CALIFORNIA
HEALTH CARE ALMANAC

California Health Care Foundation

REGIONAL MARKETS / CROSS-SITE ANALYSIS / OCTOBER 2016

Stepping Up to the Plate:
Federally Qualified Health Centers Address Growing Demand for Care

California's Federally Qualified Health Centers (FQHCs) are key primary care providers for low-income people, and have been expanding their capacity due to several market and policy factors, particularly the implementation of the Patient Protection and Affordable Care Act (ACA). FQHC expansion is happening both within individual organizations, through the creation of new organizations and sites of care, and through collaborations with other providers, driven by the main goals to serve more patients — particularly given the huge expansion in Medicaid (called Medi-Cal in California) enrollment across the state — as well as to improve integration and efficiency of care, and position these providers for a potential movement to value-based payments. These collaborative strategies involve not only extending primary care capacity but also improving access and integration for behavioral health, specialty care, and social services. At the same time, FQHCs and their partners strive to reduce hospitalizations and patients' episodic use of emergency departments (EDs) for nonurgent care needs to control overall costs of care.

The California Health Care Foundation's longitudinal Regional Markets Study of seven California health care markets — Fresno, Los Angeles, Orange County, Riverside/San Bernardino, Sacramento, San Diego, and the San Francisco Bay Area — provided a unique opportunity to track FQHC capacity expansion, collaborative strategies over time, and variation across regions. (For definitions of the regions and study methodology, see "Background on Regional Markets Study" box on page 21.)

This paper focuses on collaborations among FQHCs, other safety-net providers and agencies, and some more mainstream providers (those that serve large populations of commercial and Medicare patients). It describes key examples highlighted by FQHCs and other safety-net providers, as well as market observers, from the seven regions, and discusses the motivations behind each strategy and the challenges they face. The analysis also explores some of the principal themes across these markets and associated policy implications. Collaborative strategies and trends among mainstream providers are discussed in a companion paper, ***Many Routes to the Top: Efforts to Improve Care Quality, Coordination, and Costs Through Provider Collaborations***.

Medi-Cal Expansion Increases Demand for Care

California has experienced significant growth in its Medi-Cal population as a result of the ACA, which provided states the option of expanding Medicaid eligibility to all lawfully present adults whose incomes are less than 138% of the federal poverty level (approximately $16,400 annually for a single-person household). Enrollment increased almost 60% statewide between December 2013 (right before the expansion went into effect in January 2014) and May 2016 (the most current numbers available), adding almost 5 million people to the Medi-Cal rolls, exceeding expectations. A total of approximately 13.6 million Californians are now covered by the program, more than a third of the population.

Across the seven study regions, there was considerable variation in Medi-Cal enrollment penetration and growth

(Table 1, page 2). Large differences in incomes across the regions is one factor in the proportion of the population covered: In the Bay Area, which is the most affluent region by far, about a quarter of the population is now covered by Medi-Cal, whereas in Fresno, the poorest region, half of the population is enrolled. Enrollment increases have also varied, from 42% growth in Fresno to 72% in San Diego. This growth rate has been affected by many factors, from demographics to local initiatives seeking to enroll people.

Table 1. Medi-Cal Expansion Across Seven Regions, 2013-2016

	ENROLLMENT*			POPULATION ENROLLED†	
	December 2013	May 2016	Change	2013	2016
Fresno	621,131	879,478	42%	36%	50%
Los Angeles	2,631,886	4,164,543	58%	26%	41%
Orange County	556,161	907,249	63%	18%	29%
Riverside/San Bernardino	1,064,295	1,703,515	60%	24%	38%
Sacramento	456,511	719,051	58%	21%	32%
San Diego	523,726	901,107	72%	16%	27%
San Francisco Bay Area	708,744	1,132,095	60%	16%	24%
7-Region Total / Average	**6,562,454**	**10,407,038**	**59%**	**22%**	**35%**
California	**8,605,691**	**13,570,195**	**58%**	**22%**	**35%**

*State enrollment data.

†Census data, July 2013 and July 2015 (most recent available); because monthly population estimates are not available, the percentages may be slightly high (assuming continued population growth).

California's Medi-Cal expansion has led to increased demand for health care services because many previously uninsured patients no longer face large financial barriers to receiving care. While some of the new Medi-Cal enrollees previously received reduced-fee or no-fee services through their local safety-net providers when they were uninsured, many received little or no regular health care. With more people in Medi-Cal receiving services through managed care arrangements, health plans are now focused on getting enrollees into medical homes to provide primary care, coordinate other needed services, and manage their overall health. Safety-net hospitals provide some level of primary care and other outpatient services for low-income people, but their capacity is typically overwhelmed. Some county health departments operate primary care clinics, but many have downsized or eliminated this function over the past decade. Also, many private practice physicians treat few Medi-Cal enrollees because Medi-Cal payment rates are lower than those from commercial and Medicare payers — in fact, they are among the lowest in the country — and because Medi-Cal patients face difficult socioeconomic challenges that make complying with appointments and care regimens challenging.[1,2]

Community health centers — and specifically FQHCs — serve as medical homes for many Medi-Cal enrollees and people who remain uninsured. FQHCs have been growing in number and overall capacity nationally over the past two decades, driven in large part by Medi-Cal payment rates that exceed the Medi-Cal physician fee schedule, as well as by federal grants, including more funding opportunities through the ACA. As a result, FQHCs have become mainstays of local health care safety nets, not only for primary care, but also for specialized care and support services (see "Background on Federally Qualified Health Centers" box on page 3). While many of California's larger county hospitals and health department clinics hold FQHC status, this brief focuses primarily on the private, nonprofit FQHCs.

FQHCs Expand Capacity and Improve Capabilities

California has by far the largest number of FQHCs among all states: By 2015 the state had about 175 grantees operating almost 1,400 sites of care. These numbers largely reflect the state's large size, but also indicate strong state and often local support, which is necessary to develop such centers and varies considerably across the country.[3] According to 2014 state data, the seven regions studied had about 150 private, nonprofit FQHC organizations operating over 500 primary care sites (plus additional smaller sites with more limited services). FQHC organizations range significantly in size and number of sites of care.

Leading up to and since California's Medi-Cal expansion, FQHCs grew their facilities and operational capacity with the help of both government and private grants. Together,

Background on Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are community clinics that meet an array of federal requirements. Most are privately operated; others are run by local health departments or other public entities. The federal Health Resources and Services Administration's (HRSA's) Bureau of Primary Health Care administers the health center program. To gain federal status, health centers must demonstrate that they meet or are poised to provide all the required services and meet other criteria: They must serve a medically underserved area or population; treat low-income people regardless of their ability to pay and offer a sliding fee scale for uninsured people with incomes below 200% of the federal poverty level; and they must be nonprofit and have a governing board composed mostly of FQHC patients. FQHCs primarily serve Medicaid and uninsured patients but also serve a small proportion of Medicare and commercially insured patients. FQHCs include Section 330 grantees, which are eligible for federal capital and operational grants, access to malpractice coverage, and potential access to National Health Service Corps providers who receive scholarships or student loan forgiveness for serving at an FQHC. Some centers or programs receive FQHC status specific to their focus on migrant health, the homeless, or public housing. A smaller number of health centers have "look-alike" status, which means they meet the requirements but don't have access to federal grants, malpractice coverage, or loan forgiveness for their providers. Look-alike status is often a stepping stone to 330 status.

FQHCs provide comprehensive primary care, and many provide additional services under their approved "scope of service," including dental care, mental health care, substance use disorder treatment, on-site pharmacy services, and/or laboratory services. Additionally, FQHCs are required to provide enabling services such as transportation, language interpretation, patient education, and/or case management. Among California FQHCs in 2014, almost all provided mental health and/or substance abuse treatment counseling, and about three-quarters provided dental care, case management, and assistance applying for insurance; about a third provide vision, pharmacy, and/or transportation services.[4] FQHCs are required to meet a range of administrative and clinical requirements, including data reporting and quality improvement programs.

FQHCs receive encounter-based Medicaid payments that are intended to cover the range of medical and social services they provide. These payments are called Prospective Payment System (PPS) rates and are based on each FQHC's historical allowable costs, with adjustments for medical inflation. Managed care health plans or other payers may reimburse the FQHC in a different manner (for instance, through capitation), but the FQHC and the state conduct a reconciliation process to compare such payments to the FQHC's PPS rate. If the former is lower than the latter, the FQHC receives "wraparound" payments to ensure they receive the equivalent to which they are entitled under the PPS.

FQHCs have grown substantially over the past few decades. The community health center model began as a federal demonstration program in 1965 as part of President Lyndon Johnson's War on Poverty. In 1975, the program gained federal authorization and funding under Section 330 of the Public Service Act, and President Jimmy Carter later doubled federal funding for the program. The number of FQHC sites jumped again in 2001 when President George W. Bush launched a large five-year expansion initiative. The Obama Administration further grew the program with an infusion of funds through the American Recovery and Reinvestment Act of 2009 (ARRA) and then the ACA in 2010.

