JUNE 2021

CHCF Issue Brief

Risky Business: California Health Centers Weakened by the COVID-19 Pandemic Prepare for the Future

The COVID-19 pandemic has had a profound impact on the entire health care delivery system. For Federally Qualified Health Centers (FQHCs),[1] which are foundational to the nation's primary care safety net, this was especially true. The core mission of health centers is to provide primary and preventive care to low-income and underserved populations. Many health centers have expanded services to offer both behavioral health and oral health care services. In 2020 alone, California's health centers provided care to 7.4 million patients, or one in five Californians.[2]

In response to the COVID-19 pandemic, health centers quickly adapted care models and operations, repurposing staff, providing outreach, leveraging telehealth modalities, and remaining open for emergencies. The pandemic reinforced that FQHCs are nimble and can reach patients in creative ways. As face-to-face visits (the primary mechanism for FQHC reimbursement) declined during the pandemic, however, health centers faced a particularly challenging time financially. The financial stability of health centers is an important consideration given that their programming benefits patients and the Medi-Cal program by supporting access, advancing health equity, and working toward broader population health.

The COVID-19 pandemic demonstrated how the current FQHC payment methodology is an increasingly outdated payment model that is ripe for change. New financial analysis reveals that — whether measured by revenue, number of patients, or number of sites — the largest health centers in the state bore the brunt of the financial losses directly resulting from COVID-19.[3] In addition, those that offer the broadest array of services — health centers that are trying to meet the medical, dental, mental health, public health, and social service needs of the community, including large and mid-sized entities — were the organizations disproportionately impacted. Health centers that serve the highest proportion of Medi-Cal patients sustained almost all the financial losses.

The Health Resources and Services Administration (HRSA) has awarded more than $1 billion to 175 California health centers through American Rescue Plan Act Awards.[4] The combination of federal relief funding paired with temporary policy changes, such as allowing for expanded reimbursement for telehealth services, provided a lifeline that helped FQHCs remain afloat and should help cover a significant portion of prior losses and new costs. In the coming months and years, it will be important to monitor the financial health of FQHCs and the safety-net health care system. However, temporary federal relief and policy changes do not solve the root issues that caused health centers to be so vulnerable in the face of the pandemic.

Because health centers serve mostly people with low incomes and communities of color, it is important to ensure that health centers' operating model is less vulnerable to fluctuations in in-person visit volume. During the pandemic, such fluctuations led to downsizing and temporary closures at 13% of California's FQHC sites.[5] Such trends threaten access to care and health equity.

This report summarizes policy options that have the potential to improve FQHC stability, address health equity, and ensure access to a broader range of services in the long term, including the following:

- Modernizing payment to FQHCs through an alternative payment model (APM)
- Recognizing the value of all telehealth modalities, including telephone calls
- Making investments in the health care workforce

California's efforts to develop an APM may prove particularly important. An APM could result in more financial predictability while providing greater operational flexibility for health centers that want to customize care delivery to uniquely meet the needs of their patient population and achieve health equity goals. FQHCs could provide nontraditional services not currently reimbursed under traditional face-to-face visits, such as integrated primary and behavioral health visits on the same day, group visits, email and phone visits, community health worker outreach, case management, and coordination of care across systems.[6]

The policy considerations are based on financial analysis of health center data, insights from an advisory panel of California FQHC experts, and reflections from several interviews with health center executives conducted between October 2020 and February 2021. Health center executives were selected based on recommendations by the advisory panel and reflect the diversity of health centers in the state, including large and small health centers; urban, suburban, and rural health centers; northern, central, and southern health centers; and health centers serving different racial and ethnic populations.[7]

Context for This Report

This report is the third in a series designed to provide a window into the financial and operational impact of the COVID-19 pandemic on California's FQHCs. The first report, *California Federally Qualified Health Centers: Financial and Operational Performance Analysis, 2016–2019* (PDF),[8] released in November 2020, provided an aggregated financial and operational profile of California FQHCs, and illustrated some of the drivers of declining financial performance prior to the onset of the pandemic. The second report, *Holding On: How California's Health Centers Adapted Operations and Care for Patients During the Pandemic*,[9] released in February 2021, analyzed the financial impact of the COVID-19 pandemic on California's health centers from March through December 2020. The report identified several key factors that enabled California's health centers to weather the financial strain caused by the pandemic, thereby enabling them to continue to serve patients at a time when access to health care was limited by shelter-in-place directives.

