The Role of Federally Qualified Health Centers in Delivering Health Care Services to Medi-Cal Beneficiaries

Urban and Environmental Policy Senior Comprehensive Project

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15 May 2017

Acknowledgements

Thank you to Urban and Environmental Policy Professors Cha and Matsuoka for their helpful and diligent guidance throughout this research project.

Thank you also to those who took the time to be interviewed, Steve Abramson and Erica Jacquez.

Thank you to friends and family who have supported me throughout this project and as I've worked towards the completion of my undergraduate degree.

Lastly, thank you to the UEP senior class of 2017 for inspiration, and congratulations on four years of hard work!

Executive Summary

This paper will examine the question: What is the role of Federally Qualified Health Centers in delivering health care services to Medi-Cal beneficiaries, and what challenges can be addressed with healthcare policies, programs, and waivers? Detailed background research is given on Federally Qualified Health Centers and their ability to expand with the implementation of the Affordable Care Act, as well as information about provider shortage and other challenges in accessing care that the Medi-Cal population faces. Interviews with executive staff at two FQHCs in Los Angeles serve to explain specific policies, programs, and practices that allow local FQHCs to effectively serve their populations.

The interviews and background research combined with supplemental charts and figures illustrate key findings about the role of FQHCs. FQHCs have largely been able to expand in recent years with the implementation of the ACA, and have more funding resources available to them which has allowed them to expand both their patient population and their workforce. However, many of these centers also face provider shortage and lack sufficient incentives to prevent high provider turn-over. There are current opportunities such as the Medi-Cal 2020 waiver and the Wrap Cap Pilot that aim to instigate payment reform, expand services for the FQHC patient population, and improve healthcare delivery.

Despite challenges that they face, it is largely agreed that FQHCs hold an extremely important role in serving those on government-funded insurance, and that they are a cost-effective way of delivering care. Recommendations include guidelines for federal healthcare legislation, such as suggestions to maintain provisions seen in the Affordable Care Act about an insurance mandate, insurance subsidies, and Medicaid expansion. It is also recommended that FQHCs take advantage of local programs that offer loan repayment to providers in exchange for

a commitment to serve in areas with provider shortage, and recommended that FQHCs engage in community outreach to spread awareness of these programs and recruit within the community.

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Terms and Abbreviations

Term	Definition
DHCS	Department of Health Care Services
Medicaid	Federal health insurance program, also partially regulated and funded by the state. Can encompass both Medicaid and Medicare.
Medi-Cal	California's expanded Medicaid. The main expansion allowed all adults under 138% of the Federal Poverty Level to enroll.
Medicare	Government health insurance program for those 65 and older. Funding and regulations are shared by state and federal government.
FQHC	Federally Qualified Health Center
ACA	Patient Protection and Affordable Care Act, also known as Obamacare

INTRODUCTION

With the implementation of the federal healthcare law entitled "Patient Protection and Affordable Care Act" (ACA) in 2010, Federally Qualified Health Centers (FQHCs) began to play a more important role in delivering primary health care and specialty services to Medicaid beneficiaries. With an increase in Medicaid recipients came an impressive yet arguably insufficient increase in funding and incentives for organizations and people providing these recipients with health care services. Policies, programs, practices and funding continue to change and develop as ACA provisions become fully implemented and healthcare delivery systems can focus on experience, development, and change. The study of these policies and programs and their implementation are important as the health care, health delivery, and health insurance landscapes continue to change, especially with the current uncertainty surrounding health care under the new federal administration. This paper will address the question: What is the role of Federally Qualified Health Centers in delivering health care services to Medi-Cal beneficiaries, and what challenges can be addressed with healthcare policies, programs, and waivers?

California specifically is an important case when looking at the health care market. California assisted in the federal expansion of Medicaid by creating a state-wide online health insurance market, allowing for automatic re-enrollment in Medicaid, and being involved in funding allocation[1]. With the largest population in the country and largest state economy, California chose to be involved in health insurance expansion and assist its citizens in obtaining health insurance and accessing health care. California also has the largest number of FQHCs, mainly due to population size, proportion of the population on public health insurance, and the

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[1] California Health Care Foundation, "Stepping Up to the Plate: Federally Qualified Health Centers Address Growing Demand for Care," October 2016.

fact that the state supports and works to integrate these health centers as health care providers[2].