The ACA permanently reauthorized the FQHC program and provided $11 billion over five years to support FQHC operations, build new FQHC sites, and expand existing ones. Funding has included New Access Point grants, which support the operation of new sites of care that provide comprehensive primary care services, and grants for targeted services, with the goal of nearly doubling the number of patients who use FQHCs as their medical homes. In 2015, Congress provided $3.6 billion annually for two additional years (FY2016 and FY2017). The ACA also increased funding for the federal physician loan repayment programs and created new repayment programs for some states. Today, the US has approximately 1,300 FQHCs operating 9,000 sites of care that serve about 23 million people.[5]

the seven regions studied have received $75 million for New Access Points from the Bureau of Primary Health Care to add new comprehensive primary care sites. With some reported exceptions, FQHCs' base grants, which help fund their operations and care for the uninsured, have been largely stable or have increased slightly over the last few years, according to respondents. FQHC directors have been relieved to continue receiving financial support from private philanthropy, although this source remains a small portion of their funding.

The presence and growth of FQHCs has varied across the seven regions studied, reflecting a number of factors, including local demographics, the presence of other safety-net providers, and the extent of local commitment to the safety net. Four regions — Los Angeles, the Bay Area, San Diego, and Fresno — have a longstanding FQHC presence. Los Angeles, with its huge population and geography, has by far the largest number of FQHCs, with about 50 organizations operating about 200 primary care sites in 2014, based on state data.[6] Some Los Angeles-based FQHCs are even expanding into neighboring counties; for example, AltaMed, the largest FQHC in California, has added eight sites in Orange County. Also, some San Diego health centers have expanded into Orange, Riverside, and San Bernardino Counties. The Bay Area also has a strong FQHC presence relative to its smaller geography and population, with about 20 organizations operating about 80 sites of care. The Fresno region has eight FQHC organizations across the five counties, which together operate over 50 sites of care.

Orange County, Riverside/San Bernardino, and the four-county Sacramento region each have about a dozen private, nonprofit FQHC organizations operating about 30 primary care sites in 2014. These regions were relatively late to seek and obtain FQHC status for community clinics. FQHC development has been aided in the last few years by the growth in federal grant opportunities.

FQHCs have expanded their capacity in several ways, which has enabled them to treat more patients. On average across the seven regions, FQHCs' sites of care increased by about a third between 2011 and 2014, according to state data. Fresno, Riverside/San Bernardino, and Sacramento had particularly robust growth in clinic sites. During this period, FQHCs across the regions grew their clinical workforce by about a third and provided about 25% more patient visits.[7]

However, these numbers do not provide the full picture of how primary care capacity and access have changed. Some of these sites do not represent new capacity but are existing clinics or physician practices that gained FQHC status. Also, some FQHCs have smaller satellite clinics with more limited services or hours that may not be captured in these estimates. And, as noted, these data do not include the primary care clinics with FQHC status that are operated by the larger counties' health departments and hospitals, nor other community clinics that lack FQHC status. In rural areas, these include the clinics run by some hospitals and private practice physicians under the federal Rural Health Clinic (RHC) program, which also provides enhanced Medi-Cal and Medicare payment rates but not grants. RHCs are most prevalent in Fresno and, to a lesser degree, in Riverside/San Bernardino. Another study found that safety-net clinics broadly serve a growing proportion of total Medi-Cal enrollees and that FQHCs serve a higher share than county clinics.[8]

In addition to expanding their capacity, FQHCs across the seven regions studied have worked to enhance other aspects of their facilities and processes to attract more patients. Leading up to the Medi-Cal expansion, many FQHC directors had concerns that uninsured patients might choose other providers once they gained Medi-Cal coverage. Some were nervous about competing with other FQHCs that were improving and expanding their services. Many participated in the Low Income Health Program (LIHP) to help foster allegiances with patients before the 2014 Medi-Cal expansion.[9] They also focused on being more visible in the community, identifying potential patients and helping them enroll in coverage. For example, an FQHC in Fresno added a community development staff position to conduct outreach in community events,

such as at schools and health fairs. As an FQHC respondent in Los Angeles said, "With the changes, everyone has been on high alert and staking out their territory."

Many health centers prepared to compete for patients by making physical enhancements and improving their customer service and processes, such as scheduling and registration, to be more patient-friendly. A common mantra among FQHC directors (and safety-net providers more broadly) was that they had to focus on being "providers of choice, not last resort." Some FQHC directors observed benefits of this increased competition. As one said, "Competition makes us better. There were a lot of areas we were complacent in. But that changed, and that is a good thing. It brought better services to our patients."

Ultimately, while some FQHCs reported increased competition for patients, most FQHC directors across regions reported that there were plenty of Medi-Cal patients to readily fill available provider capacity. A few FQHC directors reported some patients leaving them for other providers, but not to a significant extent. They observed that some patients began to receive care at providers closer to home, which they considered good for the patients' access to care. Other directors reported that some patients who left ultimately returned because of the culturally competent care and support services FQHCs provide.

According to respondents, Medi-Cal patients generated much of the growth in patient volumes. State data show a significant shift in the average payer mix (based on patient encounters) of FQHCs across the seven regions, from Medi-Cal comprising approximately 46% of patient encounters in 2011 to 64% of encounters in 2014. Commensurately, the proportion of patients either in a county program or who were otherwise uninsured dropped from 41% in 2011 to 19% in 2014.[10] An analysis of federal utilization data from most of the private, nonprofit FQHCs in the state found a slightly smaller shift from uninsured to Medi-Cal status during the same period.[11]

The shift in payer mix generated more Medi-Cal revenues for FQHCs and reportedly helped improve their financial status. On average, the FQHCs across the seven regions experienced slight improvement in their financial margins, from 2.4% to 3.8%.[12] In 2015 interviews, many health center directors reported that Medi-Cal revenues and financial margins had continued to improve, which has allowed for further expansions and improvements to facility and infrastructure.

Pressures Straining Capacity

Despite the considerable capacity expansions, FQHCs still find themselves in some cases unable to meet demand for services, with a number of pressures continuing to strain their capacity and limit growth. Most of these pressures are interrelated and involve funding constraints, inadequate staffing levels, changes in patient needs, and dampened productivity. In fact, while state data indicate that the FQHCs in the seven regions overall provided more visits between 2011 and 2014, about one in six FQHC organizations experienced at least a 5% decline in patient visits.[13] A few FQHCs overextended themselves; for example, a Sacramento FQHC expanded rapidly and reportedly struggled to manage this growth, resulting in inefficiencies and strain on staff.

Funding constraints. Some FQHCs do not have the financial resources to add sites or expand in other ways. Despite the considerable increased federal support for FQHC growth, the federal expansion grants are limited and difficult to obtain. A number of FQHC directors reported they applied for but did not receive a grant; some of these FQHCs were able to move forward with planned projects through other fundraising efforts, but others were not. Also, while patient mix improved for many FQHCs, many still have sizeable proportions of uninsured patients and haven't seen large increases in Medi-Cal revenues. For example, at one of the San Bernardino County FQHC sites, reportedly almost two-thirds of patients remain uninsured. While FQHC margins have typically grown over the past few years, about a quarter

of FQHCs in the state faced negative operating margins in 2014.[14]

Difficulty securing sufficient numbers of providers. Many FQHCs are struggling to establish and retain enough clinicians to staff new sites and longer hours of operation. Overall, FQHCs across the seven regions added clinical staff between 2011 and 2014, but about 1 in 10 saw their provider staff shrink.[15] While access to medical malpractice insurance is helpful in recruiting (one FQHC respondent described it as "a major game changer"), many FQHCs reported not receiving sufficient (in some cases any) student loan forgiveness for physicians via the National Health Service Corps program.

FQHCs rely heavily on the same pool of primary care physicians (PCPs) and other clinicians (for example, nurse practitioners and physician assistants) as other physician practices, hospitals, and other providers in their communities. With more people insured and more focus on primary care as part of value-based care models and population health management strategies, competition among providers for PCPs and mid-levels has increased significantly between FQHCs and large hospital systems, which also are expanding their affiliated physician organizations.[16] Many FQHC directors emphasized particular difficulty competing with Kaiser. One director said that, when a physician candidate mentions he or she is also interviewing at Kaiser, he knows his chances of hiring the physician plummet. There is also competition with other safety-net providers: For example, FQHCs operating in rural parts of Fresno reported that the many new Rural Health Clinics have financial advantages over FQHCs and are able to offer higher compensation and other benefits. As one FQHC director lamented, "While we may have facilities and physical capacity, and people have the insurance cards, I don't have any providers. It has turned into a huge food fight in California because no one has the providers."

Intense competition for a scarce supply of PCPs has led FQHCs to spend more on salaries and benefits than they have in the past. California FQHCs typically spend about three-quarters of their budget on personnel, so rising clinician salaries could significantly impact FQHCs' financial health.[17] For example, one FQHC director reported having to increase salaries twice in one year to retain PCPs. Some FQHCs are using temporary (locum tenens) physicians, which are expensive.

