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The Changing Landscape of California's Federally Qualified Health Centers

Executive Summary

Federally Qualified Health Centers (FQHCs) are public or nonprofit clinics that care for patients regardless of insurance status or ability to pay. FQHCs are as diverse as they are widespread and are integral to the state's safety-net provider landscape. Many FQHCs experienced rapid growth in the period immediately following the implementation of the federal Affordable Care Act (ACA) in 2014. In the post-ACA period, FQHCs have continued to add patients and clinic sites at a rapid pace in regions throughout the state, and many health centers have increased offerings of specialty services and care for elderly patients.

This report, part of the California Health Care Foundation's Regional Markets Study series, examines the changing FQHC landscape, focusing on emerging trends and regional differences in FQHCs across the state. Some of the key findings include these:

▶ Across the state, FQHCs have continued robust growth and expansion in the post-ACA period; some regions experienced a tripling of patient visits over the 2014–2019 period, while regions with more established FQHCs saw continued, if more modest, growth.

▶ Data suggest more room for expansion, particularly in regions where the number of FQHC visits per person is lower.

▶ Growth has occurred both through acquisitions of existing private medical practices and clinics and also through construction of new facilities.

▶ Expansion of FQHCs has been accompanied by some growing pains, including occasional conflicts with existing private practices and other providers as well as difficulties with recruiting enough qualified staff.

▶ FQHCs have become increasingly large and sophisticated; FQHCs in nearly all regions can join a clinic consortia or association, many clinics are part of large and growing clinic networks, and service offerings are increasing.

▶ FQHCs are increasingly participating in independent practice associations (IPAs) and exploring ways continue to serve patients as they age by adding Medicare Advantage and Programs of All-Inclusive Care for the Elderly (PACE).[1]

▶ The COVID-19 pandemic had a significant impact on FQHCs, causing severe financial hardships for many health centers while hitting FQHC patients harder than many other groups in the state; the financial dislocation, however, has caused some to look at value-based payment methodologies in a new light.

► Looking ahead, questions have emerged about whether increasingly large organizations will lose their community focus and whether the highly regulated environment surrounding FQHCs limits their ability to be innovative and respond to community needs.

Introduction

FQHCs are an integral component of the state's safety-net provider landscape. These public or nonprofit health centers provide care to patients regardless of insurance status or ability to pay. Operating in every region of the state, FQHCs are as diverse as the populations they serve. From small clinics to multisite networks, FQHCs provide a wide and increasing array of services and have grown in scope, capacity, and sophistication in recent years.

### FQHCs Have Grown – and Changed – in the Post-ACA Period

FQHCs have been a key component of the state's safety net for years. However, in the period following the implementation of the federal Affordable Care Act, FQHCs experienced significant growth as more Californians gained health insurance under the state's expanded Medi-Cal program. As shown in Figure 1, FQHCs have experienced significant growth statewide since 2014, with the number of patients increasing every year, from 3.7 million in 2014 to 5.3 million in 2019. And, while the number of organizations (i.e., clinic networks) has largely leveled off, the number of clinic sites has steadily increased each year as existing FQHCs expanded. In 2014, excluding county-run clinic networks,[2] FQHC organizations operated 776 sites across the state. Over the following five years, 157 new sites opened, an increase of more than 20%.

Regional Differences in FQHC Growth

While FQHCs have grown across the state, the overall results mask some important differences. Indeed, FQHCs vary tremendously in size, extent of service offerings, and areas of focus. As one respondent in Los Angeles said, if "you've seen one FQHC, you've seen one FQHC."[3]

FQHCs have been a key component of the state's safety net for years. However, in the period following the implementation of the federal Affordable Care Act, FQHCs experienced significant growth as more Californians gained health insurance under the state's expanded Medi-Cal program.

FIGURE 1. Growth in Federally Qualified Health Centers Statewide, 2013–19
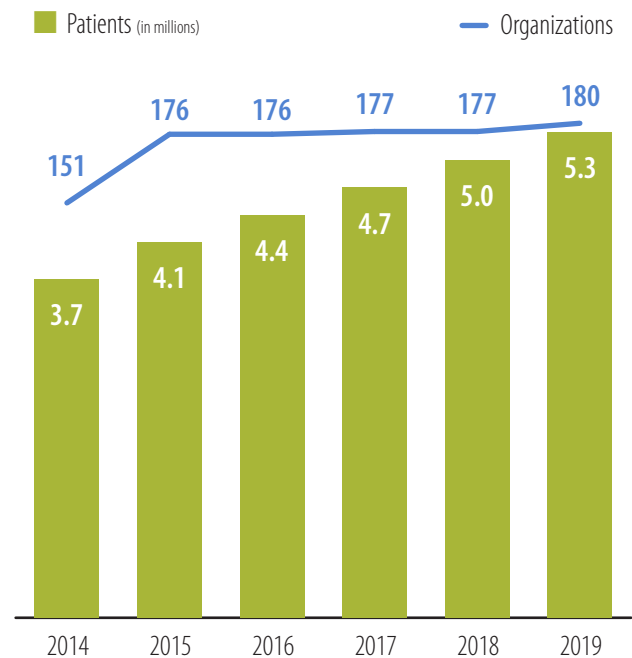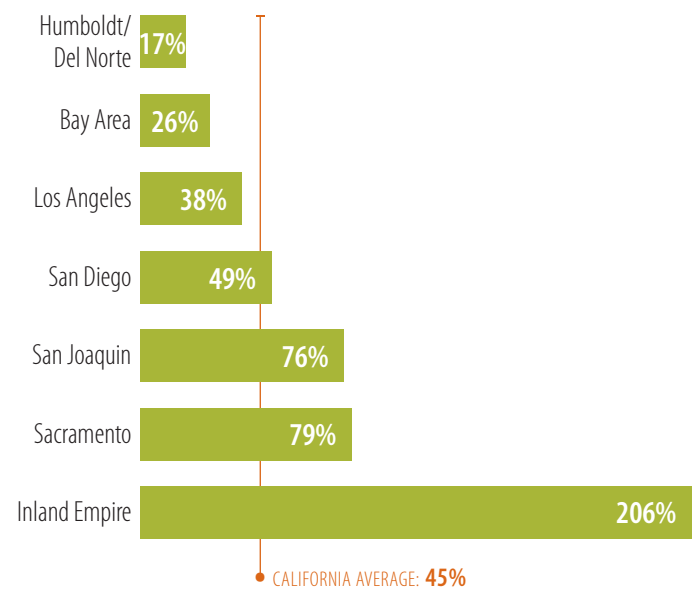

Source: "California Health Center Data," Health Resources and Services Administration, accessed February 1, 2021.

As shown in Figure 2, FQHCs in every region increased patient visits between 2014 (immediately following implementation of the ACA) and 2019; however, the extent of that growth varied widely across the state.[4]

For example, the number of FQHC patient visits in the Inland Empire has grown at a pace much faster than in the state as a whole. As new clinic sites opened in the region, the number of FQHC patient visits tripled, from just under 500,000 in 2014 to more than 1.5 million in 2019. The number of patient encounters also increased at a fast pace in the San Joaquin Valley and Sacramento regions, while the trend in the San Diego region more closely mirrored overall state growth.

In other regions of the state, a more stable FQHC landscape continued to show growth, but at a slower pace. In the Humboldt and Del Norte region, the region's largest FQHC, Open Door Community Health Centers, has expanded to fill a gap created as some private practices closed. Having started as a single clinic in 1971, Open Door now has 12 sites across Humboldt and Del Norte Counties, offering primary care, dental care, and behavioral health care. An FQHC since 1999, Open Door also operates three mobile clinics (two providing dental care). As the number of physicians in independent practice continues to decline, Open Door has become the main provider of primary care services in the area. "[Open Door's] population has been redefined from the core disenfranchised population to almost everyone in our area," according to a respondent.[5] Open Door has grown from 200 employees and a $14 million budget in 2004 to more than 700 employees and an $80 million budget in 2020. Open Door serves more than 60,000 patients annually, about a third of the area's total population. In spite of the scope of Open Door's presence, the overall increase in FQHC patient visits there during the recent past lagged the overall statewide growth, with visits increasing by just 17% compared with statewide growth of 45% — reflecting the fact that Open Door had already established a strong position in the region prior to 2014.