BACKGROUND

Medicaid Expansion and the ACA

President Obama's Patient Protection and Affordable Care Act (ACA) was passed in 2010, with various provisions taking effect at different times throughout the following years. A provision that expanded the federal health insurance program, Medicaid, went into effect in 2014, which allowed millions of people nationally to become eligible and enroll in Medicaid. Medicaid now provides health insurance to nonelderly adults up to 138% of the poverty line, as well as some disabled individuals, pregnant women, children, and refugees, given certain qualifications[3]. In California specifically, millions of citizens became eligible for California Medicaid (often referred to as Medi-Cal), and while some of these groups were eligible for Medi-Cal prior to the ACA, its implementation resulted in an enrollment increase of 60%, or 5 million people, from October 2013 to May 2016.[4] Current numbers show that about 13.6 million people, over a third of the California population, are now covered by Medi-Cal.[5] The ACA expansion also increased incentives for both private and public health care providers to accept Medi-Cal as a form of insurance, and increased funding for safety net clinics that were already serving Medi-Cal populations.

Through the ACA, over 1,000 health center sites throughout California received federal grants to conduct outreach in eligible and vulnerable communities to increase enrollment in Medi-Cal. Additionally, Medi-Cal payment rates, federal grants, and other forms of funding

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2 Ibid.

3 Centers for Medicare and Medicaid Services, "Affordable Care Act," *Medicaid.gov*, December 30, 2015, http://www.dhcs.ca.gov/provgovpart/Documents/Letter_to_State-CA_Redacted.pdf.

4 California Health Care Foundation, "Stepping Up to the Plate."

5 Ibid.

increased.[6] However, many of the healthcare resources available to Medi-Cal recipients still tend to be underfunded, overcrowded, and inefficiently managed. Even prior to Medicaid expansion, there was a lack of sufficient providers to serve the California Medicaid population. In 2012, participation of primary care physicians in the California Medicaid program was very low compared to other states; California had the second lowest percentage of primary care physicians accepting new Medicaid patients, and the third lowest Medicaid primary care physician payment rate.[7] Studies have shown that low payment rates for physicians participating in Medicaid deter physicians from participating and result in an insufficient number of providers for this population.[8]

Medicaid expansion was incredibly important to California's population. Prior to the ACA, California had 5.8 million uninsured individuals, reflecting 15% of the population, and housed the largest number of uninsured people in a state.[9] One reason for this dramatically high number was that the majority of nonelderly covered Californians were covered by insurance through their job, but with a high unemployment rate job-based insurance was not an option for many people[10]. Other health insurance options, such as private insurance, were also not necessarily feasible due to high premiums and generally high costs. Prior to the ACA, California Medicaid covered certain groups of children, such as those up to 250% of the poverty line, and had limited coverage for select groups of impoverished adults such as pregnant women and individuals with disabilities. Expenditures for California Medicaid encompassed both these

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[6] Ibid.
[7] Janet Coffman et al., "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?"(California Health Care Foundation, August 2014), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20P/PDF%20PhysicianParticipation MediCalEnrollmentBoom.pdf.
[8] Ibid.
[9] Kaiser Family Foundation, "The California Health Care Landscape," *Kaiser Family Foundation*, August 2015, http://kff.org/health-reform/fact-sheet/the-california-health-care-landscape/.
[10] Ibid.

adults and children as well as the disabled and the elderly on Medicare, but the difference in enrollment between these groups was not reflected in the distribution of funds. Based on 2011 figures, 82% of enrollees in California Medicaid were children and adults, although they accounted for only 36% of expenditures, while the elderly and people with disabilities accounted for 18% of enrollees but 64% of total program costs.[11] These figures, as well as the high number of uninsured, illustrate how and why Medicaid expansion was both necessary and feasible.

Prior to 2014, California was granted a waiver and participated in an early expansion of Medi-Cal, although the fully expanded coverage was not enacted until 2014. Additionally, California was already working on redesigning the health care delivery system.[12]

Medi-Cal insurance and delivery of health care relies on both federal and state funds, which are constantly fluctuating. Projected increases in caseload and changes in the healthcare landscape necessitate that the budget constantly be changed. These changes continually effect the role of FQHCs and the services and resources that they can provide.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are community clinics that meet various federal requirements are eligible for funding under the Public Health Service Act, Section 330 grant. They qualify for higher reimbursements from Medicaid and Medicare and are eligible for extra benefits and grants.[13] The purpose of FQHCs is to serve communities that may have financial disadvantages, language barriers, geographic barriers, or other specific needs. They serve high-need areas determined by the federal government that might be facing high levels of

[11] Ibid.
[12] Ibid.
[13] California Health Care Foundation, "Stepping Up to the Plate."