This third report includes findings and considerations developed through additional financial analysis of health centers during the COVID-19 pandemic and discusses the characteristics of the California health centers hardest hit by the pandemic prior to the March 2021 federal funding provided by the American Rescue Plan Act. This paper also discusses how the COVID-19 crisis magnified issues related to health disparities and access to care, as well as the policy and reimbursement considerations that could strengthen the FQHC model and ensure access to high-quality, team-driven care for low-income Californians. The financial analysis was also recently released in a separate issue brief and infographic titled *The Pandemic's Financial Impact on California's Community Health Centers: Largest Centers Suffer Significant Losses*.[10]

Financial Analysis

The following tables reflect findings from financial analyses of the FQHC experience in California during the COVID-19 pandemic and the characteristics of the California health centers hardest hit by the pandemic as of December 2020. The analyses estimate health center operating losses resulting from a precipitous decline in patient visits due to stay-at-home orders; additional COVID-19-related costs incurred by the centers, including personal protective equipment (PPE), facility modifications, and the rapid deployment of telehealth technology; and offsetting federal relief from various agencies, including HRSA, the Department of Health and Human Services (HHS), the Federal Trade Commission, and the Small Business Administration. The analyses incorporate health center financial audits as well as operational and utilization data reported by the Uniform Data System in 2018 and 2019; survey data collected by HRSA, Capital Link, and the National Association of Community Health Centers (NACHC); and estimates of federal relief funding provided between April and December 2020. For more information about the methodology, please see the second report in this series, *Holding On*.[11]

The largest health centers in California (those in the "Top Quartile" as indicated in Table 1) experienced the greatest financial losses between April and December 2020 due to the pandemic. The two most important factors that appear to have financially disadvantaged larger health centers across all California FQHCs were the lack

of Paycheck Protection Program (PPP) loans and the level of HRSA Bureau of Primary Health Care (BPHC) grant funding. These funding streams greatly favored smaller health centers (the "Bottom Quartile[s]" in Table 1). Recognizing the importance of small health centers is an important policy objective; they often serve as a lifeline for rural and underserved communities, so ensuring their viability in communities that might otherwise completely lack access to care is essential.

While there were some minor differences in the decline in the average number of visits (which affects revenues) and the average percentage of visits conducted virtually, centers of all sizes and across all regions were fairly tightly clustered, with an average visit decline of about 19% to 26%, and 49% to 56% of all visits conducted virtually. Table 2 outlines the results of the loss analysis by region and urban/rural location (see page 4).

While some health centers had net gains through December 2020, COVID-19 relief funds received by that time were intended to cover costs into 2021 — so any "surpluses" some health centers may have realized are likely to ultimately be used to cover pandemic-related losses in 2021. The methodology for allocation of the American Rescue Plan Act Awards[12] varied significantly

Table 1. Impact of COVID-19 Pandemic on FQHCs, by Demographic Factors

	TOP QUARTILE	BOTTOM QUARTILE(S)
Federal PPP funding and BPHC grants	**PPP loans.** Many of the largest health centers were not eligible to apply for PPP funding, and these centers sustained the largest financial losses. Only 42% of health centers with revenues above $36.7 million (those in the fourth quartile) received a PPP loan. **BPHC grant funding.** The largest centers (those in the fourth quartile) received an average of $44 per patient.	**PPP loans.** 100% of health centers in the bottom three quartiles received a PPP loan. **BPHC grant funding.** BPHC grant funding averaged $153 per patient for the smallest health centers in terms of revenue size (those in the first quartile).
Revenue	FQHCs with revenues in excess of $36.7 million in 2019 absorbed 95% of the total losses in 2020, totaling approximately $557 million (equal to an 11% operating loss).	The lowest two quartiles of health centers, those with revenues below $16 million, had combined surpluses totaling $64 million (equal to an 8% operating gain).
Number of patients	The top quartile of health centers, those with more than 31,000 patients in 2019, absorbed 97% of losses, totaling approximately $547 million (a 12% loss).	The lowest quartile of health centers, those with fewer than 6,500 patients, had estimated surpluses totaling $41 million (a 17% gain).
Number of sites	The top quartile of health centers, those with between 14 and 52 sites, absorbed 91% of losses, totaling $506 million (a 12% loss).	Health centers with three or fewer sites had collective surpluses of $32 million (a 5% gain).
Proportion of Medi-Cal patients	Health centers that serve the highest proportion of Medi-Cal patients sustained almost all the financial losses, totaling an estimated $549 million, with 96% of losses concentrated in the fourth quartile, representing those centers serving between 20,266 and 243,421 Medi-Cal patients in 2019. This group sustained average losses of $145 per patient, based on total patients served that year.	The 51 health centers that served fewer than 3,555 Medi-Cal patients in 2019 (those in the first quartile) had an aggregate gain of $42.5 million. They experienced average gains of $222 per patient.
Service mix	Health centers with the most diversified service mix sustained the greatest financial losses. The quartile of health centers with the highest losses also had the highest proportion of dental visits (13% in 2019). The "high-loss quartile" also provided the highest proportion of enabling visits (4% vs. 1% in 2019) and the highest proportion of "other professional visits" (5% vs. 2%). Both groups of health centers provided an equal proportion of mental health service visits (5% in 2019).	Dental visits composed only 1% of visits for the quartile with the lowest losses or gains.