FIGURE 2. Change in Federally Qualified Health Center Encounters, by Region, 2014–19

Region	Change
Humboldt/Del Norte	17%
Bay Area	26%
Los Angeles	38%
San Diego	49%
San Joaquin	76%
Sacramento	79%
Inland Empire	206%

CALIFORNIA AVERAGE: **45%**

Notes: Excludes patient encounters at county-run clinics. Includes encounters at FQHC Look-Alikes, community health centers that meet the requirements of the Health Resources and Services Administration Health Center Program but do not receive Health Center Program funding.

Source: "Primary Care Clinic Annual Utilization Data," California Office of Statewide Health Planning and Development, accessed February 1, 2021.

Similarly, in the five San Francisco Bay Area counties, between 2014 and 2019, the number of FQHC patient visits grew by 26%, and the number of clinic sites increased by 14% — from 98 to 112 sites. A similar pattern was observed in Los Angeles County, where a well-established network of FQHCs plays an essential safety-net role but exhibited much slower growth during this period compared with the FQHC networks in the Inland Empire and other regions. Between 2014 and 2019, the number of FQHC sites in Los Angeles increased by 20% — to 233 — while the number of patient encounters rose by 38%. This growth was on a much larger base yet nevertheless reflects a slower pace than the tripling of patient visits seen in the Inland Empire. Indeed, it is a testament to the tremendous growth in FQHCs across the state that growth of "only" 38% over five years (as was observed in Los Angeles) counts as slow.

FQHCs Provide an Increasing Share of Care, but Still Have Room to Grow

The rapid increase in FQHC visits shown in Figure 2 presents just one part of the FQHC expansion story. Another important and related topic is the extent of FQHC penetration, or the share of patients who use FQHCs. One important measure of penetration is the share of a region's Medi-Cal enrollees who are receiving care at FQHCs. As shown in Figure 3, across the state, the share of Medi-Cal enrollees visiting an FQHC has increased steadily from just 18% in 2014 to more than 27% in 2019.[6]

Increasing along with the share of Medi-Cal enrollees visiting an FQHC has been the share of all Californians doing so. Between 2014 and 2019, the share of Californians visiting an FQHC increased from 9.6% in 2014 to 13.5% in 2019. As shown in Figure 4, the number of FQHC encounters per capita varied from a low of just 0.3 in the Inland Empire to a high of 1.8 in the Humboldt and Del Norte region — a more than five-fold difference. These data help to explain in part the differences in FQHC growth presented in Figure 2, which showed that the Humboldt and Del Norte region had the slowest growth in FQHC encounters of any region, whereas the Inland Empire had the highest. That is, in the Humboldt and Del Norte region, an established FQHC network already provides a substantial amount of care, whereas in the Inland Empire, in spite of a tripling of encounters over the 2014–2019 period, the number of encounters per capita remains relatively small.

These data present a story of robust growth as well as continued potential for expansion, with most Californians and most Medi-Cal enrollees still receiving care elsewhere. While the factors governing a patient's decision about whether and how to access care are complex and include factors such as the availability and quality of alternative providers, available data on FQHC penetration and interviews with FQHC leaders suggest there is room for continued growth in the future.

FIGURE 3. Share of Medi-Cal Enrollees Receiving Care at Federally Qualified Health Centers, 2014–19
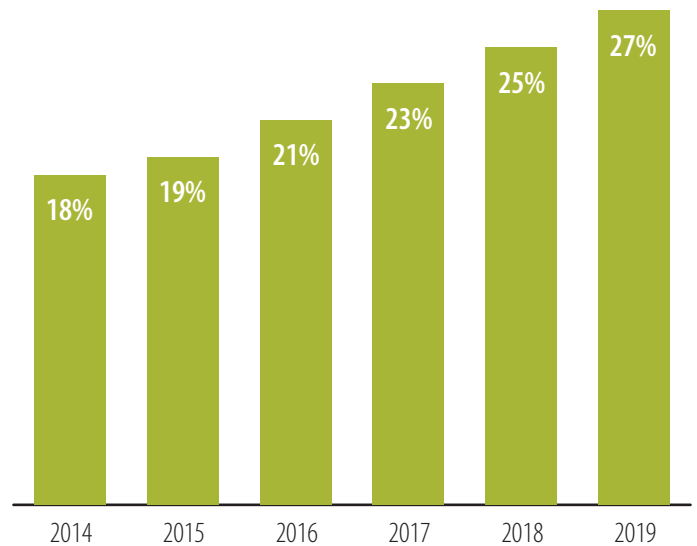
Notes: To determine the share of Medi-Cal enrollees each year who visited an FQHC, the number of Medi-Cal patients visiting an FQHC, as determined by the Health Resources and Services Administration (HRSA) data, was divided by the total number of Medi-Cal enrollees, as provided by the California Department of Health Care Services (DHCS). This estimated measure may somewhat understate the role that FQHCs play in the provision of care for Medi-Cal enrollees, as in any given year not all Medi-Cal enrollees will visit a health care provider. However, because FQHC patients may be counted more than once if they visit multiple health centers, the data may overstate the fraction of Medi-Cal enrollees that utilized FQHCs.

Source: "California Health Center Data," Health Resources and Services Administration, accessed February 1, 2021; "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility," California Department of Health Care Services, accessed January 1, 2021.

FIGURE 4. Encounters per Capita at Federally Qualified Health Centers, by Region, 2019
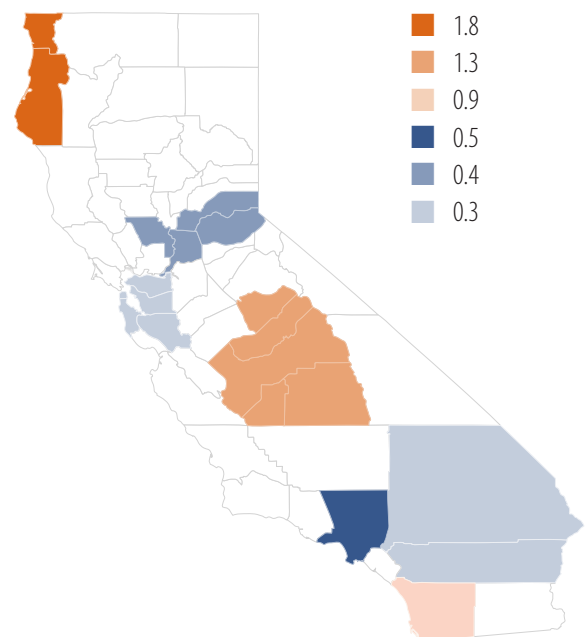
Notes: Excludes patient encounters at county-run clinics.
Includes encounters at FQHC Look-Alikes, community health centers that meet the requirements of the Health Resources and Services Administration Health Center Program but do not receive Health Center Program funding. Counties shown in white are not included in the Regional Markets Study analysis.
Source: "Primary Care Clinic Annual Utilization Data," California Office of Statewide Health Planning and Development, accessed February 1, 2021.
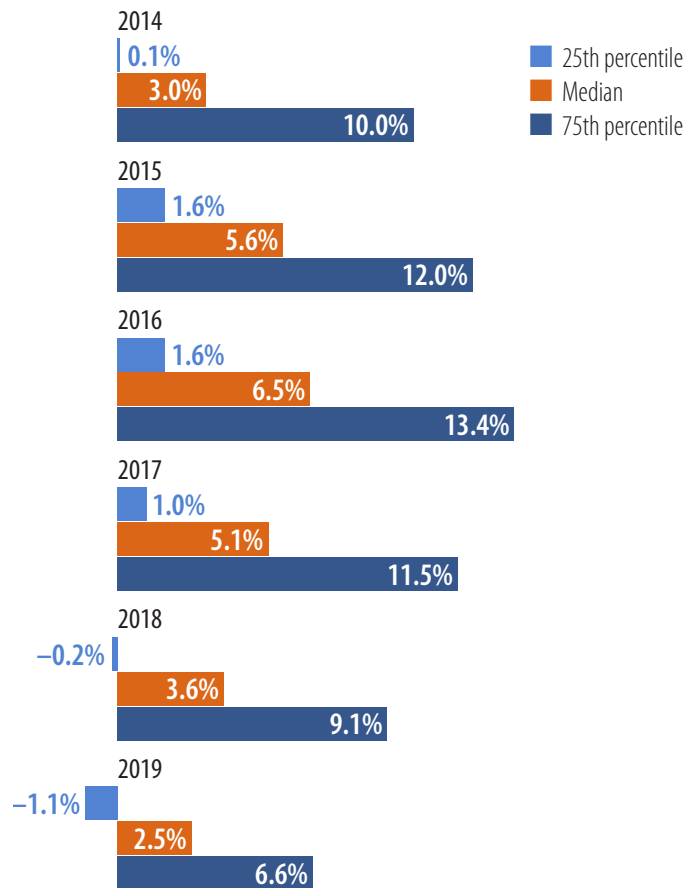
Changes in Financial Performance

In recent years, as FQHCs have increased their scope, reach, and patient volume, they have also experienced changes in their financial condition. The operating margin measures the difference between revenues and expenses for FQHCs. After initially rising in the period immediately following implementation of the ACA, FQHC operating margins have steadily declined since 2016. As shown in Figure 5, the median health center operating margin reached a high of 6.5% in 2016 and then declined to just 2.5% in 2019.