poverty, negative health outcomes, and limited access to health care services.[14] FQHCs are usually located in rural areas or economically disadvantaged city areas, and provide services to all community members regardless of insurance status or ability to pay. They often offer specialty services as needed by the population, such as transportation vouchers, translation services, case management, and health education.[15]

FQHCs and other safety net clinics play an important role in delivering health care services to those insured by Medi-Cal. Although Medi-Cal provides health insurance it does not guarantee access to health care services, and physician participation as a health care provider accepting Medi-Cal is voluntary. One study showed that 92% of physicians in community health centers and public clinics had Medi-Cal patients, while only 64% of all physicians surveyed had any Medi-Cal patients[16]. Additionally, while the National Health Service Corps is in charge of student loan forgiveness to encourage employment by safety-net clinics, some studies have shown that this policy is not always observed.[17]

FQHCs also face a unique challenge in that in addition to accepting Medi-Cal and Medicare, they accept those without insurance and those who are covered by local programs. This diverse population means that their patient pool may be more vulnerable, have more targeted and specific needs, and that the expenses for those patients may be complicated and susceptible to little-to-no reimbursement. FQHCs attempt to provide as many services as possible to their patients. In 2014, almost all of California's FQHCs provided primary care, mental health counseling, and substance use disorder counseling, and about 75% provided dental

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[14] National Association of Community Health Centers, “America’s Health Centers,” March 2016, http://www.nachc.org/wp-content/uploads/2015/06/Americas-Health-Centers-March-2016.pdf.
[15] Ibid.
[16] Coffman et al., “Physician Participation in Medi-Cal: Ready for the Enrollment Boom?”
[17] California Health Care Foundation, “Stepping Up to the Plate.”

care, case management, and assistance with insurance enrollment. Many FQHCs also include dental care, vision, substance use disorder treatment, pharmacy services, and laboratory services.[18]

The ACA expanded health care to millions of individuals and helped them gain access to primary care and specialty health services, possibly for the first time. Because of this expansion, the new population that FQHCs are serving are more likely to be high-need, have comorbidity, and have socio-economic needs that must be addressed in conjunction with physical health needs.[19]

Despite positive expansions, there are still multiple factors that limit FQHCs and make it difficult for them to fill some gaps in service. Although there was a dramatic increase in federal support with the ACA, those grants may be limited and difficult to obtain, and numerous FQHC directors reported that they applied for but failed to obtain these grants. [20] There are also still large numbers of uninsured patients across the country, and although they make up significant proportions of the FQHC client base, funding for their services has not seen much increase. Although on average profit margins have increased for FQHCs across California, 25% of these clinics operated at a loss in 2014.[21]

Despite increased incentives, provider retention is a major problem facing FQHCs. The National Health Service Corps Program is supposed to offer some student loan forgiveness for physicians that commit to FQHC employment, but many FQHCs reported not receiving sufficient, if any, loan forgiveness for their providers[22] . Lack of provider incentives to work at

[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.

FQHCs are particularly dangerous because competition among primary health care provider organizations is increasing, and providers may be likely to seek out private employment with better benefits and incentives. Due to the lack of federal incentives for FQHC employment, FQHCs themselves may be forced to offer incentives such as higher pay and more benefits, hurting their organization economically and jeopardizing their financial security. An additional challenge for FQHCs is that the increase in those insured included many people who may not have had access to primary care services before. This could mean more serious diseases, comorbidity, and social service needs that require more case-management resources.[23]

Declines in productivity, caused by an attempt to increase care coordination, are costs that are being absorbed by the centers themselves rather than the government.[24] With an increase in patients that have a variety of needs comes a necessity to organize the care of these patients. Care coordination is a strategy to assure that the patient's mental health, physical health, and socio-economic needs are being met and that each patient's providers are communicating to deliver the most effective care possible. Electronic health records and other strategies to implement care coordination are being used, and with these changes and developments comes a decrease in productivity while providers and the organizations learn and adapt. This decrease in productivity can be costly and those costs are being absorbed by the FQHCs, due to Medi-Cal costs not having increased comparably to cover these types of changes.[25]

Waivers and Programs

Medi-Cal 2020

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[23] Ibid.
[24] Ibid.
[25] Ibid.

