Medicare Diversification Strategy

A Health Center's Medicare services should include a turnkey, results-focused approach. This starts with ensuring a clean encounter capture, smart scheduling, and solid documentation. Standing up reliable care-management workflows and building simple processes and checklists to drive annual wellness visits, post-discharge follow-ups, and risk-adjustment touchpoints.

A smart Medicare diversification plan can boost margin and strengthen the impact of Health Centers. Organizations should fortify their positions with strong attribution, data-sharing, and care-management operations to ensure long-term success. Here are some strategic considerations tailored to FQHCs, highlighting what to pursue, why it matters, and the distinct levers to move revenue and margin while staying mission-focused.

A resilient Medicare strategy will blend:

- Fee for service, care management revenue
- Measured expansion into Medicare Shared Savings Program (MSSP) and primary-care Accountable Care Organization (ACO) models
- Selective Medicare Advantage (MA) contracts
- Targeted senior-care offerings (such as PACE or partnerships with local providers)

Keep an Eye on Policy and Market Changes:

The current policy environment favors balancing accountable care and care-management payments. Using contracting playbooks will help organizations avoid taking unmanaged risks and help mitigate against imminent policy changes such as the October 2025 change in telehealth policy coverage.

- Telehealth authority ending September 2025. Health centers will need to budget for in-person substitution if this policy is not renewed.
- CMS momentum towards accountable care with a 2030 goal. Expecting continued expansion of prospective primary care payments and continued model adjustments favoring total cost of care accountability.
- MSSP Performance. ACOs with robust primary care enablement are well-positioned to capitalize on shared-savings rates.
- MA guardrails and benefit design shifts. Rulemaking continues to tighten marketing, utilization management, and network standards. Health centers need to continue to

prepare for plan strategy changes that affect FQHC contracting.
- PACE growth will depend upon state policies. Check with individual state's PACE positioning and reimbursement specifics before investing in conversion.

What to Prioritize:

- Strengthen Medicare FFS revenue fundamentals
  - Maximize encounter capture for PPS and ensure accuracy of care-management add-ons such as proper coding as G0511 sunsets. Stand up a care management engine to reliably add recurring revenue and improve quality scores. Establish panel identification, outreach cadence, and documentation templates ensure success.
  - Protect and expand telehealth where allowable. Plan for coding/budget shifts. FQHCs will no longer be eligible distant-site providers for non-behavioral Medicare telehealth after September 2025.
- Grow value-based Medicare revenue
  - Join or deepen participation in an MSSP ACO with capability for attribution management, care coordination, post-acute follow-up, and data transparency.
  - Evaluate newer primary-care oriented models (e.g. ACO Primary Care Flex) offering prospective, population-based payments and infrastructure dollars.
  - Track CMS' broader push for accountable-care relationships, signaling where contracting policy and guidelines are heading.
- Negotiate Medicare Advantage (MA) contracts
  - Seek rate floors at or above the PPS equivalent, prompt payment terms, risk-adjustment support, and data feeds. Include wrap-around mechanics when applicable and strong guardrails on delegated risk.
  - Watch MA/Part D rule changes that add guardrails, beneficiary protections, and network expectations as these will alter plan behavior and the health center's leverage.
- Expand senior-focused service lines and partnerships
  - Assess PACE (either operate as a PACE or partner with one) where state policy and local dual-eligible density support it. PACE becomes the single source of Medicare/Medicaid benefits for enrollees (capitated financing means that risk must be modeled carefully).
  - Use FQHC-specific PACE guidance and checklists to plan capital, workforce, and organizational risks before launching a PACE transition.

Mission-Focused Milestones:

- Care-management add-ons
  - Ensure bundled coding (G0511) workflows are accurate and updated (panel stratification, monthly touch cadence, documentation). Monitor monthly volumes, no-shows, and net margin per enrolled participant.
- Impact of Telehealth policy changes
  - Maintain telehealth pathways that continue, address visit mix, provider schedules, and patient communications immediately (if not previously addressed)
- ACO pathway selection
  - If new to value-based care, join an MSSP ACO with strong primary-care enablement.

    - If already in MSSP, evaluate PC Flex participation to add predictable dollars for primary care infrastructure.
- MA panel strategy
    - Map Medicare Advantage penetration and star ratings locally, focusing contracting on 2-3 plans with scale, data connectivity, and care-coordination funds. Make sure to include risk-adjustment and quality bonus workflows.
- PACE diligence
    - Use state policy checks and NPA or NACHC toolkits to build a pro forma to evaluate capitation versus full cost of care, transportation, adult day health, and specialty networks)

Strengthen your organization with the following:

- Attribution and panel management
    - Weekly rosters, automated outreach lists, post-discharge transitional care management, and gaps in care
- Coding and documentation
    - Risk-adjustment accuracy (tied to visit types and care-management touches), encounter integrity for PPS, and compliant telehealth coding
- Data and contracts
    - Timely claims data, care-gap files, and member changes
    - Define risk corridors and stop-loss (use NACHC contracting guidelines as a checklist)
- Workforce operations
    - RN and Medical Assistant care management team to manage proper coding (CPT G0511), pharmacist team to optimize medications, Community Health Workers for engagement, and an analyst for panel and performance ops.
    - Stay on top of risk management and process improvement opportunities

Policy and Market Watch At-A-Glance
Telehealth *– Budget for in-person shifts as FQHC distant site authority ended September 30*
Accountable Care *– Expect more prospective primary-care payments and total-cost-of-care models as CMS pushes towards 2030 goals*
MSSP *– ACOs with strong primary –care enablement are best positioned for shared savings*
Medicare Advantage (MA) *- Prep contracting and data-sharing as guardrails continue tightening regarding marketing and utilization management*
PACE *– Confirm policy and reimbursement before investing as viability is state-specific*
Contracts and Risks *– Use clear playbooks to avoid unmanaged risk and stay ahead of policy changes*