Table 2. Losses, by Region or Location

	HIGH-LOSS QUARTILE(S) OR GROUPS	LOWER-LOSS QUARTILE(S) OR GROUPS
Region	Regionally, the losses were more balanced, although the southern and central regions sustained the heaviest total losses as well as the heaviest per-patient losses. Losses were highest for health centers in the southern region, at $179 million in total and $150 per patient. Seventy percent of the patient population in the southern region was enrolled in Medi-Cal in 2019. In 2019, health centers in the central region — with 66% of patients enrolled in Medi-Cal — collectively lost $163 million, or $101 per patient. Health centers in the Sacramento Valley region were close behind, with losses at $100 per patient. Seventy-three percent of Sacramento's patient population was enrolled in Medi-Cal in 2019.	The San Francisco Bay Area and Los Angeles regions were in the middle in terms of revenue losses per patient, at $70 and $66, respectively. Centers in the northern region sustained the lowest net losses, at $21 per patient.
Urban/rural	Ninety-four percent of financial losses were concentrated in urban centers.	Six percent of financial losses were sustained by rural centers. Rural centers were greatly aided by a special distribution from HHS's Provider Relief Fund targeted for rural providers.

from earlier awards, greatly increasing the funding available to the largest health centers. This funding will provide vital short-term relief to address the precarious financial position of many centers resulting from the pandemic, while also providing support for a massive vaccine deployment effort.

Policy Options That May Improve Financial Stability of Health Centers

Modernizing Payment to FQHCs Through an Alternative Payment Model (APM)

According to the NACHC, more than 24 states have adopted an APM for Medicaid enrollees.[13] Discussion of widespread adoption of an FQHC APM has been underway for several years in California.[14] Under an APM, FQHCs would no longer be paid based on in-person visits, but instead would receive a set per-patient per-month payment. By implementing an APM that aligns payments with the comprehensive services provided by FQHCs, state policymakers can recognize the value and the breadth of services health centers provide. Full APM implementation would enable health centers to care for patients in new ways and protect them from financial downturns when in-person visit volume fluctuates due to unforeseen circumstances, such as the COVID-19 pandemic.

Over the last several years, many health centers have expanded their business lines beyond traditional primary care to include dental, mental health, and substance use disorder treatment services, and some have developed programs aimed at serving people experiencing isolation and homelessness. These services would be well supported by an APM that values greater integration across service lines. Integrated care models support more comprehensive care and facilitate "one-stop shopping" for individuals and families. There is a strong evidence base for integrated care models that allow for warm handoffs between providers, which in turn result in reduced patient no-show and cancellation rates.[15]

Interviews with health center executives revealed interest and urgency in transitioning to an APM. Ralph Silber, executive director of the Alameda Health Consortium, expressed enthusiasm for getting to a place "where we

have more predictability and flexibility about revenue — we would be able to get off this hamster wheel where we are only getting paid for face-to-face encounters with a licensed provider."

Although FQHCs provide both primary care and mental health services, they cannot currently be reimbursed for both if services are provided on the same day, limiting the advantage of colocation and integrated care delivery.[16] An APM that supports broader integration would resolve same-day billing challenges. Many states allow FQHCs to bill for medical, behavioral health, and dental services on the same day, but California only allows same-day billing for medical and dental services.[17] In addition to strengthening the financial stability of health centers and encouraging integration, expanding access to behavioral health services acknowledges an increased need and can help reduce stigma when such services are offered in the same setting as physical health services.