In 2010, California received the §1115 Medicaid Demonstration Waiver, which allowed the state to implement a county-based coverage expansion program and receive matching federal funds for this expansion program.[26] The program covered low-income adults who were not eligible for Medi-Cal through the Low-Income Health Program (LIHP). These 650,000 adults participating in this program were transferred to Medi-Cal in 2014 once the ACA Medi-Cal expansion occurred. Included in this waiver was also funding for the Medicaid Delivery System Reform Incentive Program (DSRIP)[27]. The goal of this funding was to reform the payment and delivery system for safety net programs. This waiver lasted from 2010-2015, and the needs and goals changed as the ACA became fully implemented and some outcomes of these new policies arose. California then applied for a renewal of the §1115 Medicaid Demonstration Waiver, and had it approved by the Centers for Medicare and Medicaid Services on Dec. 30, 2015, under the new name "Medi-Cal 2020 Waiver." [28]

The Medi-Cal 2020 Waiver will expand funding and programs to 42 safety net institutions in health care districts that are mainly in rural areas and often the main provider of health care services for their population. As stated by DHCS, the goal is that "this extension allows California to extend its safety net care pool for five years, in order to support the state's efforts towards the adoption of robust alternative payment methodologies and support better integration of care."[29] The waiver initiatives are extensive and include the following: a Public Hospital Redesign and Incentives program, which will improve the care provided by safety net hospitals; a Global Payment Program that improves funding for care for the remaining

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[26] California Department of Health Care Services, "Medi-Cal 2020 Waiver," *California Department of Health Care Services*, January 2016, http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx.
[27] Kaiser Family Foundation, "The California Health Care Landscape."
[28] California Department of Health Care Services, "Medi-Cal 2020 Waiver."
[29] Kaiser Family Foundation, "The California Health Care Landscape."

uninsured; a Whole Person Care Pilot program to improve and integrate care for certain Medi-Cal's high-risk population; and a Dental Transformation Initiative to improve Medi-Cal's dental care system.

Wrap Cap Pilot

The Wrap Cap Pilot is a program experimenting with alternative payment methodology with the goal of improving health care delivery in health centers to the Medi-Cal population. Senate Bill 147 passed in 2015 and allows this program to implement payment reform in participating health centers.[30] A recent budget report by DHCS highlights that this program will be delayed due to a need to prioritize federal regulations, and determined that it can be implemented no sooner than January 1st, 2018.[31]

California FQHCs currently receive reimbursement for medical services for Medi-Cal insured patients based on number of visits as well as number of Medi-Cal patients. For every person enrolled in Medi-Cal, a clinic gets a certain amount of payment per month, which accounts for 20% of the cost of services for this individual.[32] 60% of this person's costs are based on a fees-for-service system, which are billed to the state. The remaining 20% comes in the form of reconciliation of the budget, wherein it is possible for the clinic to owe the state or for the state to owe the clinic.[33]

The pilot aims to simplify payment rates and move away from visit-based payments

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[30] California Primary Care Association and California Association of Public Hospitals, "CPCA/CAPH FQHC Payment Reform Pilot Proposal," November 2013, http://www.cpca.org/cpca2013/assets/File/Policy-and Advocacy/Active-Policy-Issues/Payment-Reform/2013-11-20-Wrap-Cap-Proposal.pdf.

[31] Department of Health Care Services, "2017-18 Govener's Budget Highlights," January 2017, http://www.dhcs.ca.gov/Documents/FY-2017-18_GB_Highlights_011017.pdf.

[32] California Association of Public Hospitals, "FQHC Issues," *California Association of Public Hospitals and Health Systems*, 2016, http://caph.org/priorities/federal-policy/fqhc-issues/.

[33] Ibid.

towards outcome-based incentives. The pilot would allow clinics to be paid a monthly amount from the state to cover patient's services rather than the more sparse fees-for-service capitation.[34] This would give the clinics more revenue up front, allowing for increased patient contact and care coordination because the clinic has the funds to offer multiple same-day services, as well as back-to-back patient appointments and encounters. The pilot includes goals for health outcomes, guidelines to monitor and evaluate these outcomes, and ways to evaluate and determine steps that should be taken under the new payment system. The proposal also mentions a focus on social determinants of health in order to assess and incorporate these factors in to the next step of reform.[35]

Medi-Cal Budget

An analysis of the 2016-17 Medi-Cal budget illustrates the changes that will be seen in Medi-Cal budgeting in the coming years.[36] The Governor's budget proposes $19.1 billion General Fund for Medi-Cal, which is an increase of $1.4 billion, 8%, above the estimated 2015-16 cost. This increase was planned due to a projected change in caseload, 2% or 13.5 million as compared to last year, and termination of the managed care organization tax. The justification of these projections comes from the fact that changes in the ACA, as well as local policies and programs, continue to increase the Medi-Cal caseload and therefore an increase in the budget is also necessary. Although the number of Medi-Cal enrollees is projected to stabilize within the next few years, there are many potential changes in Medi-Cal in that same time period that will result in cost pressure. Some of these changes include the sunset of the hospital quality assurance

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[34] Community Health Center Network, "FQHC Payment Reform Demonstration Q&A," August 2015, http://chcnetwork.org/wp-content/uploads/2015/09/QA-Wrap-Cap-20150831-Final.pdf.

