CHCF Issue Brief

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by OCHIN

Building Medicare Capacity in California Community Health Centers

As California's population ages, older adults are projected to make up nearly one-quarter of the state's population — almost 10 million people — by 2030.* For community health centers (CHCs), navigating Medicare effectively is increasingly critical to providing high-quality care, retaining patients as they age, and maintaining financial stability.

At the same time, California's Medicare landscape is becoming more complex. The state's rollout of specialized health plans for people enrolled in both Medicare and Medi-Cal (Dual Eligible Special Needs Plans, or D-SNPs), growing enrollment in Medicare Advantage plans, the expansion of Program of All-Inclusive Care for the Elderly, and ongoing threats to Medi-Cal eligibility and funding at the federal level all place new operational and financial demands on CHCs. As more CHC patients gain Medicare coverage, many CHCs are prioritizing older adult care and the systems needed to support these programs — but often without the infrastructure required to do so effectively.

Managing Medicare can be particularly challenging for CHCs, which typically operate with limited staffing and narrow financial margins. These challenges are compounded by the fact that Medicare enrollees served by CHCs tend to have higher medical and social needs than the broader Medicare population, including higher rates of chronic conditions and disability. To remain financially sustainable while meeting the needs of older adult patients, CHCs must better align their people, processes, and technology to streamline workflows, improve operational efficiency, and ensure accurate billing and revenue capture.

If CHCs are unable to adapt their care delivery and operations for Medicare, they risk losing older adult patients to larger health systems, undermining both access to care and financial viability. Retaining older adult patients within CHC settings is crucial, as CHCs provide high-quality, cost-effective, and often more accessible care closer to home.

Based on a survey and interviews with California CHCs that are members of OCHIN, this issue brief examines CHCs' strengths, barriers, and readiness for Medicare and value-based payment. It highlights key gaps in care delivery, operations, data, and staffing and identifies priority areas where additional support is needed to help CHCs succeed in serving a growing Medicare population.

Analysis Process

In late 2025, OCHIN assessed the readiness of California CHC members to deliver care for a growing population of aging, Medicare-enrolled patients. As part of this assessment, OCHIN examined CHCs' care delivery practices, operational and data infrastructure, payment strategies, and approaches to training and incentivizing both clinical and nonclinical staff.

From OCHIN's national membership, 60 California CHCs across the state were identified as potential participants in the Medicare and value-based-pay readiness analysis.

* Master Plan for Aging (website).

To develop a well-rounded understanding of CHCs' current capabilities, barriers, and goals related to Medicare care delivery, OCHIN collected both quantitative and qualitative data. This work included analysis of existing OCHIN data on patient populations and payer mix for each CHC, deployment of a standardized assessment tool examining a variety of care delivery and financing domains, and conducting individual interviews to provide additional context and insights.

In total, 24 California CHCs completed the standardized assessment tool, and six CHCs volunteered to participate in extensive interviews. Insights from these assessments and interviews informed the key findings and implications presented in this brief.

Key Findings

OCHIN's assessment process revealed several themes about California CHC capabilities and readiness for caring for an expanding Medicare population.

Opportunities for Growth in Fee-for-Service Medicare and Value-Based Payment Arrangements

- **Varying experience.** Among participating sites, California CHCs demonstrated wide variation with Medicare. Some had limited Medicare experience, while others participated in Original (fee-for-service, or FFS) Medicare, enrolled patients in D-SNPs and other Medicare Advantage plans, or engaged in accountable care organizations (ACOs). Based on Medicare readiness scores from the OCHIN assessment, 85% of CHCs with the highest-readiness scores participated in the Medicare Shared Savings Program or an ACO. In contrast, CHCs with the lowest readiness scores primarily participated in FFS Medicare or Medicare Advantage plans only.
- **Inconsistent or absent billing practices.** Assessment results indicate that while most CHCs deliver care coordination services — such as chronic care management, remote patient monitoring, and transitional care management — they are not consistently or effectively billing for the associated enhanced Medicare benefits. This suggests that care delivery processes are often in place, but billing and documentation practices do not reliably support reimbursement, resulting in unclaimed revenue.
- **Limited use of data for payer engagement.** Among survey respondents, no participating California CHCs reported running reports on Medicare or dually eligible patient populations to support contract negotiations. Contract negotiation and data-informed payer engagement were identified as the lowest areas of readiness overall. To perform strongly in FFS Medicare and value-based payment, it is essential that CHCs establish robust data and reporting infrastructure within a single integrated platform. Such a system enables effective quality improvement, identification of care gaps, and ongoing monitoring of operational and financial health. Success relies on collaborating with strategic partners, leveraging technology solutions, and developing clear plans to optimize their data infrastructure and reporting capabilities.