Margins for both the highest and lowest performing FQHCs followed a similar pattern. Margins for the clinics in the 75th percentile increased to a high of 13.4% in the years following ACA implementation before falling to 6.6% in 2019. Meanwhile, margins for clinics in the 25th percentile climbed to a high of 1.6% in 2016. By 2019 — in the period leading up to the COVID-19 pandemic — clinics in the 25th percentile were operating at a net loss of −1.1%.

Several factors may help to explain the change in margins. As shown in Figure 6, the increase in FQHC sites, patients, and encounters over the period from 2014 to 2019 has been associated with a significant change in the payer mix (i.e., the share of revenue from different entities responsible for paying for care, such as health insurance companies and Medi-Cal managed care plans). Prior to the implementation of the ACA, nearly 20% of FQHC patients were uninsured. By 2019, the fraction of patients without insurance had declined to less than 10%. Most of the change in payer mix was a result of the increase in Medi-Cal coverage stemming from the ACA's coverage expansion. The fraction of FQHC patients with Medi-Cal increased from about 58% in 2014 to more than 65% by 2019. Moreover, as shown in Table 1, the net patient revenues for each Medi-Cal managed care visit increased dramatically in the period following ACA expansion, rising by more than 30% over this period (see page 6).

FIGURE 5. Operating Margins at Federally Qualified Health Centers, 2014–19

Source: *California Federally Qualified Health Centers: Financial and Operational Performance Analysis, (2016–2019)* (PDF), Capital Link.

FIGURE 6. Payer Mix at Federally Qualified Health Centers, 2014–19
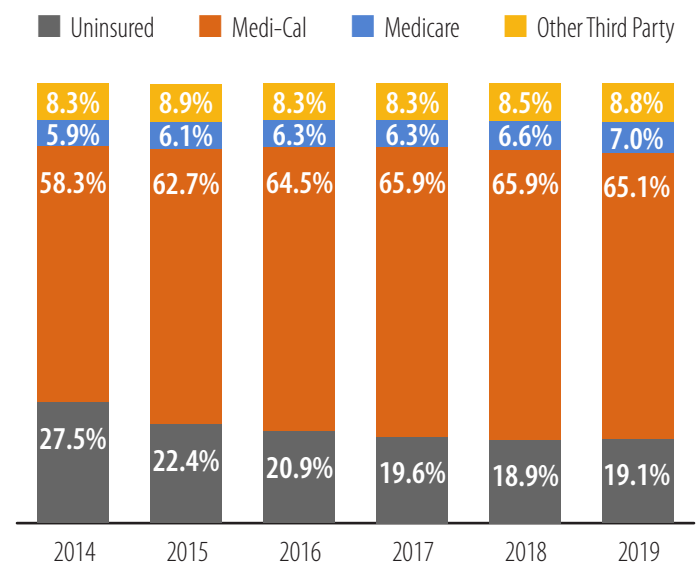
Note: Segments may not sum 100% due to rounding.

Source: "California Health Center Data," Health Resources and Services Administration, accessed February 1, 2021

TABLE 1. Net Patient Revenues and Share of Encounters, by Selected Payers

	NET PATIENT REVENUES		SHARE OF ALL ENCOUNTERS 2019
	Per Encounter 2019	Growth 2014–19	
Medi-Cal	$230	17.7%	22.2%
Medi-Cal managed care	$207	30.6%	45.7%
Medicare	$201	47.8%	6.7%
Medicare managed care	$140	3.3%	2.0%
Private insurance	$118	4.9%	6.3%
Self-pay / sliding / free	$56	16.1%	9.3%

Notes: Excludes net patient revenues from other public payers. Includes net patient revenues at FQHC Look-Alikes, community health centers that meet the requirements of the Health Resources and Services Administration Health Center Program but do not receive Health Center Program funding. Per-encounter payment includes any "reconciliation payments" reported by the clinic, including those received under the prospective payment system (PPS).

Source: "Primary Care Clinic Annual Utilization Data," California Office of Statewide Health Planning and Development, accessed February 1, 2021.

TABLE 2. Change in Revenues and Expenses per Encounter, 2014–19

	2014	2019	Change (2014–19)
Total revenue	**$204**	**$254**	**24.2%**
▶ Net patient revenues	$63	$69	9.6%
▶ Other revenues	$141	$185	30.7%
Total expenses	**$198**	**$249**	**25.9%**
▶ Personnel-related expenses	$137	$175	28.5%
▶ Other expenses*	$61	$74	20.1%
Average operating margin	**3.1%**	**1.7%**	**−1.4%**

Other expenses comprise supplies, rent, utilities, information technology, and all other non-personnel-related expense types.

Notes: Includes net patient revenues at FQHC Look-Alikes, community health centers that meet the requirements of the Health Resources and Services Administration Health Center Program but do not receive Health Center Program funding.

Source: "Primary Care Clinic Annual Utilization Data," California Office of Statewide Health Planning and Development, accessed February 1, 2021.

Coincident with this growth in net patient revenue, however, was more sluggish growth in nonpatient revenue from federal grants and other sources, as shown in Table 2. During the 2014 to 2019 period, federal grants declined from 14% of FQHC revenue to just 11%, as net patient revenue increased from 71% to 75%. As a result of these changes, between 2014 and 2019, while net patient revenues grew nearly 31%, total revenue growth was considerably lower, at just 24%. At the same time that total revenue growth was slowing, expenses were increasing, largely driven by increases in staffing costs. Between 2014 and 2019, FQHC personnel-related costs rose from $125 per patient visit to $175 — a 41% increase. As a result, expense growth over this period, at 26%, outpaced total revenue growth, leading to lower overall operating margins.

Examining operating margins on a regional basis reveals that most regions followed these statewide trends. In the Central Valley, for example, average FQHC operating margins decreased between 2014 and 2019, from 5.2% to 3.8%. About this decline, a clinic leader observed that revenues and operating margin increases in 2014 immediately after the ACA expansion were unprecedented, but then operating margins declined in subsequent years as clinics' expenses rose, largely as a result of expansion and staffing costs.

A similar result can be observed in the Humboldt and Del Norte region. Following ACA coverage expansions, the proportion of Open Door's uninsured patients dropped significantly, contributing to a positive bottom line. Open Door's payer mix has shifted in recent years as the health center gained more privately insured patients — a mixed blessing because, in contrast to cost-based Medi-Cal reimbursement, commercial reimbursement reportedly does not cover operational costs.

Financial performance in the Inland Empire also followed the statewide trend, with margins falling over the 2014 to 2019 period. However, average margins for Inland Empire clinics remained consistently negative during this period, averaging −5.7% in 2014 and falling to −7.9% by 2019. This decrease occurred despite the region's clinics enjoying a large increase in Medi-Cal coverage and decline in the share of patients without insurance. In 2014, FQHC patients receiving care free or on a sliding fee basis accounted for 16.4% of all encounters. By 2019, these groups accounted for just 5.7% of all encounters. In spite of the reduction in care for the uninsured, expenses per encounter increased more rapidly than net patient revenues during this period, leaving operating margins further weakened from 2014.[7]

Margins in two regions defied the statewide trend, increasing between 2014 and 2019. In the San Diego region, average margins increased from 5.6% in 2014 to 7.1% in 2019. Sacramento also saw an increase over this period, from 5.4% in 2014 to 15.4% in 2019, although the results were very volatile, with a single health center accounting for much of the change in 2019.

Innovations: How FQHCs Have Responded to a Changing Landscape

As FQHCs across the state have grown in size, many have become large and sophisticated organizations, increasing the range of services they provide and adding programs to serve elderly patients. Most FQHCs participate in local associations or consortia to advocate for policies of common interest, collaborate on recruitment strategies, and negotiate and manage contracts with health insurers and managed care plans. Each of these innovations and tools has helped FQHCs to thrive and cement their place in the safety net in the communities the FQHCs serve.