State policymakers can also promote collaboration for care delivery transformations between health centers and Medi-Cal managed care plans since more than 80% of Medi-Cal enrollees are in Medi-Cal managed care plans.[18] For example, as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the state is considering In Lieu of Services (ILOS) options. ILOS are flexible wraparound services that a Medi-Cal managed care plan could pay for in lieu of an avoided Medi-Cal expense, such as an unnecessary emergency room visit. One of the ILOS options is Housing Tenancy and Sustaining Services. Under this option, Medi-Cal managed care plans may enter contractual relationships with organizations such as FQHCs that are well positioned to offer wraparound services to patients in need.

As an example, Neighborhood Healthcare, based in Escondido, has a partnership with a community-based organization that embedded a Complex Care Resource Specialist on-site to provide employment, housing, recovery, and behavioral health support services. This position — while important — is subject to the community-based organization's resources. By leveraging the ILOS option under CalAIM (assuming federal approval), Neighborhood Healthcare would have a more sustainable revenue stream to support this work.

Foundational to making improvements in health care delivery and addressing health equity is access to data. Having the ability to analyze data about patient health and treatment history at the individual and population level is essential to inform quality improvement initiatives and improve health outcomes. Across the state, many health centers, particularly smaller and rural safety-net providers, lack the infrastructure to optimize technology.[19] This is due to both the prohibitively expensive investment required to update outdated electronic health record technology and the lack of broadband access, both of which limit analytic and data-sharing potential and put such health centers at a disadvantage.[20] There is opportunity for improved investment in technological capacity among FQHCs to level the playing field.

Recognizing the Value of All Telehealth Modalities, Including Telephone Calls

Prior to March 2020, adoption of telehealth across the nation and within FQHCs was limited, in part due to reimbursement and technological limitations. However, the COVID-19 pandemic created both an opportunity and a necessity to leverage alternatives to in-person services and to support physical-distancing goals. Once the federal government and states adjusted the payment and coverage policies for telehealth, FQHC visits increased (though they have still not returned to prepandemic levels in most cases).[21] As part of its response to federal flexibilities offered to states in response to the pandemic, the California Department of Health Care Services (DHCS) authorized payment parity to FQHCs for telehealth services provided to Medi-Cal patients. This means that FQHCs are temporarily receiving the same Medi-Cal payment for services provided in-person, by video, or by phone while the public health emergency is in effect.

In March 2020, FQHCs rapidly substituted in-person visits with both telephone and video visits. Telephone visits were critical to FQHC patients. According to a RAND analysis comparing data from prepandemic to March to August 2020 for a group of FQHCs in California that received funding to expand telehealth capacity, 48.1% of primary care services were delivered in person, 48.5%

via telephone, and 3.4% via video. For behavioral health, 22.8% of services were delivered in person, 63.3% via telephone, and 13.9% via video. Telephone visits peaked in April 2020, composing 65.4% of primary care visits and 71.6% of behavioral health visits.[22]

Telephone-only visits increase access and are convenient for patients. A September 2020 consumer survey conducted by the California Pan-Ethnic Health Network suggested that telehealth holds significant promise for increasing access to care in communities of color, and for making health care more patient centered.[23] In some cases, the shift to telehealth meant faster access to more services, with scheduling and appointments occurring on the same day. Neighborhood Healthcare, based in Escondido, implemented an open access model in October 2020, reserving same-day appointment slots for new patients, which included telephone visits.

Health centers were better able to maintain access to care during the first six months of the pandemic because of telehealth.[24] Rakesh Patel, MD, chief executive officer at Neighborhood Healthcare, indicated that rapid access to health center services reduced transportation barriers that previously led to no-shows, allowed for speedy medication adjustments, and resulted in better service for patients.

A February 2021 DHCS policy proposal extended most of the telehealth flexibilities established as part of the public health emergency response and largely received praise from health centers; however, it excluded reimbursement of telephone-only visits for FQHCs.[25] DHCS maintained that telephonic/audio-only visits are less costly and should not be reimbursed at the same rate as visits conducted in-person or through synchronous telehealth modalities, which would be a requirement under Prospective Payment Systems.[26] The policy recommendation stated that "DHCS recognizes the value of being flexible in the use of telehealth across the health care safety net, while protecting the integrity of the Medi-Cal program from a health care quality and fiscal perspective."[27] DHCS used the February policy proposal as an opportunity to engage in discussions with health center stakeholders about telehealth in the context of an APM; those discussions are now underway.