Readiness Enhancement Strategies for Growth in FFS Medicare and Value-Based Payment

- ✓ Strengthen and invest in care management and coordination to engage in FFS Medicare programs that provide additional revenue opportunities.
- ✓ Ensure billing practices are optimized, with electronic health record billing automation tools or streamlined documentation workflows for care management and billing staff.
- ✓ Prioritize data governance and infrastructure to support payer engagement.
- ✓ Develop strong strategic partnerships with vendors and technology solutions focused on integration and interoperability.

Opportunities to Optimize Medicare Care Delivery and Clinical Processes

- **Leveraging risk stratification and reporting.** Based on average assessment scores across all participating sites, risk stratification and data-driven decisionmaking were identified as needs with low readiness. Lower-scoring CHCs reported that risk adjustment, stratification, and reporting capabilities were not well optimized for older adults, highlighting the need for stronger data infrastructure to support high-quality care for Medicare enrollees. In contrast, high-readiness CHCs prioritize robust reporting systems and use risk stratification data to guide clinical decisions.
- **Standardizing and simplifying workflows.** Also, most interview sites reported a lack of standardized processes and documentation workflows within their centers. CHCs expressed the need for turnkey solutions and simplified workflows. When CHCs lack the capacity to develop these workflows internally, support from collaborative networks, foundations, payers, and solution partners becomes critical to share best practices and streamline care delivery processes.

Readiness Enhancement Strategies to Optimize Medicare Care Delivery and Clinical Processes

- ✓ Leverage reports and clinical support tools to inform care delivery practices.
- ✓ Develop end-to-end workflows and continuously evaluate their effectiveness for clinical providers, care teams, and staff.

Opportunities to Better Support Health Center Staff

- **Building Medicare operational competence.** Many CHCs reported greater experience serving Medicaid populations than Medicare or older adult patients. One organization highlighted a key challenge: Before they can expand Medicare services, they must first optimize Medicare performance — but they remain uncertain about how to approach this. Multiple lower-scoring CHCs noted wanting to better understand Medicare quality measures and how they can optimize operations within their clinics. Yet 62% of participating CHCs did not educate or train key staff regarding the Medicare model and aims.
- **Strategic focus on Medicare optimization.** All interviewees emphasized the importance of Medicare to health center financial diversification and sustainability. Assessment findings show about 80% of respondents are likely (greater than 7 on a scale of 10) to prioritize Medicare optimization initiatives in the next three years. While CHC Medicare readiness varies, the need for a data-driven Medicare strategy — focused on expanding participation in both fee-for-service and value-based payment Medicare models — is clear.
- **Staff training for Medicare success.** While CHCs want to expand their Medicare capabilities, many currently lack clear strategies or support for the upskilling and building of foundational Medicare knowledge among staff needed to help drive Medicare care delivery decisions and to strengthen data infrastructures.

Readiness Enhancement Strategies to Better Support Staff

- ✓ Build a strategic plan to optimize Medicare care delivery operations, finances, and reporting.
- ✓ Offer training and provide educational resources to CHC staff regarding care for aging populations.
- ✓ Structure staff incentive programs around Medicare measures or operational best practices.

Conclusion

California's CHCs play a critical role in ensuring older adults receive high-quality care close to home. As the state's Medicare-eligible population continues to grow, patient retention and complex care delivery have become pressing challenges for CHCs.

Meeting these demands will require partnerships with technology providers and payers to navigate regulatory complexity and to strengthen data and reporting capabilities.

Integrated platforms that connect care delivery and payment can equip clinicians with actionable data at the point of care and support staff efficiency, improving decisionmaking, patient outcomes, and Medicare compliance. This data-driven, collaborative approach will be essential for long-term sustainability and success.

Medicare maturity assessments and CHC interviews revealed significant opportunities to help California members prepare for growth and success in Medicare care delivery. These insights underscore that Medicare is complex and that CHCs need to consider strategies to address gaps, build on strengths, and position themselves competitively in an evolving Medicare landscape.

About the Author

Claudia Der-Martirosian, PhD, is a research investigator; Grace Geremias, MSPP, is a program manager; and Oyinkansola Bukky Ogunrinde, MHSA, is a strategic transformation consultant at OCHIN, a nonprofit health care innovation organization and consultancy supporting community health centers across the nation.

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About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.