While many FQHCs heavily use nonphysician staff (including physician assistants, nurse practitioners, nurses, medical assistants, and midwives) as a way to help expand capacity while controlling costs, they too have become more difficult to find — and their salaries are rising as well. For example, FQHCs in Riverside/San Bernardino, where PCPs are particularly difficult to recruit, report using a high and growing proportion of nonphysician clinicians. Some FQHCs also employ additional types of staff (e.g., community health workers, peer providers, nutritionists) to help meet their patients' need for other supportive services.

Changes in patient needs. According to respondents, the Medi-Cal expansion brought considerable pent-up demand for care, and many newly insured patients are presenting to FQHCs with more complex needs than FQHCs' existing patients. Many new patients are adults with chronic medical conditions, have behavioral health needs, and face socioeconomic challenges including homelessness. These needs require more intensity and volume of services per patient, which has challenged many FQHCs, especially those with a previously large base of relatively healthy "moms and kids."

Declines in productivity. Several changes have dampened staff productivity at FQHCs. While many FQHCs have implemented electronic health records as a way to better manage and coordinate patient care, clinicians need a lot of time to learn the systems and to input information. Similarly, moving to team-based care and transitioning to become medical homes (see "Collaborative Strategies to Improve Care Access and Coordination" section) reportedly has reduced productivity, with many patient encounters taking more time and resources. FQHCs have had to absorb these increased costs, at least in the short term because their Medi-Cal payments have not similarly grown.

Reflecting these trends, the number of patient encounters provided per clinical full-time equivalent (FTE) staff declined slightly across the regions overall.[18] This decrease also could be due in part to changes in the way health centers are providing care — for example, by treating patient conditions outside of traditional face-to-face encounters with a physician.

Collaborative Strategies to Improve Care Access and Coordination

While FQHCs have done a lot on their own to expand their capacity to serve more Medi-Cal patients and meet more needs, they are increasingly partnering with other community health centers and clinics (often through local consortia), hospitals, physicians, Medi-Cal health plans, counties, and community organizations. The intent of such collaborations is not only to improve access to primary care, but also to provide the follow-up services beyond primary care for more patients, which is difficult because of the lack of specialists, behavioral health providers, and others willing to treat Medi-Cal and uninsured patients.[19]

Over half of the FQHCs in California have achieved patient-centered medical home recognition from the National Committee for Quality Assurance, which provides a framework and foundation for collaboration.[20] FQHCs recognized as medical homes demonstrate proficiency in several areas, which include tracking patient diagnoses and their referrals outside of the health center; providing enhanced access and communication (e.g., during off-hours and outside of traditional in-person visits); and collecting and reporting performance data. These capabilities have been shown to improve access to care and coordination of care, including specialty care.[21]

The federal government endorses collaboration among safety-net providers, including FQHCs. The Health Resources and Services Administration (HRSA), the federal agency overseeing FQHCs, encourages such collaborations; in a key example, FQHCs are expected to establish linkages and collaborative arrangements with other providers for services they do not provide directly. However, HRSA is not prescriptive about the collaborative strategies FQHCs should adopt.[22] In addition, the ACA authorized funding in several areas to foster collaboration among safety-net providers, including FQHCs. These include medical home initiatives, colocation of primary and mental health clinics, and new payment arrangements that promote more value-based care and population health management (for example, accountable care organizations and global payments). The ACA also changed regulation to facilitate relationships between FQHCs and rural providers but has not authorized funding.[23]

Across the seven regions studied, FQHCs have embarked on collaborative strategies in response to additional federal grants and other initiatives, as well as some state policy changes. The state changes include workforce development grants, changes in responsibility for behavioral health services, new programs under the state's 1115 Medicaid waiver, and a state plan to pilot replacing FQHC encounter rates with a capitated structure (see "Potential Shift in FQHC Medi-Cal Payments" box on page 8).

Many of the collaborations observed in the seven study regions fall into eight categories, with some degree of overlap of strategic objectives:

1. Convening through community health center consortia
2. Establishing physician training programs
3. Developing risk-bearing FQHC networks
4. Developing closer affilitations with hospitals
5. Improving access to specialty care
6. Integrating behavioral health
7. Fostering whole-person care
8. Participating in programs for the uninsured

Some of these collaborative strategies have been in place for several years, while others are newer. Collaborations typically have components of building workforce internally and/or

Potential Shift in FQHC Medi-Cal Payments

FQHCs are preparing for the state's plan to transition to more risk-based Medi-Cal payments. The state would do this through a federal Alternative Payment Methodology option, which means they will abide by underlying funding protections for FQHC payments but restructure the flow of payments, replacing the encounter and wraparound payments with a capitated rate. This transition is expected to begin with a pilot program in late 2017. The number of counties in which the pilot will operate and the number of FQHC sites that will participate has not been established, and participation is voluntary.[24] The California Primary Care Association (which represents FQHCs statewide), together with the California Association of Public Hospitals and Health Systems (representing the public FQHCs operated by county health systems), as well as many individual FQHCs collaborated with the state to develop the plan. According to respondents, many involved considered the move to more risk-based payments as an inevitability and wanted to be at the table during the design and rate-setting process.

While the movement to capitation presents some anxiety, FQHC directors interviewed for this study are generally supportive of the concept. They reported that per-member per-month payments would provide a more predictable, reliable and steady revenue flow compared to the current encounter and wraparound payment structure. Also, because encounter payments can be restrictive in the types and frequency of services covered and the types of clinical staff who can bill for them, capitated payments would offer more flexibility to treat patients in a more integrated, coordinated, and holistic manner, which aligns with many of their collaborative strategies to better address medical specialty and behavioral health needs. Capitated payments also introduce incentives to provide care more efficiently. As the leader of a large FQHC in Los Angeles said, "The more risk we have the more creative we can be and can move the decisionmaking closer to the patient level. . . . It's a win-win for everyone." However, successfully managing risk could be challenging for some health centers, especially for smaller FQHCs with fewer patients.

facilitating referrals to other providers, and range from rather informal collaborations to formal joint ventures or other legal arrangements. We provide several examples of each type of strategy, but these do not represent an exhaustive list of all the activity across the seven regions. The degree to which each region and individual FQHC have embraced these strategies varies.[25]

All these strategies face challenges, some common and some more specific to the initiative, region, or health center. Competition over funding, providers, and other resources can limit the extent to which FQHC directors want to share their plans and collaborate with one another. In addition, some services that FQHCs provide or want to provide are outside of their established scope of service or otherwise not reimbursable under state rules.

Also, a lack of shared, integrated electronic health records (EHRs) and other health information technology (HIT) is commonly a limiting factor. While most FQHCs have an EHR, and some of the FQHC networks have shared HIT among their FQHC members, connectivity with non-FQHC providers is very limited, and the low availability of timely, complete data about patients limits the reach of many of these efforts.[26] Frequently, inadequate data systems hamper the ability to assess whether the strategies are achieving their intended aims of improving patient access and outcomes more efficiently and cost-effectively. In mid-2016, however, a few of the study regions received federal Health Center Controlled Network grants to help them develop shared health information technology among FQHCs.[27]

1. Convening Through Community Health Center Consortia

All seven regions studied have community health center consortia to bring together and provide assistance to FQHCs and other community clinics. Most of the regions (Fresno, Los Angeles, Orange County, San Diego, and San Francisco and Alameda County) have longstanding associations with broad membership; a couple — Alameda and Orange Counties

— began as early as the 1970s. Others are newer: San Bernardino County's consortium started in 2010, and some of the smaller counties in the Bay Area have established their own consortia. Health center consortia often serve as hubs for information, technical assistance, and shared functions in areas including general administrative and billing services, managed care contracting, management, fundraising, developing EHRs, clinical assistance (such as care management approaches), and advocating for and adjusting to policy changes. In the words of one association director, the organization allows FQHCs the ability to "speak with one voice" as organizations and on behalf of their patients.

Health center consortia appear especially helpful for clinics pursuing FQHC status, and for smaller clinics/FQHCs that have fewer resources. In fact, the longer-standing entities started before many of their members were FQHCs; these organizations reportedly helped build their capabilities and supported their applications for federal status. These consortia also often serve as conveners and forums for the development of other collaborative strategies, as many FQHC directors display growing interest in partnering more with their peers and other organizations. To foster cross-regional collaboration, the leaders of these consortia meet formally every couple of months and reportedly communicate informally on a regular basis.