More recently, the governor's "May Revision" to the state budget (PDF)[28] proposes a reduced rate for audio-only telehealth services. While it is an acknowledgment of the role of audio-only care, an APM would provide greater payment predictability for health centers. Decisions about which modality to use should be driven by patient needs and available technology. Telephone-based services contribute to health equity and influence the extent to which disparities in health and access to health care for Californians with low incomes, who are disproportionately people of color, begin to shrink or widen.[29] RAND study authors found that while "telemedicine can serve as a tool to reduce disparities in health care access, . . . limiting reimbursement to video visits may actually increase them."[30]

A recent study of more than 1,600 primary care and specialty care practices within an integrated health system found that patients who were older than age 65; Black, Hispanic, or Spanish-speaking; nonportal users; or from areas with low broadband access were less likely to use video visits. The study concluded that institutions should make concerted efforts to promote equitable access to all telemedicine modalities.[31] Telephone-based appointments also eliminate challenges with access to broadband as well as the risk of video visits exceeding patients' data plans. RAND's telehealth study leader acknowledged the conundrum that the quality of telephone-only visits may not be as high as other modalities, but that such flexibility is important to ensure access to care for underserved populations.[32]

Long-term cost savings to the health care system may also be a consideration for telephone-only visits. Jane Garcia, chief executive officer of La Clínica de la Raza, an FQHC based in Oakland, relayed the story of a 91-year-old patient who was prescribed antibiotics during an after-hours telephone-based visit. The medications were promptly picked up and administered, and the doctor followed up with the patient the next day. The telephone visit saved Medi-Cal the cost of an emergency room visit and avoided an unnecessary inconvenience for an older patient.

Telephone-only visits complement the other innovative care delivery models that health centers are considering. Shasta Community Health Center, based in Redding, is implementing a home monitoring program with supportive technology for patients who are medically compromised. Comprehensive Community Health Centers, based in Los Angeles, has new plans for a mobile van, where telehealth can connect providers and patients. Physicians will remain in clinics, but patients can access laboratory and telehealth services through mobile technology after visiting with mid-level staff about their health care needs. In this case, the health center is leveraging telehealth to extend the reach of the entire care team while increasing access to individuals who might not otherwise easily make it into the clinic.

Making Investments in the Health Care Workforce

Maintaining and growing a health care workforce has been one of the biggest challenges FQHCs have experienced during the COVID-19 pandemic. All health center executives interviewed indicated that the pandemic has exacerbated long-standing recruitment and retention issues, which became even more acute due to frontline worker fatigue and burnout. Despite steps to retain workers such as offering employees the opportunity to work from home, providing hazard pay, offering incentive payments, and providing additional time off, recruitment and retention remain challenging. One health center executive remarked that potential medical assistant recruits could earn more money by collecting unemployment than by risking exposure to SARS-CoV-2 in the health care setting.

A previous Capital Link report found that rapidly increasing staffing costs were the biggest driver of shrinking margins for health centers between 2016 and 2019.[33] Competition for providers accelerated, pushing up costs, while reimbursements grew more modestly. During the pandemic, retaining staff became increasingly difficult, as financial losses mounted and the pressures on staff increased. Across the state, median personnel-related expenses represented three-quarters of operating revenue in 2019.[34]

According to the California Future Health Workforce Commission report from 2019, within the next 10 years California is expected to have a shortage of over 4,100 primary care providers and only two-thirds of the psychiatrists needed.[35] The report estimates that up to 75% of primary care services could be provided by nurse practitioners and physician assistants, which are also expected to be in short supply by 2030 based on projected demand and the number of providers per 100,000 residents, respectively.[36] Further, there is a maldistribution of providers, with certain provider types overrepresented in some areas and underrepresented in others, and the demographics of the workforce do not align with the demographics of the state. For instance, despite representing nearly 40% of the state, the Latinx population composes just 7% of the physicians.[37]

Investing in the health care workforce can have revenue and health equity benefits. The cost to replace a physician is estimated to be two to three times the annual salary of the previous employee due to the cost of recruiting, lost billing revenue, and the time it takes to become efficient in the job.[38] By improving representation of the workforce to reflect the population, health care providers can close gaps in language barriers, improve cultural competency, and strengthen the trust of patients.[39]

