilot will include enough health centers to demonstrate the impact of the new payment methodology without becoming unmanageable from an administrative and rate-setting perspective. The health center associations have indicated that 75 health center sites in 14 counties, in both rural and urban settings, have expressed a strong interest in participating. The pilot will likely be rolled out in two or three phases over a short timeframe.

The state will develop the application process and criteria for selecting health centers for the pilot based on the broad requirements described in SB 147. In addition to verifying with its Audits and Investigations team that health centers are in good standing, DHCS is also considering the following eligibility criteria for health centers: (1) experience with strategic practice transformation; (2) data capabilities; (3) a documented strategy to move to the new payment model; (4) organizational commitment to transforming primary care practices; (5) quality improvement infrastructure; (6) staffing and capacity; and finally, (7) adequate pilot membership to drive the health center's transformation.

The stakeholder work groups served as a productive forum for identifying how the state would determine which health centers would have the capacity and readiness to successfully participate in the pilot. The health center associations drafted a set of criteria, based on the broad requirements outlined in SB 147, which were discussed during the work group meetings. The health centers and health plans collaboratively built on this document and submitted a proposal to the state to help guide the final selection criteria.

The health center associations were actively involved throughout the pilot development process to increase the likelihood of a successful pilot. First, the associations worked with their members to identify health centers that would potentially be interested in participating in the pilot and would have the capacity to successfully undertake the initiative. Second, with funding from a consortium of foundations, the Capitation Payment Preparedness Program (CP3) was created to help prepare potential health center sites for the pilot.⁷ CP3 is a structured technical assistance program designed to support the pilot sites with preparation, ranging from change management to population health management. CP3 provides planning and assessment tools, training on a variety of financial and operational topics, and technical assistance to interested health centers. Stakeholders were engaged from early on in the policy design process through implementation.

Evaluation

As required by SB 147 the state will contract with an independent entity to conduct an evaluation of the pilot. The evaluation will examine payment adequacy, delivery system transformation, and quality measures. The state has not yet defined its evaluation plan, and the stakeholder work group is expected to weigh in on specifics, particularly the quality measurement activities.

Lessons for States Contemplating an APM Model for FQHCs

Following are lessons from California's experience for other states that are considering an APM model for FQHCs:

- 1. *Engage and partner with health center associations and managed care associations early on.*** Given that the state cannot require FQHCs to participate in an APM, Medi-Cal's success has been driven in part by the ongoing partnership with health centers to develop the program goals and overall pilot approach. DHCS' partnership with CPCA and CAPH ensures that the program design and implementation approach are beneficial to all parties involved, and that participation among FQHCs will be sufficiently high to warrant state investment in the program. Involvement of the managed care plans was critical as well, since implementation requires their knowledge, time, data, and resources.
- 2. *Understand how health plan contracts with FQHCs are structured and may vary, and address needed modifications.*** Several key decisions, such as which populations and services to include in the APM, hinged upon the current structure of contracts between the health plans, FQHCs, and other providers such as IPAs. In California, FQHCs often contract directly with health plans and with IPAs, to whom plans delegate risk and delivery of primary care services. Medi-Cal needed to understand the various ways in which these contracts might be structured and what it would take to revise those contracts to determine how to structure the APM pilot.
- 3. *Allocate actuarial resources for data modeling and methodology testing.*** From the beginning, DHCS recognized the value of having actuaries involved in technical aspects of the pilot planning process. DHCS was able to include its actuarial contractor, Mercer, in early discussions with staff and stakeholders about data needs for the pilot. Informed by those discussions, and with support from the stakeholders, DHCS collected data from a subset of FQHCs and health plans and worked closely with Mercer to analyze the data, identify gaps, and build a model for pilot rate setting.
- 4. *Have stakeholder work groups in place to address technical issues.*** Creating technical work groups that included relevant experts from both the managed care plans and FQHCs enabled Medi-Cal to work through and come to agreement on highly complex issues. The work groups served as technical "staff extenders" and ensured that issues concerning the payment methodology were explored from all perspectives — state, payer, and provider — before decisions were made.