CHALLENGES. Respondents note several limitations of health center consortia. In San Diego the largest FQHC opted to not join the local consortium, likely because its size affords it more resources and in-house expertise. The absence of major FQHCs can result in a real or perceived lack of unity to other community stakeholders and funders. Also, some FQHC directors reported that, while the consortia are helpful ways for FQHC directors to get to know one another and for convening meetings, building trust among FQHCs takes time. In San Bernardino, where the FQHC consortium is newer, some FQHC directors noted an increase in communication among member clinics but that actual collaborative activities have been slower to develop. Part of the challenge of bringing FQHCs together in that community is that some of the FQHCs serving Riverside belong to the consortium based in San Bernardino, while others belong to the San Diego consortium.

2. Establishing Physician Training Programs

In several of the study sites, a few FQHCs have begun working with medical schools and hospitals to establish FQHC-based training programs for primary care physicians (and in at least one case, other types of physicians). In the face of growing competition for primary care providers, FQHCs view these programs as a way to "grow their own" providers who, once they establish a relationship and familiarity with the FQHC model and patients, will be more likely to continue working for them after the training ends. The medical schools are interested in such partnerships because they want to train more primary care clinicians in the community as part of their efforts to increase the overall supply of PCPs. Of the six teaching health center programs in California, three are in the study regions: Fresno, San Bernardino, and San Diego.[28]

Working with FQHCs helps expose physicians to the particular needs of underserved populations and fosters culturally competent care. Many hospitals are seeking to train and develop more PCPs as part of their population health management and value-based payment strategies, in which they are looking for the most cost-effective ways of treating patients (i.e., outside of inpatient and emergency department settings). These programs are supported with funding through the Primary Care Residency Expansion (PCRE) program under the ACA, which prioritizes training in a health center, rural hospital, or other community-based setting.[29] Additional funding support comes from the state's Song-Brown residency program and, in some cases, local sources and private foundations.[30] California also has a longstanding physician loan repayment program, for which many FQHCs from the seven regions are eligible.[31] Adding providers at FQHCs can help hospitals meet requirements to receive federal graduate medical education funding, as well as expand the number of

residents they train beyond the number for which they receive federal graduate medical education funding.[32]

Many physician training efforts involve partnering with the University of California medical schools and hospitals. In Fresno — a community with a particularly severe shortage of PCPs — Fresno Healthy Communities Access Partners, a nonprofit of providers and community organizations focused on improving access to care, has created the three-year Sierra Vista Family Medicine Residency Program at Clinica Sierra Vista FQHC. This program is operated in collaboration with UCSF-Fresno Family Medicine Center and the main safety-net hospitals in the area (Community Regional Medical Center and Children's Hospital Central California). In San Diego, UCSD, Scripps Mercy Hospital, and San Ysidro FQHC are partnering on a family medicine residency program in which UCSD provides the education; Scripps Mercy the funding and inpatient facilities, staff, and experience; and San Ysidro the outpatient services, staff, and experience.

Given the particularly acute provider shortages in regions such as Riverside/San Bernardino and Fresno, FQHCs are developing community training programs for new physicians and even younger reaching out to younger students to introduce them to health care and clinician jobs in the hopes that they will both enter the field and continue to live in these regions. The San Bernardino County clinic consortium has been working with organizations on pipeline programs for the past two years and most recently partnered with local medical schools to discuss enhanced community-based trainings for medical providers. For the past five years, the Fresno clinic consortium has partnered with local high school districts to sponsor annual Growing Healthy Leaders Youth Conferences that introduce high school juniors and seniors to different career options in the health field. San Bernardino is working with schools as part of their STEM (science, technology, engineering, and math) initiatives on a "health academy" in which students can shadow health center staff to expose them to work at FQHCs.

CHALLENGES. While FQHCs and their partners view these training efforts as having potential, they are considered a longer-term strategy, as it takes several years to produce fully trained PCPs who can bill for services. While having residents in some ways boosts provider supply and capacity, the need for staff PCPs to spend time with the residents could impede productivity, although respondents did not raise this as a significant issue. Also, these programs are quite limited in their overall prevalence and in the numbers of students trained each year, and reportedly have more applicants than they can accommodate. FQHC directors consider the programs a "drop in the bucket" compared to the need. For instance, four residents completed training through the Sierra Vista program this year. The funding future is also uncertain; PCRE funding under the ACA started in 2010 and lasts five years, so whether these programs will be sustained after federal funding ends is unknown.

3. Developing Risk-Bearing FQHC Networks

While the regional community health center consortia often assist the member FQHCs with managed care contracting, in several communities (including Alameda County, Los Angeles, San Francisco, and more recently, San Diego) FQHCs and their associations go a step further by forming separate entities to negotiate contracts as a group and form an FQHC network, which can assume risk collectively. Some of these are independent practice associations (IPAs), a common structure in California for physician practices and clinics to collectively contract with HMOs, collectively pooling risk and removing the need for each individual provider to hold its own managed care contracts. The IPAs typically assume financial risk for professional services (which can include, depending on the contract, specialty care, laboratory, and radiology) and capitate the FQHCs for primary care. With FQHC IPAs, the individual FQHCs are protected from risk because they ultimately receive wraparound payments from the state. Still, because there is a time lag in receiving the wraparound payments, FQHCs are exposed to cash-flow risk.

FQHC networks have several goals: to ensure that the FQHCs receive sufficient assigned patients from the Medi-Cal HMOs; to facilitate patients' access to a range of services and coordinate care; to bolster clinical quality; and to improve FQHC efficiency and financial performance. A couple of FQHC networks also include private practice physicians (mostly specialists) and other providers. The networks establish the infrastructure (in some cases a formal management services organization structure) so that individual FQHCs do not need to create it themselves. For example, the networks coordinate and authorize the specialty, radiology, lab, and other ancillary services, as well as provide clinical protocols and perform quality assurance. Because FQHCs range in size and length of time as an FQHC, these networks also are intended to help support smaller, newer clinics.

Los Angeles has a particularly established FQHC IPA. Health Care LA, IPA was formed in 1991 and has grown significantly under the Medi-Cal expansion, serving approximately 360,000 patients. Reflecting the county's size, this IPA is quite large, with about 40 FQHCs participating, with 500 primary care providers, 1,200 specialists, and about two dozen urgent care centers. The IPA has established processes to help its member FQHCs with administrative functions (e.g., billing, referrals) and clinical protocols to promote a standard of care in areas including immunizations, screening, and diagnostic testing. The IPA also helps FQHCs with quality improvement measurement and performance, completion of patient health assessments, and other health plan requirements. AltaMed, the largest FQHC in Los Angeles and the state, operates its own separate IPA.

More recently, in early 2016, 12 San Diego FQHCs formed Integrated Health Partners of Southern California (IHP). IHP has started to contract with Medi-Cal health plans as an IPA. IHP receives capitated payments for primary care and other services such as behavioral health that they refer to as "primary care plus," but otherwise it has a more limited network than Health Care LA, IPA. With a focus on controlling costs under a capitated rate, IHP is working to develop a clinically integrated network to improve the efficiency and quality of care at its member clinics. One aim is to provide support to the FQHCs with fewer medical home capabilities in place by collecting and sharing clinical data and developing shared clinical protocols. The FQHCs have agreed to share those data so that IHP can identify and assist as needed throughout the member health centers.

CHALLENGES. While the longevity of some of these FQHC networks suggests they benefit the FQHCs, the extent to which the FQHC networks, even the more established ones, have impacted care access, quality, and efficiency is unclear. In many cases, the individual FQHCs still appear to function rather autonomously, and it remains challenging to create a seamless network from many separate organizations of different sizes, patient populations, services, capabilities, and organizational cultures. These networks generally stop short of achieving advanced clinical integration that would direct patients as needed to the FQHCs that might be more specialized in handling certain patients and conditions. The networks could foster efficient allocation of resources, especially for certain specialized services like cardiology or orthopedics, as well as improve patient care and boost efficiency, but this is not occurring yet in a significant way (see also "Improving Access to Specialty Care" section). Competitive tensions could limit the ability to fully capture, share, and analyze data among health centers and limit collaboration between the more advanced and the fledgling organizations. Also, clinical integration might run counter to many FQHCs' focus on colocating services within clinic sites to create "one-stop shops," a concept considered helpful because patients face transportation and other challenges obtaining care in different places.

4. Developing Closer Affiliations with Hospitals

California FQHCs have long had referral relationships with safety-net hospitals in their communities to arrange follow-up tests, specialty care, inpatient procedures, and emergency care for their patients. Yet many of the FQHC-hospital arrangements have been ad hoc and limited by hospital capacity constraints. FQHCs in a number of communities have sought closer and more formal partnerships with hospitals over the last few years, particularly to gain more timely access to specialty care (see also "Improving Access to Specialty Care" section). Indeed, a survey of FQHCs found that affiliations with hospitals improve an FQHC's ability to obtain testing and follow-up care for its patients.[33]

From the hospitals' perspective, partnering with FQHCs enhances their ability to help expand low-income patients' access to primary care and may reduce patients' reliance on hospital EDs and other services. Many of the arrangements are spurred by hospitals unable to or uninterested in expanding or maintaining primary care for low-income people on their own. These hospitals see collaborating with FQHCs as a valuable long-term strategy, particularly given FQHCs' access to enhanced Medi-Cal rates and grant funding.