State investments in loan repayment, pipeline, and scholarship programs can increase the number and diversity of people who enter health care safety-net professions and alleviate FQHC financial pressures. These strategies are particularly important given the number of Health Professional Shortage Areas (HPSAs) in California. The HPSA score is a HRSA-developed formula designed to allocate resources to states for primary care, dental care, and mental health care. California HPSAs include some of the state's largest and fastest-growing regions, such as South Los Angeles, the San Joaquin Valley, and the Inland Empire. Almost one-third of Californians live in a primary care HPSA,[40] and according to the California Future Health Workforce Commission report, approximately 70% of those living in HPSAs are Latinx, African American, and Native American, highlighting serious concerns about the impact of California's workforce shortage on health equity.[41]

Many health centers cannot compete on salary alone for recruitment. However, according to Jane Garcia from La Clínica de la Raza, loan repayment combined with mission is a strong recruiting tool. David Lontok, chief executive officer at Comprehensive Community Health Centers in Los Angeles, concurs, saying that loan repayment is an important tool that allows his health center to augment provider salary demands. As a major factor for health center recruitment, augmenting state investment in loan repayment programs will alleviate one of the major cost drivers in health center operations.

California has several existing loan repayment programs. The National Health Service Corps (NHSC) remains a powerful tool for recruitment, with federal funds covering 100% of employee salaries combined with loan repayment. Federal data reveal that 72.3% of NHSC participants serving in FQHCs continue to practice in HPSAs 10 years later, making it a reliable strategy to retain clinical staff.[42]

California is one of 41 states and the District of Columbia that participate in the federal Student Loan Repayment Program (SLRP), which requires a 50% match by program participants.[43] In addition, California's Office of Statewide Health Planning and Development administers a number of other loan repayment programs [44] for primary care and other providers, some of which align with HPSA designations, and others such as the County Medical Services Program Loan Repayment Program, which prioritizes high-need counties across the state.[45]

One workforce policy consideration may be to have the state pay 100% of the debt instead of requiring the 50% match from the health centers. Some health plans, such as L.A. Care, have grant programs that provide the match on behalf of the health center. While such investments are helpful, health centers consider this a short-term solution because health plan discretionary spending programs are subject to reserves that could be cut back during economic downturns.

In addition to loan repayment programs that allow health centers to recruit individuals who are already trained, longer-term investments could be used to increase the number of people who enter health care professions. Pipeline programs can be designed to connect people to professions in the safety net and build a workforce that represents the racial and ethnic diversity of the community.

A study by USCF's Healthforce Center and Latinx Center of Excellence found that the racial and ethnic diversity of the state is not reflected in medical school enrollments, with significant underrepresentation of Latinx and Black / African American physicians in California. The study attributes this finding to Proposition 209, which prohibits use of affirmative action practices. This disparity demonstrates an opportunity to implement strategies that will increase the racial and ethnic diversity of California medical schools.[46] The California Future Health Workforce Commission report makes multiple recommendations to expand and scale pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers starting as early as middle school.

Scope of practice changes can also facilitate workforce innovations. While physicians are critical to health center operations, maximizing the skills of other health care providers — such as nurse practitioners (NPs), physician assistants, social workers, medical assistants, and community health workers — can help address capacity. Recent policy changes will help build capacity of other members of the team. In September 2020, California passed A.B. 890,[47] which gives NPs independent practice authority. Health centers were active participants in the development of the California Future Health Workforce Commission report and identified providing NPs with full practice authority as a significant benefit for FQHC workforce expansion. By allowing providers to practice at the top of their license, the independent practice authority may be effective in recruiting NPs from out of state.

Jane Garcia of La Clínica de la Raza discussed how the new scope of practice authority has increased capacity in the delivery of telehealth and freed up time for physicians who no longer need to supervise or sign off on NP decisions. Some health center executives, however, indicated reluctance on the part of their staff, including NPs themselves, about readiness for the transition. This speaks to the fact that policy change is not enough.

Practices need to thoughtfully evaluate opportunities for training and workflow modifications to realize the full potential of workforce flexibilities.

Scholarship programs aimed at cultivating health professions in underserved areas are another important workforce development tool. By expanding scholarships for qualified students who pursue priority health professions and locate in underserved communities, such as the Emerging California Health Leaders Scholarship Program and Programs in Medical Education, California can recruit qualified individuals who might not otherwise be able to afford such an education.