Many FQHCs Have Joined Forces to Share Information and Collaborate on Ways to Improve Patient Care

Throughout the state, FQHCs have increasingly banded together, joining consortia or clinic associations. In some regions these affiliations are simply tools for sharing information resources and advocating for policies of common interest. In others, clinics participate in independent practice associations (IPAs) to manage health plan contracting, pay-for-performance programs, and access to specialists.

In Alameda County, most of the community-based FQHCs participate in the Alameda Health Consortium. The consortium also operates an IPA, Community Health Center Network (CHCN), which contracts with health plans and takes professional risk for 155,000 managed care enrollees on behalf of member FQHCs. CHCN also participates in the Medi-Cal pay-for-performance (P4P) program, which ties enhanced payments to performance on a combination of quality measures and hospital and emergency department (ED) utilization metrics as well as encounter data standards. Because CHCN takes professional risk, the IPA operates its own P4P program, which also focuses on quality measures and hospital utilization.[8]

In Los Angeles County, many FQHCs participate in Health Care LA, a nonprofit IPA that contracts with health plans and manages the network for physician professional services — specialist as well as primary care. Most of the 300,000 lives under contract at Health Care LA are Medi-Cal enrollees, but the IPA also holds contracts in other lines of business: Medicare Advantage, Cal MediConnect, Covered California, and commercial HMOs. Health Care LA, in turn, delegates responsibility for Medi-Cal (and other) enrollees to FQHCs and pays them a capitated rate, generally for primary care services. (The FQHCs reconcile with the Department of Health Care Services at year-end to ensure they receive the reimbursement they are entitled to under the prospective payment system.)

The regional clinic consortium for the rural northwest, North Coast Clinics Network (NCCN), serves Open Door, Redwoods Rural Health Center in Humboldt, and Southern Trinity Health Services in neighboring Trinity County. NCCN joined forces with the Health Alliance of Northern California (HANC) — the regional clinic consortium for many other rural northern counties, including Siskiyou, Modoc, Shasta, Lassen, Shasta, Mendocino, and Plumas Counties — on an initiative to support health centers in identifying and addressing quality gaps through data analysis and quality improvement (QI) activities. NCCN and HANC have collaborated on a toolkit to help build FQHC capacity for data analysis and QI and to support a population health approach. The QI collaboration helps close gaps in patient care, generates health center revenue in the form of performance incentives, and focuses attention on improving quality scores.

In San Diego, Integrated Health Partners (IHP) — a subsidiary of Health Center Partners of Southern California, a consortium of 17 FQHCs and Planned Parenthood health

centers across San Diego, Riverside, and San Bernardino Counties — contracts with health plans for 250,000 managed care enrollees in San Diego and Riverside Counties through IHP's clinically integrated network, capable of taking full professional and facility financial risk. IHP's nine members include a mix of large and small FQHCs in the region, although the largest, Family Health Centers of San Diego (FHCSD), is not a member.[9] IHP, which functions similarly to an IPA, contracts with health plans in San Diego on behalf of member FQHCs, including the two largest Medi-Cal health plans — Community Health Group and Molina Healthcare of California — as well as Blue Shield Promise.[10] IHP also contracts with health plans for Covered California, Medicare Advantage, and dual-eligible products and recently launched a new data platform, Arcadia, to provide population health management tools to member FQHCs.[11]

In other parts of the state, FQHC collaboration has developed only more recently. In the Inland Empire, FQHCs can participate in the Community Health Association Inland Southern Region, founded in 2009. The association, the state's newest regional area consortium, provides advocacy, technical assistance, workforce development, education, quality improvement, and networking opportunities for members, but the association does not offer more coordinated financial functions as associations in other regions do. In the Sacramento region, numerous respondents remarked that FQHCs, which have historically been somewhat competitive, are slowly working toward more collaborative relationships. Some are participating in the Central Valley Health Network (CVHN), a membership organization of FQHCs that provides technical assistance and learning networks. The CVHN convenes regular calls for FQHC chief operating officers, chief medical officers, and human resource directors to share best practices and discuss common issues.

In addition, FQHCs in the Sacramento area are working together with the county and hospitals on initiatives targeting mental health and homelessness. As primary care homes offering integrated behavioral health and other services for patients with complex needs, FQHCs play an instrumental role in addressing the myriad needs of persons who are unhoused. The upcoming reprocurement of managed care plans for Sacramento County's Geographic Managed Care (GMC) Model has rallied FQHCs to coalesce around influencing how the model evolves. A respondent observed that FQHCs have relationships with each of the participating plans and their provider networks and therefore have a stake in how plans prepare for the reprocurement.[12]

FQHC Networks Expanding

Beyond collaborating with other FQHCs, many individual systems are increasing in size, through either organic growth or acquisitions. The number of networks operating statewide has increased just 2.3% since 2015. Yet the number of clinic sites (excluding those belonging to county-run clinics)[13] has increased 9.1%.

One example of consolidation occurred in 2020 in the San Francisco Bay Area, where the largest private FQHC in Santa Clara County, Foothill Community Health Center, with 13 sites, was acquired by Tri-City Health Center, which serves patients in southern Alameda County. Following the merger, the combined organization was renamed Bay Area Community Health. Also in 2020, Ravenswood Family Health Network in San Mateo acquired MayView Community Health Center, an FQHC Look-Alike.

In the Inland Empire, much of the growth has been driven by the expansion of FQHCs from neighboring counties, such as San Diego–based Borrego Health, which now has 17 health center locations across Riverside and San Bernardino Counties and accounts for roughly half of all non-county-run FQHC patient visits. Neighborhood Healthcare, which started in Escondido, now has four Inland Empire locations and accounts for 6% of all non-county FQHC visits.

Another important source of growth, both in the Inland Empire and across the state, has been the acquisition of independent private physicians' practices. Many of these practices have struggled financially; some have viewed selling a

practice to an FQHC as a way to manage the retirement of an aging physician population. Regardless of the cause, such acquisitions have been an important source of clinic system expansion. As one observer in the Inland Empire noted, FQHCs are "hoovering up private practices" across the region.

In other cases, growth has been driven by existing clinics that changed and broadened their focus to become FQHCs. For example, in Sacramento County, a previously existing clinic focusing on care for those with HIV/AIDS — Cares Community Health — became an FQHC with a broader mission to serve everyone in need of care. Now known as One Community Health, the FQHC has expanded its previous single-site clinic into a broader campus with a range of services including preventive care and screening, nutrition counseling and weight loss management, podiatry, laboratory, and pediatric services including a teen clinic.

One respondent observed that as FQHCs face the future, they face another challenge: balancing the two distinct and sometimes contrary organizational objectives of remaining community-based systems where patients feel "known" while also becoming sophisticated organizations that work across multiple sites with multiple lines of service. The same respondent proposed that FQHCs might consider mergers or shared administrative infrastructure to reap economies of scale and scope but, in the same breath, lamented the prospect of losing organizational identity and personality that allows for a personal touch with patients. While increased scale offers many advantages, including a better ability to manage patient data and improve outcomes, the lack of a more intimate connection to patient populations remains an important concern for expanding clinics.

Hospital Partnerships

FQHCs are increasingly integrated into their local health care landscapes, often through partnerships with local hospitals. For example, in the Inland Empire, Loma Linda University Medical Center, provides financial support to SAC Health System, an FQHC that runs clinics in six locations and is

among the largest teaching health centers in the country. With a half dozen locations across the Inland Empire (as well as mobile health and dental units), SAC Health System accounts for nearly 10% of all non-county FQHC encounters in the region and boasts more than 35 unique specialties. Riverside University Health System, which includes the county hospital for Riverside County, also operates 12 integrated FQHCs.

Alameda Health System (AHS) operates an FQHC with four sites, including one located at Highland Hospital. In the Sacramento region, UC Davis Medical Group physicians, mostly primary care, staff the Sacramento County FQHC, which also serves as a physician residency teaching site.