Still, motivation behind the partnerships and their structures vary based on the type of hospital. Although county hospital systems typically have their own primary care clinics (and in some cases FQHC status), their capacity is limited. They typically have close, longstanding partnerships with private, nonprofit FQHCs because they have served very similar populations: primarily Medi-Cal and uninsured patients. In many communities with county hospitals, FQHCs typically report that those hospitals are their main source of specialty and hospital services. The University of California hospitals and other nonprofit private hospitals that play a safety-net role also have many low-income patients but often try to find different ways of treating them in order to free up hospital capacity for commercial patients, because the higher reimbursement they generate helps the hospitals' financial health. Other hospitals that largely serve commercial and Medicare patients may participate in such partnerships as a means of explicitly limiting the number of Medi-Cal and uninsured patients they treat.

Some county hospital collaborations with the FQHCs are part of hospitals' efforts to develop broader integrated systems to support population health management strategies and value-based payments. In particular, county hospitals will be moving to a Global Payment Program under California's Medi-Cal 1115 waiver over the next five years, intended to encourage use of outpatient care over inpatient care.[34] FQHCs could help hospitals not only expand primary care capacity geographically and in total, but also culturally competent and social supportive services.

Many of the noncounty hospital partnerships with FQHCs tend to be between one hospital and one or two FQHCs in their neighborhood rather than broader arrangements with many FQHCs in a community. For example, the small community hospitals that dot the vast, largely rural areas of San Bernardino County reportedly are increasingly partnering with their nearby FQHCs and RHCs; the long distances to the county hospitals in this community and general shortage of providers means that the hospitals and FQHCs are particularly reliant on each other. In Los Angeles, there are several full-risk arrangements for a subset of Medi-Cal patients between small- to medium-size safety-net hospitals and a single or several health centers in their geographic service area (coordinated through their IPA and Medi-Cal health plans, discussed earlier); in some cases these FQHCs have built clinics on the hospital campus.

Across regions, many hospital-FQHC partnerships tend to involve hospitals providing direct funding, residents/staff, or other in-kind support to FQHCs to help them expand capacity. The hospitals calculate that the resources they provide cost less than the uncompensated care costs and Medi-Cal shortfalls the hospitals would otherwise incur by treating this population themselves. Such contributions also help nonprofit hospitals meet their community benefit requirements to maintain their tax-exempt status. For example, in Alameda

County, Sutter — the largest hospital system in that area — pays for discharge nurses at several FQHCs to help reduce Medi-Cal readmissions. Also, Kaiser and the John Muir Health system funded a large FQHC (LifeLong) in that community to open a new clinic with urgent care services at the site of a closed hospital. In some communities, FQHCs are building new facilities near or on hospital campuses in an effort to better facilitate low-income patients' relationships with a primary care provider after discharge from the hospital.

For instance, Sacramento hosts a variety of hospital-FQHC collaboration models. Lacking a county hospital, the community's safety-net responsibility is shared among the Sutter, University of California (UC) Davis, and Dignity hospital systems. These hospitals (as part of their community benefit requirements) have extended grants to help fund clinic expansion and develop partnerships with FQHCs to operate facilities nearby or on hospital campuses. Sutter has been partnering with a few FQHCs to help them establish clinics on or near their hospital campuses and has partnered with WellSpace FQHC on a T3 (Triage, Transport, Treat) program in which WellSpace steps in to care for many of the frequent users of the ED, many of whom have complex medical, behavioral, and other needs. This program also includes placing homeless people in supportive housing, and overall reports significant reductions in ED use and substance abuse among its enrollees.[35] Additionally, UC Davis and Dignity have been transferring operations of their safety-net clinics to FQHCs; for UC Davis, this is related in part to training medical residents at FQHCs. Dignity has transferred operations of three of its clinics to WellSpace and the fourth to an FQHC headquartered in a nearby county. In this arrangement, Dignity still owns the physical clinic space but allows the FQHCs to operate the clinics at no charge.

Shared, integrated EHR systems are particularly valuable tools in hospital-FQHC relationships but, as noted, few yet have them. Share Our Selves FQHC in Orange County chose the same EHR system as two of the main hospital systems in the county because the health center works closely with them. The system is integrated, so they share patient records across providers, which facilitates post-discharge follow-up and referrals to specialty care.

CHALLENGES. Many hospital-FQHC partnerships are still new or emerging, and many remain informal, which may limit their overall effectiveness. Some FQHC directors reported that lack of understanding of the FQHC model can dampen collaborative efforts. For example, some hospitals are not aware that FQHCs' enhanced Medi-Cal and Medicare payments are to cover comprehensive patient encounters (so are not directly comparable to a fee-for-service primary care payment), that they aren't fully supported by grants, and that they too face funding and capacity constraints. In some cases FQHCs are unable to handle the increased demand generated by the hospital affiliation, which disappoints the hospital partners. One hospital executive reported that its FQHC partner "overpromised and underdelivered" on its ability to provide a medical home for the new Medi-Cal enrollees who had sought primary and urgent care in the hospital system's EDs; patients couldn't obtain timely appointments, so their utilization patterns did not change. Further, the degree to which the arrangements across regions result in improved access to specialty care and other services via the hospitals is not clear.

Further, because these individual hospital-FQHC affiliations are typically one-on-one and do not involve broad numbers of FQHCs, the FQHCs not included sometimes express concerns that they and their patients are missing out on opportunities. For instance, some nascent discussions among hospitals to align with an individual FQHC to assume responsibility for the hospitals' primary and specialty care clinic services reportedly have caused concern among other FQHCs that their patients will lose out and not have the same access to those services (i.e., that the partnering FQHC's referrals would receive priority).

5. Improving Access to Specialty Care

With FQHCs providing little specialty care themselves, strained safety-net hospital capacity, and little incentive for other physicians to serve this population, study respondents indicated that timely access to specialty care is a significant challenge for low-income people across the study communities. Beyond some of the strategies already mentioned, FQHCs are increasingly working with hospitals, private practice specialists, and health plans in several additional ways to help improve this access. The community health center consortia typically play a role in linking patients to specialty providers, including those that volunteer their services for the uninsured. For example, the San Bernardino County consortium has a project manager dedicated to managing referrals to specialty care providers for its members' patients.

Another approach is for FQHCs to partner with specialists at safety-net hospitals and in private practice who agree to treat low-income patients at the FQHC sites on a routine basis — perhaps one day a week or month. Because the need for any particular specialty may be low for an individual FQHC, in some communities the FQHCs band together to share physicians or other clinicians. For example, a partnership between the Orange County health center consortium and a free clinic allows health centers to refer their uninsured patients to specialists who volunteer their time at the free clinic. The Los Angeles consortium employs a clinical pharmacist to help member health centers manage complex patients, whether or not the center has on-site pharmacy services.

Providing specialty care at health centers also helps create a "one-stop shop" model so that patients are potentially able to obtain care for multiple needs in the same day. This can foster access, support coordination with primary care, and leverage other FQHC services (e.g., language interpretation) to enable and enhance the visits. As noted, placing medical residents in FQHCs enables hospitals to more efficiently expand the number of medical residents they can train. Treating Medi-Cal patients at FQHC sites also allows specialists to limit the number of Medi-Cal patients they see, especially within their own private practice offices.

FQHCs are also involved in innovative strategies that depart from traditional face-to-face encounters with specialists. One type of strategy involves specialists advising PCPs at FQHCs on how to either address specialty care needs themselves or to ensure that a face-to-face visit with a specialist is necessary. There are several examples of this strategy. The FQHC association in Alameda has a program in which PCPs shadow specialty care physicians from Alameda Health Services (the county hospital) for approximately three days in one of seven specialties (dermatology, neurology, orthopedics, pain management, podiatry, rheumatology, and urology) with the goal of expanding the PCPs' scope of practice. The FQHCs receive reimbursement for the time the PCP is away from the health center to receive training.

FQHCs in San Francisco and Los Angeles are using telemedicine in what is often called eReferral or eConsult. With eConsult, a specialist reviews a referral from the PCP and the patient's case online through a shared EHR; the specialist then either advises the referring PCP how to treat the patient, or if needed, staff schedule the patient for an in-person consultation. In the Los Angeles County health system, the number of patients referred who require a face-to-face visit with a specialist reportedly has declined by a third, reducing wait times for specialty appointments substantially. Because the county health system and FQHCs are not in the same networks for Medi-Cal managed care, the FQHCs use a different eConsult system (through L.A. Care Health Plan, the public Medi-Cal health plan) for their Medi-Cal patients, with a different set of specialist physicians.