Research by the Healthforce Center at UCSF suggests that "American Indian, Black, and Latino graduates are more likely to have educational debt than White graduates and more likely to have debt of $100,000 or more [while] Black and Latino dental school graduates are also more likely to have educational debt than White graduates."[48] The report suggests that the decision to take on large sums of debt may influence individuals' decision to pursue career pathways that help pay off debt more quickly. In addition, the potential for such debt may deter some from entering health professional schools entirely. Therefore, in addition to loan repayment programs, the paper discusses the potential for scholarship programs that reduce or eliminate tuition expenses for students of specific racial and ethnic backgrounds and/or make targeted reductions based on commitments to practice in specific areas of need.[49]

Conclusion

Although the significant infusion of federal dollars strengthened health centers in recent months, the pandemic has demonstrated the fragility of long-standing FQHC financial health. Further, temporary flexibilities have highlighted the potential to improve equitable access to care. Policymakers may want to consider strategies that will insulate FQHCs from unexpected volatility in in-person patient visit volume in the future, and acknowledge the breadth and depth of services provided by health centers to low-income and underserved communities. Many health centers have significantly increased services beyond traditional primary care to include behavioral health, dental care, and social services, as well as serving clients beyond the clinics' walls. Modernizing FQHC payment policies through adoption of an APM can facilitate service delivery and workforce innovation across the state.

Continued flexibility to provide telephone-only visits is another strategy that may help support FQHC financial stability, facilitate patient access, and address health disparities across the state. Furthermore, an important consideration to help bolster health center access and address health equity is investment in the state's health workforce, particularly those individuals and entities who provide care as the state's safety net. Combined, these policy and reimbursement changes can help stabilize health center operations and long-term sustainability.

The health centers that serve the highest number of Medi-Cal patients face the most financial risk going forward. That is why this moment, when health centers are entering the postpandemic future, is particularly important to consider policy and reimbursement options that may ensure health centers can continue to provide much-needed equitable access to care for all Californians.

About the Authors

Carol Backstrom, MHA, is the vice president for Medicaid Policy and Programs, and Lauren Block, MPA, is a principal for Medicaid Policy and Programs at Aurrera Health Group, a mission-driven national health policy and communications firm based in Sacramento. Allison Coleman, MBA, is the chief executive officer of Capital Link, a national nonprofit organization focused on strengthening FQHCs — financially and operationally — in a rapidly changing marketplace. **Capital Link** helps health centers plan for sustainability and growth, access capital, improve and optimize operations and financial management, and articulate their value.

Acknowledgments

CHCF and the authors would like to thank the following people for their contributions as part of the advisory panel that informed this paper and the selection of health center leaders who participated in interviews. Advisory panel members included Louise McCarthy, president and CEO, Community Clinic Association of Los Angeles County; Jackie Bender, former vice president of policy, California Association of Public Hospitals and Health Systems; Andie Martinez Patterson, senior vice president, Strategy, Integration & System Impact, California Primary Care Association; and Bobbie Wunsch, founder and partner, Pacific Health Consulting Group.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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.

Endnotes

1. FQHCs are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. They include federally funded health centers known as "Section 330 grantees" and those that meet certain federal requirements but do not receive federal grant funding, known as "Look-Alikes." In this document we refer to all types as "health centers."
2. "CHC Data and Reports," California Primary Care Assn., accessed May 2021.
3. Allison Coleman and Carol Backstrom, *Holding On: How California's Health Centers Adapted Operations and Care for Patients During the Pandemic*, California Health Care Foundation (CHCF), February 2021.
4. "California American Rescue Plan Act Awards," Health Resources & Services Administration (HRSA), last reviewed April 2021.
5. Coleman and Backstrom, *Holding On*.
6. Greg Howe, Tricia McGinnis, and Rob Houston, *Accelerating Value-Based Payment in California's Federally Qualified Health Centers: Options for Medicaid Health Plans* (PDF), Center for Health Care Strategies, April 2019.
7. *The Pandemic's Financial Impact on California's Community Health Centers: Largest Centers Suffer Significant Losses*, CHCF, March 2021.
8. *California Federally Qualified Health Centers: Financial and Operational Performance Analysis, 2016–2019* (PDF), Capital Link, 2020.
9. Coleman and Backstrom, *Holding On*.
10. *The Pandemic's Financial Impact*.
11. Coleman and Backstrom, *Holding On*.
12. "California Awards," HRSA.
13. *Health Centers and State Environments 2018 Chartbook* (PDF), National Assn. of Community Health Centers (NACHC), 2019.
14. *Time to Modernize Payment to Health Centers: How Old Rules Jeopardize Patients During the COVID-19 Pandemic*, CHCF, June 2020.
15. N. D. Young et al., "Warm Handoff, or Cold Shoulder? An Analysis of Handoffs for Primary Care Behavioral Health Consultation on Patient Engagement and Systems Utilization," *Clinical Practice in Pediatric Psychology* 8, no. 3 (2020): 241–46.
16. Curt Degenfelder, *Same-Day Billing for Medical and Mental Health Services at FQHCs: Estimating the Fiscal Impact*, CHCF, April 2020.
17. *Behavioral Health in Primary Care* (PDF), National Assn. of Community Health Centers (NACHC), August 2018.
18. "Total Medicaid MCO Enrollment" (2018), KFF.
19. Jonah Frohlich, Eric Bartholet, and Jonathan DiBello, *Why California Needs Better Data Exchange: Challenges, Impacts, and Policy Options for a 21st Century Health System*, CHCF, March 2021.