In the San Joaquin Valley, respondents noted that several hospitals collaborate with FQHCs to provide outpatient services and referrals to inpatient care. In Madera County, Camarena Health, the county's sole FQHC, is a referral source for Valley Children's Hospital and Madera Community Hospital. In Fresno, Family HealthCare Network (FHCN) took over two outpatient clinics on the campus of the Community Regional Medical Center (CRMC), operating the clinics and billing Medi-Cal for services through the FQHC, which receives enhanced payments. FHCN contracts with the Central California Faculty Medical Group to provide some physician services at FHCN sites, again allowing the FQHC to receive enhanced Medi-Cal payments. Regional experts believe this relationship serves both CRMC and FHCN. CRMC benefits by having outpatient services available on its campus at no financial risk while also relieving ED crowding and having outpatient services available for patients after discharge. Before developing the relationship with FHCN, CRMC reportedly struggled to make its outpatient clinics financially viable. Additionally, the clinics provide physician residency training locations. FHCN benefits by increasing patient access to physicians and residents across a broad scope of specialty services and improving continuity of care for patients discharged from the hospital. The relationship also allows FCHN an opportunity to recruit physicians to stay in the area after completing residency training.[14]

Expanding Services and Specialties

As FQHCs have grown and become more sophisticated, many have expanded the scope of services they provide. Many FQHCs now provide behavioral health, dental, and vision services and even podiatry and chiropractic services. Some FQHCs operate mobile clinics, provide laboratory and pharmacy services, and even hire hospitalists to follow and manage patients admitted to the hospital.

Table 3 highlights two encounter categories experiencing particularly rapid growth. The provision of services included within the "Medicine — Special Services" encounter category (as reported by clinics to the Office of Statewide Health Planning and Development) more than doubled, far outpacing growth in overall encounters statewide. In both Sacramento and San Diego, increases were especially pronounced. Similarly, dental visits now compose more than 17% of all encounters statewide; in the Inland Empire, there were more than six times the number of dental visits in 2019 than in 2014.

TABLE 3. Specialty Services and Dental Encounters, by Region, 2014–19

	SPECIALTY SERVICES ENCOUNTERS		DENTAL ENCOUNTERS	
	Growth 2014–19	Share of Total 2019	Growth 2014–19	Share of Total 2019
Bay Area	51.3%	9.0%	28.2%	16.5%
San Joaquin Valley	236.1%	4.7%	65.4%	16.1%
Inland Empire	238.7%	5.3%	564.5%	42.9%
Los Angeles	119.9%	5.2%	116.5%	11.1%
Humboldt / Del Norte	36.3%	4.1%	−9.5%	14.2%
Sacramento	299.9%	9.1%	51.8%	19.0%
San Diego	210.3%	11.6%	106.0%	20.7%
California	**128.9%**	**8.1%**	**79.7%**	**17.1%**

Notes: Includes encounters at FQHC Look-Alikes, community health centers that meet the requirements of the Health Resources and Services Administration Health Center Program but do not receive Health Center Program funding.

Source: "Primary Care Clinic Annual Utilization Data," California Office of Statewide Health Planning and Development, accessed February 1, 2021.

Other clinic encounter data suggest an expansion in specialty services beyond specialty medicine and dentistry. In 2019, for example, 1.5% of all encounters were coded as belonging to various specialties—such as anesthesia, radiology, and cardiovascular and respiratory services—that clinics had not even tracked for reporting purposes in 2014.

Behavioral Health Integration

One of the most significant developments across the FQHC landscape has been the increasing move to provide — and integrate — behavioral health services. According to a recent survey of FQHCs, all respondent clinic networks reported offering mental health services (up from 84% in 2016).[15] In expanding behavioral health services, many FQHCs now contract with Medi-Cal managed care plans' provider networks for less severe mental health conditions (also referred to as "mild-to-moderate" conditions), while a few FQHCs provide specialty mental health and substance use disorder services under contract with county behavioral health departments. Between 2014 and 2019, visits to FQHCs related to behavioral health increased by 62.5% across the state, outpacing the 44% increase in encounters overall during this period. Like the growth in total number of clinic visits, growth in the number of behavioral health visits to FQHCs varied significantly across regions (see Table 4 on page 11). In the Inland Empire, this number nearly quadrupled, outpacing the tripling in FQHC visits overall. In the Bay Area, where behavioral health services were more frequently offered in 2014, growth over the period lagged slightly behind the growth in the total number of encounters regionwide.

One of the most significant developments across the FQHC landscape has been the increasing move to provide — and integrate — behavioral health services.

	Growth in Number of Behavioral Health Encounters 2014–19	SHARE OF ALL FQHC ENCOUNTERS	
		2014	2019
Bay Area	20.6%	7.6%	7.2%
San Joaquin Valley	113.2%	4.0%	4.9%
Inland Empire	279.3%	5.6%	6.9%
Los Angeles	43.4%	5.8%	6.0%
Humboldt / Del Norte	48.7%	10.5%	13.4%
Sacramento	87.9%	12.7%	13.4%
San Diego	106.4%	7.3%	10.1%
California	**62.5%**	**7.0%**	**7.8%**

Notes: Behavioral health encounters are here classified as encounters with patients diagnosed with "mental, behavioral, and neurodevelopment disorders." Includes encounters at FQHC Look-Alikes, community health centers that meet the requirements of the Health Resources and Services Administration Health Center Program but do not receive Health Center Program funding.

Source: "Primary Care Clinic Annual Utilization Data," California Office of Statewide Health Planning and Development, accessed February 1, 2021.

Across the regions covered by this report, several clinics added or expanded behavioral health services. For example, HealthRIGHT 360 contracts with San Francisco County to deliver specialty mental health and substance use disorder (SUD) services. In Santa Clara, the county has integrated behavioral and physical health care in county FQHCs by having psychiatrists and licensed clinical social workers on-site to provide behavioral health services.[16] Zuckerberg San Francisco General Hospital also has integrated behavioral health into the primary care clinics on the hospital's campus. Alameda County provides psychiatric consultation services to primary care and behavioral health providers at private FQHCs.

In the Sacramento region, many of the larger FQHCs focus on providing integrated physical and behavioral health care and have invested in care management staff, quality improvement, and information technology infrastructure to improve care coordination. One FQHC leader said that 70% of the FQHC's more than 40,000 patients need some type of behavioral health service. These services range from mild-to-moderate mental health counseling to specialty mental health treatment and SUD services. WellSpace Health is one

of the largest SUD and medication-assisted treatment (MAT) contractors for Sacramento County, while CommuniCare Health Centers contracts with Yolo County to provide both specialty mental health and SUD services. In Placer County, Chapa-De Indian Health has a contract with the county to provide specialty mental health services. El Dorado Community Health Centers (EDCHC) has 10.5 full-time equivalent (FTE) employees dedicated to MAT, has another seven FTEs for counseling services, and offers psychiatry services 30 hours per week. EDCHC also has a relationship with Marshall Medical Center, which has a CA Bridge program and also collaborates with Barton Memorial Hospital for MAT and coordinates with the county for patients needing specialty mental health services. In the Central Valley, both Camarena Health and FHCN provide services on site and also use mobile vans to provide mental health services to hard-to-reach populations.

In Los Angeles, several former substance use disorder clinics have obtained FQHC status, increasing the scope of services offered and enhancing the integration of behavioral health and physical health services. In San Diego, some FQHCs have integrated behavioral health with physical health care — for example, by having a mental health therapist or SUD counselor on-site who can assist with warm handoffs or direct referrals from primary care physicians to psychiatrists or state-certified SUD counselors as appropriate. FQHCs in the region also contract with San Diego County to provide specialty mental health services. These FQHCs include FHCSD, which reportedly employs the majority of Medi-Cal participating psychiatrists in the region as well as more than 100 licensed therapists. In recent years, however, FHCSD decided to curtail some work with San Diego County because of significant administrative contractual requirements. San Ysidro Health also provides mild-to-moderate services to patients and has two sites that contract with San Diego County to serve the specialty mental health population. In addition to working with the county, FHCSD has partnered with local health plans and hospitals (e.g., Scripps Mercy Hospital) to

address the behavioral health needs of people who access care through hospital EDs. This effort includes placing social workers and SUD counselors in EDs to assist with diversions to community resources or to mental health care as appropriate.