Project ECHO (Extension for Community Healthcare Outcomes) is another strategy that FQHCs in communities including Riverside/San Bernardino are using to expand PCPs' ability to manage certain conditions themselves and reduce referrals to specialists. Created at the University of New Mexico in 2003, Project ECHO has expanded geographically and involves linking local PCPs with specialists at academic

medical centers to share knowledge through trainings and to develop patient treatment plans through virtual clinics.[36]

FQHCs in the seven regions also participate in several additional examples of telemedicine strategies focused on particular conditions and/or that use store-and-forward images or live video communication. In Fresno, FQHCs and CalViva, the local Medi-Cal plan, use something akin to eConsult for dermatology, psychology, and joint pain, which also has reduced demand for in-person visits with specialists. In Los Angeles, "teleretinol" allows PCPs at FQHCs to provide retinal screens on-site, with ophthalmologists off-site reviewing them. In Orange County, St. Joseph Hoag hospital system provides psychiatric services to FQHC patients via telehealth.

CHALLENGES. Securing sufficient numbers of specialists willing to treat low-income patients remains difficult for FQHCs. While some of the longer-standing health center networks/IPAs have many specialists, the degree to which these networks provide timelier access to needed specialty care than standard Medi-Cal health plan networks is unclear. Establishing these networks can be a challenge, as FQHCs in Orange County discovered. They attempted to create an IPA structure that could accept broad professional risk, but the local Medi-Cal health plan rejected its proposal, citing lack of a sufficient specialty network. As an alternative, the FQHCs created the Orange County Safety Net Foundation to start taking capitation for primary care only.

Telemedicine strategies face several limitations. Some specialties and conditions are less amenable to being handled remotely, and for all cases it is important that PCPs have the right handoff when more assistance is needed. Many start with a limited number of specialties, although the San Francisco and Los Angeles systems reportedly have demonstrated that eConsult can be used for all adult specialties.

Placing more responsibility on FQHCs for specialty care can be challenging, hinder productivity, and present new costs. A telemedicine effort for dermatology in Riverside/San Bernardino ended reportedly because the PCPs weren't able to effectively integrate it into their workflow. A telemedicine pilot project between an FQHC in Orange County and UC Irvine for behavioral health, orthopedics, and dermatology reportedly worked well but ended after the grant funding expired because the FQHC was not able to charge Medi-Cal for these services. FQHCs in Fresno and elsewhere perform some telemedicine without getting paid and reported frustration that billing policies have not kept up with the technology.

6. Integrating Behavioral Health

Integrating behavioral health into primary care is a major focus area for many FQHCs across all seven regions. FQHCs want to provide more behavioral health services, given the high prevalence of behavioral health needs among their patients — especially among the Medi-Cal expansion population — that often go untreated because of the short supply of behavioral health providers for the population at large, and particularly for Medicaid and uninsured patients. Behavioral health providers are interested in partnering with FQHCs largely because of the growing recognition that medical and behavioral health issues often coexist. In some cases these providers also face significant funding and other resource constraints and seek greater financial stability that the FQHC model can provide. Some hospitals are motivated to assist with behavioral health integration because they see significant numbers of patients in their EDs and hospitals with behavioral health issues; some patients have quite serious conditions and end up staying in hospitals for long periods because the community lacks sufficient numbers of psychiatric beds and other behavioral health resources.

While behavioral health integration started before the ACA, it has ramped up in recent years. Several studies have found that behavioral health integration can be cost-effective.[37] The ACA provides grants to enhance substance abuse treatment and to encourage behavioral health integration; FQHCs across the seven regions have received $27 million total from these sources. This increased attention to the issue has led the number of behavioral health visits at California

FQHCs to grow more than the number of visits for medical services and dental care.[38]

ACA requirements also have stimulated Medi-Cal to expand behavioral health benefits and to divide responsibility for behavioral health needs between the Medi-Cal health plans and the county mental health agencies. Previously, Medi-Cal enrollees who did not meet medical necessity requirements for specialized mental health care had access to a very limited set of services (e.g., medication management and limited psychology services), providers, and number of visits through the Medi-Cal fee-for-service program. Now, the Medicaid health plans are responsible for providing an expanded set of services to manage mild-to-moderate issues, while the counties handle severe mental illness.[39] Several Medi-Cal health plans subcontract with a behavioral health plan (Beacon Health Options is common), intended to help patients obtain the appropriate services between PCPs and county specialty mental health providers. Some FQHCs report that these arrangements offer a helpful single point of contact for patient referrals.

Many FQHCs are changing their processes and adding providers in order to better integrate behavioral health services into their regular clinical operations. Major changes include adding screenings for mental health issues to primary care visits, care management, and providing "warm handoffs" to behavioral health professionals after the primary care visits; the team of providers routinely reviews patient caseloads together.[40] Integration allows PCPs, care managers, and behavioral health staff (psychiatrists, therapists, others) to collaborate on treating the patient and monitoring patient progress. For instance, the FQHC consortium in San Diego has created "care team conferencing" to discuss shared treatment plans and ways to transfer patients to providers across the health care system.

A number of workforce expansion efforts are also underway to add psychiatrists and other behavioral health staff at FQHCs. San Bernardino County has assigned a psychiatrist to its county FQHCs one to two days per week to treat patients and to train the FQHC staff to address less severe needs. Riverside County implemented something similar among its hospital and county FQHCs and found that it helped alleviate potentially harmful "cross prescribing" patterns between PCPs and psychiatrists. Neighborhood Health Center in San Diego recruits PCPs with double board certification in family medicine and psychiatry. Given the costs and challenges in recruiting psychiatrists, however, many FQHCs hire licensed clinical social workers (LCSWs) to provide counseling and facilitate other social services. The state allows LCSWs to bill Medi-Cal as providers, further supporting this strategy.[41] A few FQHC directors also mentioned using more licensed marriage and family therapists; a new state law will allow FQHCs to bill for their services starting in 2017.

The Bay Area stands out for its degree of formal integration of FQHC and behavioral health services. In San Francisco, the provider organization HealthRight 360 was formed in 2012 as a merger of an FQHC (GLIDE Health Services Clinic), a free clinic (Haight Ashbury Free Clinics), and a provider of mental health, substance abuse disorder, prison treatment, and vocation and housing services for people transitioning back into their communities (Walden House).[42] In Alameda County, the largest FQHCs, La Clínica and LifeLong, have achieved strong behavioral health integration; the latter has psychiatrists at each of its sites. Also, the Alameda Health Consortium works in partnership with Alameda County Behavioral Health Care Services and the AIMS Center at the University of Washington to train FQHC PCPs on behavioral health treatment.

About a decade ago, WellSpace in Sacramento (then called The Effort, which had started as a substance abuse treatment facility) merged with Sacramento's Family Service Agency, bringing child and family therapy, crisis intervention, and violence prevention under its umbrella. Today, WellSpace provides a continuum of comprehensive primary care, mental health, and addiction treatment services.

More recently, Riverside/San Bernardino has become very active in integrating behavioral health into primary care. As one FQHC director in that community said, "Behavioral

health integration is where most of the action is taking place." In a particularly high-profile initiative, the local public Medi-Cal plan, the Inland Empire Health Plan, in 2016 started the two-year Behavioral Health Integration Initiative (BHII). Partners include the county FQHCs and a couple of other large FQHCs (Borrego Health and SAC Health System), as well as the county hospitals and local behavioral health providers. The goal of BHII is to build multidisciplinary teams to adopt best practices from elsewhere, but also develop customized approaches for providing integrated behavioral health to patients with multiple chronic mental health conditions, substance abuse disorders, and medical issues.

CHALLENGES. While FQHCs have succeeded in bringing more behavioral health services into their organizations and facilities, they continue to face challenges in adequately growing the net capacity of these services and in fully integrating behavioral health into primary care. Finding enough behavioral health providers is a significant limitation: They are typically in even shorter supply than PCPs. While many FQHCs would like to add more psychiatrists, they are particularly difficult to find and expensive to hire; LCSWs are in short supply too. Also, the behavioral health services that FQHCs need are sometimes outside the licenses of available staff; FQHCs in Riverside County have worked with the county hospital to pursue legislation to expand the role of counselors and other types of behavioral health staff.

Also, many FQHC directors lamented that Medi-Cal does not reimburse FQHCs to provide a patient both a medical visit and a behavioral health visit on the same day. Handing off a patient to a behavioral health provider immediately following a primary care visit — which providers think is the best way to address these issues in a timely fashion — can prove costly to the FQHCs because they receive just a single encounter payment.

In addition, FQHC directors and other providers have found the division of responsibility blurry between mild-to-moderate and serious mental health issues, and face significant challenges coordinating patient care across their sites, county clinics, and other behavioral health providers in the community. Many FQHC directors reported challenges because these distinctions are open to interpretation, and patients are "bouncing back and forth" between them and the counties' specialty mental health providers.

7. Fostering Whole-Person Care

As noted, FQHCs have long provided enabling services (e.g., language interpretation and transportation) either themselves or through referrals to county agencies or community organizations. FQHCs also are increasingly providing more supportive services, such as housing and food. FQHCs observe that the lack of basic supports can exacerbate medical conditions, leading to the need for more medical care.