- 5. Address payment flow and administrative issues with an eye toward reducing the burden on payers and providers.** Payment reform presents an opportunity not only to pay for value and provide greater flexibility in care delivery, it can also be structured to reduce administrative burdens and expenditures, which can be a powerful incentive to participate. It was important to understand and, to the greatest extent possible, address the existing challenges around the PPS approach for both the state and the health centers to help inform the APM pilot. Key PPS issues for California included the time lag of up to two to three years for full payment to the FQHCs and the multiple payment streams, particularly in the managed care environment.
- 6. Be clear on care delivery transformation goals before turning to the issue of payment methodology.** From the outset, California set a primary pilot goal to make it easier for FQHCs to innovate how care is delivered. To support innovation, the pilot was designed to: (1) enable clinics to address the increased demand for services; (2) attract and retain providers; and (3) improve patient care and satisfaction. These goals tie directly to the upfront capitation approach that DHCS developed. Other care delivery goals may have led to other types of APMs, such as shared savings or pay for performance.
- 7. Align initiative with existing state policy goals.** California has a strong commitment to improving the health care delivery system. This is evidenced by the focus of the state’s Section 1115 Waiver Renewal (Medi-Cal 2020) that contains various delivery system and payment reforms. However, the waiver does not have a specific strategy for addressing FQHC payment reform. By harnessing this existing policy momentum, along with an overall commitment to the goals of the Triple Aim, the FQHC APM project has a coordinated direction with other key Medi-Cal policies and programs.
- 8. Develop a strategy for communicating the state’s vision to CMS before submitting the State Plan Amendment (SPA).** In an informal and pre-SPA submission approach, it is helpful to share a concept paper with CMS to identify any flags that may require adjustments. Providing this preview also gives CMS an opportunity to orient to and understand the state’s model before a SPA is submitted for approval. Providing CMS an early opportunity to view and comment on the state’s approach should ideally help to streamline the federal review and approval process.

Conclusion

As a result of a thoughtful and deliberative design process, led by state officials and informed by engaged stakeholders, California is preparing to launch a promising pilot that aims to simplify and improve the FQHC payment structure. The new payment structure provides FQHCs greater flexibility in delivering better care to their patients. Understanding the impact of the payment restructuring on stakeholders, anticipating and addressing potential implementation challenges, and engaging relevant experts were critical pieces in the process. While the California pilot was developed in the context of the state’s unique health care landscape, lessons from California’s experience can inform other states building APM models.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

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

ENDNOTES

¹ California Department of Health Care Services. *California's Fee-for-Service Medi-Cal Program Health Care Access Monitoring Plan*. September 2016. Available at: <http://www.dhcs.ca.gov/formsandpubs/laws/Documents/2016AccessMonitoringPlan.pdf>.

² P. Shin, J. Sharac, Z. Barber, S. Rosenbaum, and J. Paradise. *Community Health Centers: A 2013 Profile and Prospects as ACA Implementation Proceeds*. Kaiser Family Foundation. March 17, 2015. Available at: <http://kff.org/report-section/community-health-centers-a-2013-profile-and-prospects-as-aca-implementation-proceeds-issue-brief/>.

³ E-mail from Jim Burkhardt, California Department of Health Care Services Audits and Investigations, February 24, 2017.

⁴ Federally Qualified Health Centers Alternative Payment Methodology Pilot – California Concept Paper. California Department of Health Care Services, October 13, 2016. Available at: <http://www.dhcs.ca.gov/services/Documents/FQHC/FQHC-ConceptPaper.pdf>.

⁵ Ibid.

⁶ State Health Official Letter RE: Prospective Payment System for FQHCs and RHCs. SHO # 10-004 CHIPRA # 15, Center for Medicaid and State Operations, February 4, 2010. Available at: <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO10004.pdf>.

⁷ For more information, visit <http://www.cpc.org/index.cfm/health-center-resources/capitation-payment-preparedness-program-cp3/>.