Same-Day Billing Limitations Hinder Behavioral Health Integration

While FQHCs have moved to provide an increasing number and variety of behavioral health services, constraints on FQHCs' ability to obtain payment for these services can make such service delivery challenging. First, clinics cannot bill for two distinct services on the same day. As a result, clinics generally cannot bill for both a physical health and mental health visit on the same day. Second, only certain types of clinicians can bill Medi-Cal (e.g., physicians, psychiatrists, licensed clinical social workers, and clinical psychologists). Finally, FQHCs seeking to provide certain Medi-Cal reimbursable SUD or specialty mental services must negotiate a contract with the local county behavioral health department and must generally maintain a separate billing infrastructure for these services (which are financed with a separate Medi-Cal revenue stream managed by counties rather than managed care plans). FQHCs that wish to provide mild-to-moderate mental health services must first negotiate contracts with the local Medi-Cal managed care plan or a mental health benefit manager if the plan has subcontracted this function, even if the FQHC already has a contract with the managed care plan to provide physical health services.

These limitations on billing have led some FQHCs to simply provide behavioral health services without reimbursement or to seek alternative funding sources to pay for these services. The situation in the Central Valley is typical of many FQHCs across the state. In the Central Valley, as elsewhere, some FQHCs are part of managed care plans' "mild-to-moderate" provider networks and are considered essential providers of mental health treatment. In other cases, however, FQHC respondents noted that they will often provide these mild-to-moderate services even without reimbursement from plans because the FQHC may not be part of health plans' behavioral health networks. FQHCs in the region typically do not provide specialty mental health or SUD services under contract with county behavioral health departments. Like many FQHCs across the state, El Dorado County's EDCHC has opted to provide behavioral health services without managed care or county contracts and instead rely on encounters and grants funded through the prospective payment system (PPS).

Aging Population Stimulates Move to Keep Serving Patients as They Grow Older

As FQHCs become larger and increase their reach, many have expanded beyond the traditional population of uninsured and Medi-Cal enrollees. In order to keep serving patients as they age, some FQHCs have participated in Medicare Advantage and PACE. PACE serves people ages 55 and older who are certified to need nursing home care but can safely remain in the community with supportive services. Most PACE enrollees are eligible for both Medicare and Med-Cal, with enrollees eligible only for Medicare paying a premium for the long-term care portion of the PACE benefit.

San Francisco's North East Medical Services (NEMS) illustrates this move toward more programs for elderly patients. NEMS is the largest community-based FQHC in San Francisco, with 10 sites in the county and satellite clinics in other counties (including Santa Clara County). In 2019, NEMS partnered with Health Net to offer a Medicare Advantage health plan, as part of a larger strategy to retain patients as they age into Medicare. In 2021, NEMS launched a PACE program.

AltaMed, the largest FQHC in Los Angeles County, now cares for about 300,000 patients in Los Angeles and Orange Counties. While the majority of its patients are Medi-Cal enrollees, AltaMed participates in other lines of business, including Medicare Advantage. PACE has played a key role in AltaMed's growth and development, both as a training ground for caring for people with complex needs and

as a major revenue source. While PACE enrollees are a small minority of AltaMed's patients, the program accounts for a substantial share of AltaMed's revenue. Started in 1996, AltaMed's program grew to 1,600 enrollees in 2014 and 2,800 in 2020 — making it the largest PACE in California and the second-largest in the US. AltaMed takes global risk for PACE enrollees, and required services include adult day care, inpatient services, prescription drugs, home health, and nursing home care in addition to routine medical services. Taking financial responsibility for this population requires active management of inpatient care, and AltaMed hires hospitalists who track every PACE enrollee admitted to the hospital and coordinate with the enrollee's outpatient providers.

In January 2020, building on experience with PACE and following an extended planning period, AltaMed entered into a full-risk contract with L.A. Care Health Plan for about 52,000 Medi-Cal enrollees. The FQHC holds a restricted Knox-Keene license permitting assumption of global risk for Medi-Cal; AltaMed reportedly plans to expand to additional Medi-Cal enrollees.

In San Diego, with the aging of the population in the region, the FQHCs are reportedly beginning to develop strategies to retain their members as they age into Medicare rather than lose them to other Medicare providers or Medicare Advantage health plans. For example, San Ysidro Health and FHCSD are PACE providers. The San Ysidro program, which launched in 2015, currently serves 1,250 individuals at two sites, with plans to expand to five sites. FHCSD's program launched in 2020, making it the fourth PACE in the region.

Impact of COVID-19

COVID-19 has had a significant impact on FQHCs across the state. During the pandemic, the volume of visits in most clinics (and for health care providers generally) declined substantially as many patients stayed home. This decline in visits was accompanied by a steep decline in clinic revenues, which are generally tied to the number of in-person clinic visits. These financial challenges compounded the difficulty many FQHCs faced in addressing their patient' health needs — particularly in light of the pandemic and economic hardships faced by many of their patients. As one respondent in Los Angeles said, "if you overlay a map of clinics and a map of COVID inequities, they line up — and the economy will make it worse," highlighting the important role that FQHCs played during the pandemic.

While emergency federal financial support began flowing to FQHCs at the time this study was conducted, the financial pressures resulting from the pandemic have undeniably caused significant challenges for FQHCs across the state. These pressures have also driven clinics to be more innovative as they seek to adapt to a changing landscape. For example, more clinics are reportedly considering alternative value-based payment methodologies.

Telehealth Adoption and Scale

One of the biggest changes to occur as a result of the pandemic has been an acceleration in the use (and acceptance) of telehealth. Across much of the state, FQHCs had already embraced this technology. The reduction in in-person visits, however, drove a renewed interest in and willingness to use this technology on behalf of providers and patients alike.[17] According to one FQHC leader, "patients adapted to telehealth, and for the most part really liked it."

In the Humboldt and Del Norte region, Open Door actively embraced telehealth, starting with grant-funded efforts to connect local patients with specialists in remote locations on a small scale and expanding to additional providers and

specialties over time. Specialty services available through telehealth include dermatology, gastroenterology, pulmonology, and psychiatry. About 40% of specialist referrals take place through electronic consultation (eConsult), provided with the support of the region's Medi-Cal managed care plan, Partnership HealthPlan of California. Open Door's extensive experience with telehealth enabled its health centers to quickly ramp up remote care during the pandemic.

Given the chronic and often acute behavioral health workforce shortages in the San Joaquin Valley, regional experts there noted that telepsychiatry is heavily utilized by hospitals and outpatient sites alike to address psychiatric needs. Central Valley FQHCs in particular already had significant experience with telepsychiatry, which facilitated the expansion of telehealth resulting from the COVD-19 pandemic. One behavioral health leader interviewed remarked that telehealth was a "game changer," and its expanded use helps mental health plans meet network adequacy requirements. FQHC leadership reported that the pandemic more than doubled behavioral health services delivered by telehealth, an innovation that has reduced patient no-show and cancellation rates. In addition, FQHCs reported that care coordination for these patients has improved as telehealth offers faster referrals, more patient contact, and improved communication among providers.

In Los Angeles, as elsewhere in the state, telehealth has been a silver lining of a pandemic that hit FQHC patients harder than many other communities and increased financial pressure on clinics. FQHCs in the region rapidly pivoted to phone and video visits as face-to-face visits dropped precipitously. An unanticipated benefit has been reduction in no-show rates, which have fallen as low as 1% for behavioral health phone visits. Similar reductions in no-show rates for telehealth behavioral health visits were observed elsewhere in the state. For example, an FQHC leader in the Inland Empire noted that "no-show rates are now as low as 3% where we formerly saw rates more like 30%."

FQHC leaders remarked that they expect telehealth, and particularly telephonic visits, to continue after the pandemic recedes — assuming billing restrictions on nonoffice visits temporarily lifted during the pandemic remain in effect. Indeed, this access-enabling technology has become widely embraced by providers and patients alike.

Adapting to a Changing Landscape

In response to the COVID-19 pandemic, many FQHCs have had to change their business models and care delivery mechanisms in order to survive. Respondents noted the essential role played by state flexibility, including allowing FQHCs to count telehealth interactions as billable visits and allowing providers to operate clinics outdoors in parking lots for services such as COVID-19 testing and vaccinations. Concern is widespread, however, about whether that flexibility will remain in place. In addition to the loss of revenue from direct patient visits, quality of care metrics in 2020 are expected to fall well short of expectations based on standard metrics given the dramatic decline in face-to-face visits required for key measures, such as preventive screenings and immunizations. The Medi-Cal pay-for-performance dollars at stake are significant, and quality measures also factor into federal FQHC grants.