FQHCs increasingly are working to better coordinate medical, behavioral, dental, and nonmedical services in what many safety-net leaders refer to as "whole-person care." Many FQHCs have been involved in creating community referral networks that link patients to outside social services, and some have ramped up such efforts with the Medi-Cal expansion, which has brought in more patients with significant chronic medical issues and socioeconomic challenges. In addition to improving access to a broad range of nonmedical services, FQHCs expect whole-person care efforts to improve patients' overall well-being in a more effective and efficient manner, as well as help control demand for medical services and ease capacity constraints so FQHCs can serve more people.

Many California counties and cities spearhead whole-person care plans and partner with their local health center consortium and FQHCs to carry out key aspects of their plans. While some counties — especially those with stronger commitments to the safety net — fund such efforts themselves, many rely on FQHCs and other providers to help fund and carry out a range of related activities. For instance, San Diego County started its Live Well San Diego Initiative in 2010. This 10-year initiative focuses on a "3-4-50" concept, in which three behaviors (poor nutrition, lack of exercise, and

tobacco use) contribute to four diseases (cancer, heart disease and stroke, diabetes, and respiratory conditions) that account for over half of deaths in the county. The initiative creates a framework for collaborating on federal grants and other joint efforts, and is developing measures and tools to track and report on efforts to address these problems. The FQHCs participate in this initiative through their FQHC consortium, but some contribute their own programs. For instance, the largest FQHC, Family Health Centers, hosts health fairs and workshops in which they provide health screenings and education in the areas of nutrition, physical activity, and mental health, and has programs to remove used syringes from the streets and achieve better hypertension control rates. Another FQHC, Neighborhood Healthcare, supports a range of programs in the areas of tobacco, alcohol, and drug abuse prevention.

The city of Ontario in San Bernardino County received BUILD (Bold, Upstream, Integrated, Local, and Data-driven) Health Challenge Implementation grants from a set of private foundations to implement the Healthy Ontario Initiative. This is an umbrella community health initiative focused on improving prevention and wellness services, health care access, education and lifelong learning, and creating safe neighborhoods. As part of this initiative, the San Bernardino health department and its FQHCs are working with local hospitals and Partners for Better Health (a nonprofit community organization focused on developing appropriate health care services) to improve access to healthy, affordable food and safe places to exercise as a way to reduce high rates of obesity and related diseases.[43]

CHALLENGES. Obtaining funding and other resources to either directly provide or coordinate access to a broad range of public health and social services is a challenge for health centers. FQHCs often do not receive funding to cover the costs of these services. The extent to which such services are considered allowable costs for FQHC Medi-Cal payment reportedly is quite varied among FQHCs and can be somewhat subjective, and other funding to support them is fragmented. Also, it is difficult to assess how well these efforts do in fact improve patient well-being and control demand for and costs of medical care at FQHCs and other providers.

More funding for such efforts will become available through the state's 2020 Medicaid waiver. Selected whole-person care pilot programs will receive federal funding to test ways to integrate care among county agencies, health plans, and providers for particularly vulnerable Medi-Cal patients (for example, frequent users of EDs, the homeless, and people with multiple chronic conditions).44 Applications for this pilot were due July 1, 2016, and could consist of a county or region, health system, or consortium of these entities; the extent to which FQHCs will be part of these programs is not yet known.

8. Participating in Programs for the Uninsured

While FQHCs have focused considerably over the past few years on ways to better serve the growing Medi-Cal population, they also remain committed to treating people who remain uninsured. Most of the collaborative strategies discussed in this brief also extend to low-income patients who lack health coverage. In addition, FQHCs in about half of the regions continue to collaborate with their county health departments and safety-net hospitals to serve the remaining uninsured through county programs that attempt to provide access to services in a proactive, coordinated fashion. However, states give counties significant latitude in how many resources to devote to these programs, so their size and scope vary dramatically.

The Bay Area counties and Los Angeles County show large commitments to the uninsured and partner with FQHCs to serve this population, covering thousands of people, including undocumented immigrants. In the Bay Area, San Francisco continues its very expansive Healthy San Francisco program (eligible to all adults with incomes up to 500% FPL), and Alameda County has its HealthPAC program for people with incomes up to 200% FPL. In both programs, uninsured people select either a county clinic or a private FQHC

as their medical home. In addition to its large program for uninsured people who use the county-run health care system, Los Angeles County has the My Health LA program for uninsured patients at FQHCs (for primary care; the county system provides their remaining services). FQHCs receive capitated payments to care for these patients, which likely will help them prepare for a potential move to Medi-Cal capitated payments. Together these two Los Angeles programs serve about 300,000 people with incomes under 138% FPL.

Fresno County has two small programs for the remaining uninsured, one specifically focused on specialty care. Faced with very limited available funds and no primary care clinics of its own, the county created this program in collaboration with the area FQHCs, which agreed to provide ongoing primary care to these enrollees through their regular federal grants and other revenues. The county did not advertise the program, in part out of concern of overwhelming the FQHCs, but lower-than-expected enrollment has led the county and FQHC to collaborate on ways to reach, and provide more services to, undocumented immigrants.

CHALLENGES. Due in part to the state redirecting a large portion of the realignment funds that previously helped support county programs for low-income uninsured people, many counties have drastically reduced the size and scope of their programs for the uninsured.45 Counties including Orange, Riverside, Sacramento, and San Diego now have very restricted programs that serve just a few hundred people, and typically just for acute needs. Some of these counties expect the FQHCs to become the medical home, given their federal grants and requirements to serve all, which can create tension between the counties and the FQHCs when FQHCs are faced with taking in potentially quite ill patients without additional resources.

Discussion and Implications

Although FQHCs have become a growing part of the safety net across California, pressures on them to serve greater numbers of patients and to address a broader set of needs also have grown, and demand for their services still reportedly exceeds supply. Collaborations between FQHCs and other providers have become increasingly important to expand access, enhance quality, and improve efficiencies. Yet many of these collaborative initiatives remain new or face other significant challenges. Several themes emerged from this study for policymakers, private funders, medical schools, hospitals, FQHCs themselves, and others interested in enhancing this key part of the safety net for the Medi-Cal and uninsured populations to consider.

FQHCs have expanded significantly, yet regional variation in safety-net capacity persists. While it is difficult to precisely assess FQHC capacity relative to the needs of a given population, quantitative estimates coupled with more qualitative assessments suggest that certain regions, such as Riverside/San Bernardino, appear to have significantly less primary care and potentially other service capacity for low-income people than places like the Bay Area. Future funding decisions should consider these gaps and consider innovative ways of creating more capacity where needed. More cross-regional comparisons and analysis could be helpful in allocating future federal and other grant support for FQHCs. At the same time, policymakers need to factor in how much of current demand may be temporary (from pent-up demand and neglected health conditions that are now better managed) and to what extent further changes could help improve efficiencies, to guard against a potential overexpansion of brick and mortar facilities. Identifying opportunities to expand capacity in existing venues (e.g., schools, housing) could enable further expansion with less capital investment.

Clinician shortages remain significant barriers. As one FQHC director described the limitations of collaborative efforts: "The relationship-building will only take me so far. Physician shortages are a huge concern." While clinician productivity may improve as FQHCs and clinicians fully adapt to the Medi-Cal expansion and other changes, there will likely continue to be a need for more providers at many FQHCs. Expansions of medical (and dental and behavioral health) residency programs that include FQHCs as training sites, and greater incentives such as loan forgiveness under the federal program, could help. Also, further assessment could help identify whether more nonphysician clinicians in areas of medical, behavioral health, and dental care should be eligible to bill Medi-Cal for their services — and potentially even expand their scope of practice to enable them to perform more functions that physicians normally do. Certain regions, such as Fresno and Riverside/San Bernardino, need particularly targeted incentives to encourage clinicians to relocate and remain in those communities.

FQHCs are more financially stable but may need more support to expand their impact. With more patients insured, FQHCs now appear less reliant on grants to support their operations. Yet Medi-Cal encounter rates still do not fully cover FQHC costs, and health centers continue to need to serve many remaining uninsured patients. Ongoing support for new capital and certain operational costs could help ensure expansion can continue, and that current successful strategies do not wind down when grant funding ends. Even if the state moves away from encounter payments to more value-based payments, this transition would take time, so changes to other payment policies could be a helpful interim step. Providing a payment mechanism for some of the different processes, staff, and other changes — for example, in behavioral health integration, providing specialty care in new ways, and participating in whole-person care efforts — could help sustain and scale up some of these efforts. Also, how the new piloted capitated payment rates are determined and implemented will affect FQHCs, and individual FQHCs may need significant assistance during such a transition, depending on several factors, such as the region in which they are located, their experience with taking risk, and the size of their patient panels. Close monitoring of the movement to risk-based payments will be important to assess the impacts on patient access to an array of services, the financial health and viability of FQHCs, and overall costs of care for Medi-Cal patients. Further, additional support for cross-provider infrastructure and processes such as interoperable EHR systems, could support many collaborative activities and generate the data needed to assess their impact.