20. Frohlich, Bartholet, and DiBello, *Why California*.

21. Ateev Mehrotra et al., "The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases," Commonwealth Fund, February 22, 2021.

22. *Behavioral Health in Primary Care*, NACHC.

23. *Equity in the Age of Telehealth: Considerations for California Policymakers*, California Pan-Ethnic Health Network, December 2020.

24. Lori Uscher-Pines et al., "Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic," *JAMA* 325, no. 11 (2021): 1106–7.

25. *Post-COVID-19 Public Health Emergency Telehealth Policy Recommendations* (PDF), DHCS, February 2, 2021.

26. *Post-COVID-19*, DHCS.

27. *Post-COVID-19*, DHCS.

28. "Health and Human Services," in *Budget Summary: May Revision — 2021–22*, State of California.

29. Rafael A. Gomez, *Reimbursing FQHCs for Telehealth Post-COVID-19 Pandemic: Medi-Cal's Options*, CHCF, January 2021.

30. Lori Uscher-Pines et al., "The Doctor Will Call Me Maybe: The Uncertain Future of Audio-Only Visits and Why We Need Them to Address Disparities," *Health Affairs Blog*, March 3, 2021.

31. Jorge A. Rodriguez et al., "Differences in the Use of Telephone and Video Telemedicine Visits During the COVID-19 Pandemic," *American Journal of Managed Care* 27, no. 1 (2021): 21–26.

32. RAND, "Nearly All Telehealth Appointments at Clinics for Lower-Income Americans Were Audio-Only, Raising Questions About Quality and Equity," press release, February 2, 2021.

33. *California Federally Qualified Health Centers*, Capital Link.

34. *California Federally Qualified Health Centers*, Capital Link.

35. *Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission*, California Future Health Workforce Commission (Commission), February 2019.

36. *Meeting the Demand*, Commission.

37. *Meeting the Demand*, Commission.

38. Sara Berg, "How Much Physician Burnout Is Costing Your Organization," American Medical Assn., October 11, 2018.

39. Christopher Toretsky, Sunita Mutha, and Janet Coffman, *Reducing Educational Debt Among Underrepresented Physicians and Dentists*, Healthforce Center at UCSF, August 2019.

40. "Shortchanged: Health Workforce Gaps in California – Region-by-Region Maps," CHCF, July 15, 2020.

41. *Meeting the Demand*, Commission.

42. Sebastian Negrusa et al., *National Health Service Corps – An Extended Analysis* (PDF), Lewin Group, September 27, 2016.

43. "State Loan Repayment Program Grantee Awards Map," Health Resources and Services Administration, accessed May 19, 2021.

44. *County Medical Services Program (CMSP) Loan Repayment Program (LRP)* (PDF), Office of Statewide Health Planning and Development, accessed May 19, 2021.

45. "Loan Repayment Programs," Office of Statewide Health Planning and Development (OSHPD).

46. Alana Pfeffinger et al., *Recovery with Limited Progress: Impact of California Proposition 209 on Racial/Ethnic Diversity of California Medical School Matriculants, 1990 to 2019* (PDF), Healthforce Center at UCSF, December 2020.

47. A.B. 890 (Cal. 2020).

48. Toretsky, Mutha, and Coffman, *Reducing Educational Debt*.

49. Toretsky, Mutha, and Coffman, *Reducing Educational Debt*.