In Los Angeles, St. John's Well Child and Family Center, an FQHC that served more than 100,000 patients in 2019, has focused on COVID-19 testing and contact tracing. In response to a lack of available testing in late March, St. John's secured test swabs, identified a small private lab, and set up 28 testing tents across South Los Angeles, reportedly reaching 50,000 people by October 2020, with test positivity rates peaking at 30% during the summer months. St. Johns also established a contact tracing program. Through a partnership with California Hospital Medical Center, St. John's monitors positive cases by calling patients who tested positive each day to check on symptoms; if the individual worsens, an ambulance is sent for immediate hospital transport. St. John's also participates in COVID-19 research efforts:

in September 2020, St. John's began to track individuals who tested positive for COVID-19 to study long-term impacts and planned to test a new treatment for COVID-19 in collaboration with the University of California, Los Angeles (UCLA) and the University of Southern California (USC).

Venice Family Clinic (VFC), an FQHC based in West Los Angeles that served 28,000 patients in 2019, has expanded services for homeless people since the pandemic began, with regular visits to multiple Project Roomkey sites and encampments where people live. In addition to street medicine teams, VFC offers mobile clinics that provide privacy for services such as breast and pelvic exams. Food insecurity spiked during the pandemic as well, and VFC launched pop-up free food markets in response. Initially 200–300 people were reached each week; a partnership with UCLA has enabled expansion to 2,000 meals a week. UCLA is contributing the labor, keeping food service workers employed while the campus is closed, and donors cover food costs; VFC handles distribution.

Limited Steps Toward Payment Reform

Under the traditional payment model, FQHCs are paid for each patient encounter. This system offers little flexibility and constrains clinics' abilities to innovate, increase value or efficiency, or improve patient outcomes. And the current prospective payment system (PPS) does not offer clinics an easy way to address complex patient needs that are beyond the reach of traditional health care, such as hunger or homelessness, which can worsen physical health outcomes.

Moving to a value-based payment system has long been a topic of discussion among clinic leaders and policymakers alike, but to date there has been little progress in shifting the way clinics are compensated. The onset of the COVID-19 pandemic, however, may have provided an additional impetus for clinics to once again look at payment reform alternatives. A 2020 survey of FQHCs conducted by the California Primary Care Association found that more than two-thirds of respondents were interested in pursuing payment reform, a significant increase from prior surveys.

This renewed interest in payment reform likely reflects the fact that, across the state, FQHCs struggled financially during the pandemic, as the volume of patient encounters suddenly declined. In contrast, many private providers that relied to a greater extent on capitated payments from health plans were better able to weather the loss in patient volume. As one San Joaquin Valley respondent noted, the pandemic highlighted the potential benefits to FQHCs of receiving capitated payments, which provide a constant revenue stream even when services and PPS payments decline. Relying on PPS payments (analogous to traditional fee-for-service payments) linked to visits, most FQHCs experienced significant declines in revenues. On the other hand, one health plan executive observed, medical groups and IPAs that take capitated payments saw a financial "windfall" in 2020 as a result of reduced utilization by patients afraid of contracting COVID-19 in the clinics and offices. For the FQHCs, the financial impacts demonstrated the need for payment reform to move from PPS to value-based payment.

Growing Pains

As FQHCs have increased in size, scope, and sophistication, some clinics have experienced growing pains. The issues confronted by FQHCs include limited access to specialty care providers, limited staffing resources, and in some cases conflicts with competing providers.

Limited Access to Specialty Care

For many FQHCs, ensuring adequate access to specialty care for patients is a significant challenge. For example, respondents in Los Angeles noted that many specialists will not accept Medi-Cal patients, while others will treat Medi-Cal patients but not at the Medi-Cal rate. "Medi-Cal rates are low, bureaucracy is high," noted one respondent. For participating FQHCs, Health Care LA is responsible for recruiting specialists

and paying for specialty care, in partnership with L.A. Care and Health Net, which are ultimately responsible, under contract with the Department of Health Care Services (DHCS), to ensure availability of specialty care. Los Angeles County Department of Health Services (LACDHS) specialists care for county-assigned Medi-Cal enrollees and uninsured patients but not for Medi-Cal enrollees assigned to other networks, so Health Care LA recruits private specialists — with mixed success. Moreover, higher rates paid to specialists to ensure access and referrals to out-of-network specialists can create financial challenges for the IPA.

To facilitate access to specialists, FQHCs rely on virtual consultations with specialists to alleviate some demand. Respondents reported strategies ranging from hiring specialists to relying on a network of private specialists willing to see Medi-Cal patients for free "as long as they don't have to deal with billing Medi-Cal."

Staffing Challenges

Hiring enough qualified staff is one of the most commonly raised challenges associated with FQHC growth. Often salaries are lower than those paid by competing providers, making retention an especially important issue. In response, FQHCs have adopted various approaches.

In the Humboldt and Del Norte region, Open Door started a family nurse practitioner (NP) residency program in 2016 in collaboration with Community Health Center, Inc., an FQHC system in Connecticut. The program, which has trained three to four NPs in each of the most recent cohorts of the 12-month program, is an outgrowth of Open Door's participation in a nationwide best practices collaborative. Humboldt State University is reopening a program to enable registered nurses (RNs) to obtain a bachelor of science degree in nursing (BSN) — known as an RN-to-BSN program — with the first cohort of 25 students slated to begin the two-year program in fall 2020. College of the Redwoods, the local community college, offers a program for paramedics and licensed vocational nurses to become registered nurses,

with sites in Eureka (Humboldt County) and Crescent City (Del Norte County). Sutter Coast Hospital in Crescent City has emerged as a partner in this program, as well as in the RN-to-BSN program; St. Joseph Hospital contributed $2 million to Humboldt State University to help launch the RN-to-BSN program.

San Diego FQHCs have a long-standing focus on addressing workforce challenges, including operating physician residency training programs. San Ysidro Health's family medicine residency program trains eight residents each year. Given a shortage of geriatricians, the health center has partnered with Missouri-based A.T. Still University's Kirksville College of Osteopathic Medicine in a program to train students interested in geriatrics. In the program, 12 second-, third-, and fourth-year medical students complete their community-based rotation at San Ysidro. San Ysidro also has started a new internal medicine residency program, which is a three-year program with six students per year. Residents complete their hospital rotations at Scripps Mercy Hospital. FHCSD also operates a family medicine residency program for six physicians a year, partnering with Scripps Mercy, Rady Children's Hospital–San Diego, and UC San Diego Health for hospital-based rotations. Between 40% and 50% of residents stay with FHCSD after completing training.

In the San Joaquin Valley, CalViva Health further supports FQHC primary care recruitment efforts with grants to help repay physicians' student loans, helping to add 70 primary care providers in recent years. A similar program in the Inland Empire run by the Inland Empire Health Plan has been used by FQHCs to pay part of the salary for newly recruited physicians.

FQHC staffing challenges are so severe that one leader described the situation as a "workforce crisis," driven not only by FQHC growth but also by increasing competition with non-FQHC providers. These providers, including hospital systems and larger health systems such as Kaiser, can reportedly pay higher salaries.

Erosion of Independent Practices

As FQHCs have increased their presence in communities throughout the state, many networks have absorbed independent physician practices. In many cases, these moves have been welcomed by providers seeking a way to both maintain employment and provide care for their patients. However, in at least some cases, the acceleration in FQHC growth has been perceived as coming at the expense of private practices.

In many cases, FQHC expansion has been in response to a lack of interest or willingness on the part of private practices to see Medi-Cal patients. In the Sacramento region, particularly in Sacramento County, for instance, FQHCs have taken on a growing role in providing care for Medi-Cal patients and uninsured people. For example, in 2017, Anthem Blue Cross shifted 10,000 Medi-Cal enrollees from Sutter Health to Sacramento Native American Health Center and other FQHCs for primary care. In late 2018, UC Davis Medical Center (UCDMC) was entangled in United HealthCare's withdrawal from participation as a Medi-Cal managed care plan, and some 4,000 Medi-Cal enrollees lost UC Davis as their primary care provider with many shifting to FQHCs. And in early 2019, Anthem Blue Cross ended its contracts with Sutter Health for Medi-Cal and Medicare Advantage over payment issues, forcing some 12,000 enrollees to find new primary care providers; many of these patients landed with FQHCs as their medical homes.

In the Humboldt and Del Norte region, where the erosion of physicians in independent practice has characterized the market for primary and specialty care, many factors have contributed: the retirement of a generation of local doctors; higher costs of running a practice, such as the expense of electronic health records (EHRs); increased complexity of coding, billing, and regulatory requirements; and low payment rates. As local rural health clinics and private physician practices closed, Open Door has absorbed many clinicians who were struggling to survive financially in private practice. For example, in 2020, Open Door worked to integrate two practices, one obstetrics and one obstetrics/gynecology; keeping these clinicians in the community was viewed as essential to maintaining on-call capacity for obstetrics.