Background on Regional Markets Study

In 2015, a team of researchers from Mathematica Policy Research visited seven California regions to understand these markets' local health care systems and capture change since 2011/2012, the prior round of this Regional Market Study, funded by the California Health Care Foundation. The purpose of the study is to gain insights into the organization, delivery, and financing of health care in California and to understand differences across regions and over time. The seven markets included in the project — Fresno (including Fresno, Tulare, Kings, Madera, and Mariposa Counties), Los Angeles County, Orange County*, Riverside and San Bernardino Counties, Sacramento (including Sacramento, Yolo, El Dorado, and Placer Counties), San Diego County, and the San Francisco Bay Area (including San Francisco, Alameda, Contra Costa, Marin, and San Mateo Counties) — together are home to three-quarters of California residents and reflect a range of economic, demographic, health care delivery, and financing conditions in the state. Mathematica researchers interviewed over 200 respondents for this study. Respondents included executives from hospitals, physician organizations, community health centers and other community clinics, Medi-Cal health plans, and other local health care leaders. For this cross-site analysis, researchers conducted follow-up interviews with select respondents (primarily market observers and executives from hospital systems and physician organizations) and tracked local media sources to capture updates since the site-visit interviews.

▶ FOR THE ENTIRE REGIONAL MARKETS SERIES, VISIT WWW.CHCF.ORG/ALMANAC/REGIONAL-MARKETS.

*Orange County was added to this study in 2015; the research team had familiarity with this market through the prior Community Tracking Study conducted by the Center for Studying Health System Change (HSC), which merged with Mathematica in January 2014.

ABOUT THE AUTHOR

Laurie Felland of Mathematica Policy Research. Mathematica is dedicated to improving public well-being by conducting high-quality, objective data collection and research. More information is available at www.mathematica-mpr.com.

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. For more information, visit us online at www.chcf.org.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system. For more information, go to www.chcf.org/almanac.

©2016 California Health Care Foundation

ENDNOTES

1. "Medicaid Physician Fee Index, 2014," Kaiser Family Foundation, kff.org. In 2014, California's Medicaid physician payment rates were 81% of the average rate in the US; only Michigan and Rhode Island had lower rates. These rates were 52% of Medicare rates; only New Jersey and Rhode Island had lower ratios.
2. Janet M. Coffman, "Physician Participation in Medi-Cal: Is Supply Meeting Demand?" (presentation, State Health Access Reform Evaluation, September 27, 2016), **www.shadac.org**.
3. Aaron Katz et al., "A Long and Winding Road: Federally Qualified Health Centers, Community Variation and Prospects Under Reform," November 2011, Center for Studying Health System Change, **www.hschange.com**.
4. "California Health Center Fact Sheet," National Association of Community Health Centers (NACHC), 2014.
5. "Bureau of Primary Health Care," Health Resources and Services Administration, August 2016, **www.bphc.hrsa.gov** (PDF).
6. Primary Care Clinic Annual Utilization Data, California Office of Statewide Health Planning and Development (OSHPD), 2011 and 2014, **www.oshpd.ca.gov**.
7. OSHPD community health center data, 2011 and 2014.
8. Bobbie Wunsch and Tim Reilly, "Medi-Cal Win-Win: Surging Enrollment Fosters Investment in the Safety Net," California Health Care Foundation, December 2015, **www.chcf.org**.
9. The Low Income Health Program (LIHP) — an option under California's Bridge to Reform 1115 Medicaid waiver to enroll low-income uninsured people into a care delivery system before 2014 to later facilitate the transition to Medi-Cal — likely played a role in early enrollment in the Medi-Cal expansion. Most California counties (55 of 58) implemented a LIHP, although some as early as 2010 and others not until 2013. Fresno County was one of the few counties in the state to forego the program. LIHP enrollment was limited, so many additional people enrolled in Medi-Cal without first being in LIHP.
10. OSHPD data.
11. *California Community Health Centers: Financial & Operational Performance Analysis, 2011-2014*, Capital Link, 2016, **www.caplink.org** (PDF). Based on federal UDS data, the percentage of FQHC patients with Medi-Cal rose from 39% in 2011 to 56% in 2014, with the percentage uninsured declining from 40% to 26%.
12. *California Community Health Centers*, Capital Link. Another analysis of a subset of California FQHCs' financial statements found that operating margins increased from 1.9% to 2.8% on average between 2011 and 2014.
13. OSHPD data.
14. *California Community Health Centers*, Capital Link.
15. OSHPD data.
16. Ha Tu, "Many Routes to the Top: Efforts to Improve Care Quality, Coordination, and Costs Through Provider Collaborations," California Health Care Foundation, October 2016, **www.chcf.org**.
17. *California Community Health Centers*, Capital Link.
18. Author's calculation from OSHPD data show an 8% decline across these two years.
19. Coffman, "Physician Participation."
20. "Fact Sheet," NACHC, 2014.
21. M. M. Doty et al., "Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers," The Commonwealth Fund, May 27, 2010, **www.commonwealthfund.org**.
22. Sara Rosenbaum et al., "Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers," The Commonwealth Fund, July 15, 2011, **www.commonwealthfund.org**.
23. Pamela Riley, Julia Berenson, and Cara Dermody, "How the Affordable Care Act Supports a High-Performance Safety Net, The Commonwealth Fund," January 16, 2012, **www.commonwealthfund.org**.
24. *Spotlight on Health Center Payment Reform: California's Alternative Payment Methodology (APM) Pilot*, National Community Health Center Association, August 2016, **nachc.org** (PDF).
25. It is difficult to precisely assess their prevalence of each strategy because the study did not include interviews with all FQHCs in all the regions. The interviews were limited and generally focused on the largest FQHCs in each community, although interviews with the community health center associations helped obtain a broader picture of FQHCs' activities.
26. "California Health Center Fact Sheet," NACHC. Ninety-two percent as of 2014.
27. "HHS Awards More Than $36 Million for Health Center Adoption of Health Information Technology" [press release], US Department of Health and Human Services, July 21, 2016, **www.hhs.gov**. Among the study regions, Los Angeles, Orange County, and San Diego have received these grants to date.

28. Janet M. Coffman, Margaret Fix, and Kristine Himmerick, *Preparing Physicians to Care for Underserved Patients: A Look at California's Teaching Health Centers*, California Health Care Foundation, August 2016, **www.chcf.org**.

29. *Affordable Care Act Primary Care Residency Expansion (PCRE) Program: Frequently Asked Questions*, US Department of Health and Human Services, July 1, 2010, **www.hrsa.gov** (PDF).

30. Coffman, Fix, and Himmerick, *Preparing Physicians*.

31. "California State Loan Repayment Program," California Office of Statewide Health Planning and Development, **oshpd.ca.gov**.

32. Matt Boll, *Unusual Hospital-FQHC Partnerships Address Payment and Access Issues*, Healthcare Financial Management Association, April 15, 2015, **www.germane-solutions.com** (PDF).

33. M. M. Doty et al., Enhancing the Capacity.

34. *The Medi-Cal 2020 Waiver and the Work Ahead for Public Health Care Systems*, California Association of Public Hospitals (CAPH) and Health Systems & California Health Care Safety Net Institute (SNI), 2016, **caph.org** (PDF).

35. "T3 (Triage, Transport, Treat)," WellSpace Health, **www.wellspacehealth.org**.

36. "Our Story," Project ECHO, **echo.unm.edu.**

37. Jurgen Unutzer et al., *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes*, Centers for Medicare & Medicaid Services, May 2013, **www.medicaid.gov** (PDF).

38. *California Community Health Centers*, Capital Link.

39. Don Kingdon, Molly Brassil, and Erynne Jones, *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions*, California Health Care Foundation, August 2016, **www.chcf.org**.

40. Unutzer et al., *The Collaborative Care Model*.

41. *Medi-Cal Enrollment Requirements and Procedures for Licensed Clinical Social Workers and Licensed Marriage and Family Therapists*, California Department of Health Care Services, **medi-cal.ca.gov** (PDF).

42. HealthRight also provides behavioral health and substance abuse services in several other counties, including Los Angeles, Orange, and San Diego, but not in formal collaboration with FQHCs.

43. "City of Ontario Receives $1 Million for Healthy Ontario Initiative" [press release], City of Ontario, April 21, 2016, **www.ontarioca.gov** (PDF).

44. *The Medi-Cal 2020 Waiver*, CAPH and SNI.

45. In an arrangement known as 1991 realignment, California counties receive funds from state vehicle license fees and sales tax revenues to support county health, mental health, and social services programs. With the expectation that many uninsured residents would gain Medi-Cal or other coverage under the ACA and the need for county medically indigent programs would decline, Assembly Bill 85 transfers either 60% or a formula-based percentage of each county's health fund to social services. Sacramento is one of the counties to have 60% of its county health funds redirected.