While much of the expansion in FQHCs and accompanying decline in private practice Medi-Cal providers has been welcomed, not all FQHC expansions have been viewed positively within local provider communities across the state. For example, in the Inland Empire, many physicians practice independently in solo or small practices. With a relative lack of FQHCs at the time of the ACA expansion, these practices provided the bulk of care to Medi-Cal patients. However, as the number of FQHCs expanded, these new health centers increasingly competed with established independent physician practices. One small medical group manager noted having "to scrape and fight to stay in business" amid the financial pressures and competition from FQHCs, which he viewed as accelerating the decline of independent practices.

Conflicts and Competition with Other Clinics

As FQHCs have grown over the past several years, some competition with existing clinics has resulted in competitive tensions in some areas. For example, in the San Joaquin Valley, some tensions have emerged between local FQHCs and competing Rural Health Clinics (RHCs). RHCs are regulated by the Centers for Medicare & Medicaid Services and, unlike FQHCs, are not required to treat uninsured patients. RHCs must be located in a Census-defined "non-urbanized area" as well as in a Health Resources and Services Administration–determined Health Professional Shortage Area (HPSA) or medically underserved area.

While only FQHCs receive supplemental federal grants to serve the uninsured, both FQHCs and RHCs receive cost-based reimbursements payments for Medi-Cal and Medicare patients. This rate-setting process can lead to highly divergent PPS rates among provider sites in the same counties. As of 2018, in four of the five counties in the region, the typical

RHC was paid more per visit than the average FQHC, and the most highly compensated clinic in many counties — often by a substantial margin — is typically an RHC.

Interviewees stated that many hospitals in the region have acquired smaller local clinics and physician practices to incorporate into existing or new RHCs in order to expand their market reach and outpatient footprint. (This strategy also reportedly supports hospitals' ability to integrate services along a continuum of care from inpatient to outpatient services and helps to expand access to care.)

According to some respondents interviewed for this study, hospital-affiliated RHCs may receive higher reimbursement because their payment rates incorporate the higher operating costs of the parent hospital. Indeed, DHCS data show that hospital-affiliated RHCs tend to receive higher rates than both other RHCs and FQHCs.[18] A clinic respondent noted that several RHCs use their higher PPS rates to contract with specialist physicians to provide services to Medi-Cal patients, because non-PPS rates were insufficient to attract specialists to see Medi-Cal patients.

Nevertheless, some FQHC respondents view RHCs as direct competitors for Medi-Cal patients and lament RHCs' "encroachment" into FQHCs' service areas. Some respondents noted that RHCs are "popping up close to FQHCs" in areas that are not very rural. Since Medi-Cal managed care plans and their affiliated IPAs include both RHCs and FQHCs in their provider networks, Medi-Cal enrollees can select either as their primary care home or for specialty care, contributing to competitive tensions between FQHCs and RHCs. Furthermore, hospitals influence where patients seek follow-up care upon discharge and often refer patients to their affiliated RHCs, even if the patients' primary care home is at another FQHC or physician's office.

Not only have conflicts emerged between FQHCs and RHCs, but some FQHC leaders have also noted the increasing competition among FQHCs in the same region. According to one observer, some FQHCs have expanded into territory that is already well served by an existing FQHC in order to continue to fuel expansion and revenue growth rather than merely to expand access to care.
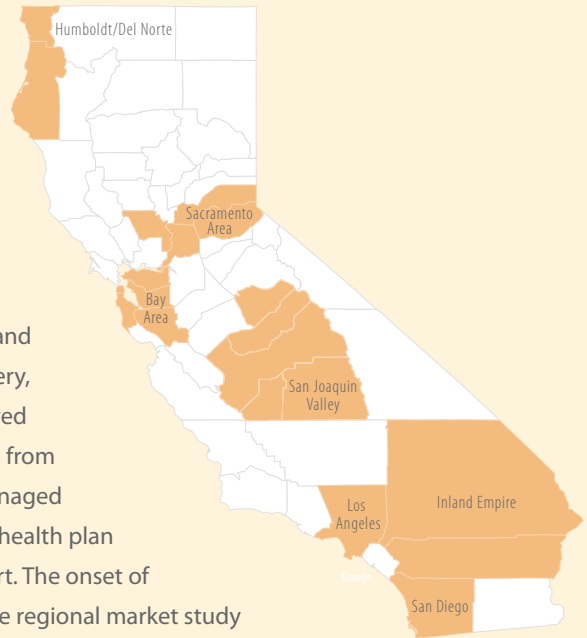
Issues to Track

► Will FQHC expansion continue and improve access to care for lower-income people and those with Medi-Cal coverage?

► Will telehealth play a larger role going forward in expanding access to specialty care, especially in the more rural, less affluent areas of the state?

► What are the next organizational developments for FQHCs as they assume more responsibility for Medi-Cal enrollees? Will FQHCs increase collaboration? Can they retain their community-based roots and close connections with patients as the FQHCs grow and develop more sophisticated capabilities?

► Will FQHCs continue to grow as rapidly? As they become more clinically integrated and offer more services, will FQHCs increase health plan participation beyond Medi-Cal? Will more FQHCs launch PACE models?

► Will the movement toward behavioral health integration continue?

► How will competitive tensions over patients and resources between FQHCs and RHCs be resolved?

► Will FQHCs move away from reliance on their traditional PPS payment model to more value-based payment methodologies?

ENDNOTES

1. IPAs or Independent Practice Associations are also sometimes known as Independent Physician or Independent Provider Associations.

2. The California Office of Statewide Health Planning and Development releases FQHC data at the site level annually, but these datasets exclude clinic networks operated by county governments. As a result, the total growth in the number of clinic sites (i.e., including county-operated sites) cannot be determined, though county clinic networks have also expanded over this period.

3. For more information about FQHCs in Los Angeles, please see Jill Yegian and Katrina Connolly, *Los Angeles: Vast and Varied Health Care Market Inches Toward Consolidation*, California Health Care Foundation (CHCF), January 2021.

4. Throughout this report, the terms "patient visits" and "patient encounters" are used interchangeably.

5. For more information about FQHCs in Humboldt and Del Norte Counties, please see Jill Yegian and Katrina Connolly, *Humboldt and Del Norte Counties: Community Collaboration in the Face of Health Adversity*, CHCF, October 2020.

6. Note that patients who visit more than one FQHC network may be double-counted in the data shown. In addition, between 7% and 11% of Medi-Cal patients did not receive any health care, according to the California Health Interview Survey.

7. For more information about FQHCs in the Inland Empire, please see Matthew Newman and James Paci, *Inland Empire: Increasing Medi-Cal Coverage Spurs Safety-Net Growth*, CHCF, December 2020.

8. For more information about FQHCs in the San Francisco Bay Area, please see Caroline Davis and Katrina Connolly, *San Francisco Bay Area: Regional Health Systems Vie for Market Share*, CHCF, April 2021.

9. FHCSD also is not a member of Health Partners of Southern California.

10. Integrated Health Partners also holds contracts with both Medi-Cal health plans in Riverside County (Molina Healthcare and Inland Empire Health Plan).

11. For more information about FQHCs in San Diego, please see Caroline Davis and Katrina Connolly, *San Diego: Competing, Collaborating, and Forging Ahead with Population Health*, CHCF, February 2021.

12. For more information about FQHCs in Sacramento, please see Len Finocchio and James Paci, *Sacramento Area: Large Health Systems Grow in a Pricey and Tumultuous Market*, CHCF, February 2021.

13. See note 1.

14. For more information about FQHCs in the San Joaquin Valley, please see Len Finocchio and James Paci, *San Joaquin Valley: Despite Poverty and Capacity Constraints, Health Care Access Improves*, CHCF, December 2020.

15. California Primary Care Association (CPCA), "2020 Behavioral Health Services Survey," CPCA (2020).

16. "Integrated Behavioral Health Division," County of Santa Clara Behavioral Health Services, accessed January 4, 2021.

17. Jen Joynt, Rebecca Catterson, Lucy Rabinowitz, *Listening to Californians with Low Incomes*, CHCF, October 2020.

18. *FQHC and RHC Current Rates* (PDF), DHCS, accessed August 1, 2020.

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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.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system.