[35] Ibid.

[36] Mac Taylor, "The 2016-2017 Budget: Analysis of the Medi-Cal Budget" (Legislative Analyst's Office, February 2016), http://www.lao.ca.gov/reports/2016/3350/medi-cal-budget-analysis-021116.pdf.

fee, restructuring of Medi-Cal managed care regulations, loss of federal funds for uncompensated care, phasing in of the state's shared Medi-Cal cost, and decreased in federal funds for safety net providers. The federal government paid 100% of the costs of providing health care services to the newly eligible Medi-Cal population from 2014 through 2016, but in 2017 this has decreased to 95%, will be 90% by 2020 and will see a continued decrease of 5% per year thereafter.[37]

The 2017-2018 budget continues to affirm these changes in funding structure that accompany fluctuations in Medi-Cal enrollment and regulations. Projections for Fiscal Year 2017-2018 include a 6.5% increase in Medi-Cal enrollees, as well as the continued phase-out of federal funds to serve the newer Medi-Cal caseload.[38]

Challenges in Accessing Care for Medi-Cal Recipients

An audit done by the state of California explains how improved monitoring of Medi-Cal managed care health plans is necessary to better ensure access to care.[39] The California State Auditor presented an audit report concerning the California Department of Health Care Services' oversight of Medi-Cal managed care health plans. The report concluded that DHCS did not verify that the provider network data it received from health plans was accurate. Therefore it could not ensure that the health plans it contracts with had adequate networks of providers to serve Medi-Cal beneficiaries.[40] DHCS contracts with health plans to provide medical services to Medi-Cal beneficiaries and generally require the plans to maintain a network of primary care providers that are located within either 30 minutes or 10 miles from a member's residence.

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[37] Ibid.

[38] Department of Health and Human Services, "5 Years Later: How the ACA Is Working for California," Text, *HHS.gov*, (November 2015), https://www.hhs.gov/healthcare/facts-and-features/state-by-state/how-aca-is working-for-california/index.html.

[39] California Department of Health Care Services, "Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care" (California Department of Health Care Services, 2014), http://auditor.ca.gov/pdfs/reports/2014-134.pdf.

[40] Ibid.

DHCS receives provider network data from each of the health plans. However, for the health plans that were reviewed, DHCS did not verify the accuracy of these data before certifying that these health plan had reported adequate information[41]. It also did not verify the accuracy of the data it received from health plans and that it provides to the California Department of Managed Health Care (CDMHC) with which it has an agreement to conduct quarterly network adequacy reviews. The plans that were later reviewed were proven to have inaccurate information. For Anthem Blue Cross, Health Net and Partnership HealthPlan, there were incorrect address, phone numbers, and information for new patients, although they were approved by DHCS for publication. DHCS did not perform all statutorily required annual medical audits of Medi-Cal managed care health plans to determine whether the health plans meet their beneficiaries' needs, and therefore there was inaccurate information about resources for the Medi-Cal population.[42]

The Future of Healthcare

There is current uncertainty as the new federal government attempts to introduce a new healthcare law and debates whether to repeal and/or replace the ACA. Many advocates of the ACA as well as those who work in the health delivery field express concerns over being able to address the needs of their patients and face another significant change in healthcare delivery and funding structure. An interview with hospital executives done by PBS News Hour delved into concerns that people in this field are currently facing. The interview discovered that rural hospitals have always struggled to stay open due to fewer patients and thin financial margins, and that dozens have closed in recent years especially in states that have not expanded

[41] Ibid.
[42] Ibid.

Medicaid.[43]

The interview communicated with employees from various hospitals, including an employee of Perry Memorial Hospital in Princeton, Illinois, who had lost a previous healthcare job due to a rural health center closure and shared that “even if you're a large, profitable hospital, we don't know what's coming around the corner and how it will affect us.”[44] The interviewer explained that Illinois did expand Medicaid, which allowed many patients at this hospital to gain coverage, and resulted in many hospitals becoming more secure as their medical service repayments increased. The hospital's CEO expressed concerns that “We have spent the last six years gearing up towards everything that we were responsible for doing in the ACA. And the idea that we might have to totally go a different direction or how will we do that, it’s going to take a lot of work. There’s a lot of effort that is going into this.”[45] The interviewer explained that many hospitals will require billions of dollars of funding in order to survive if the ACA is repealed, because “Hospitals made a high-stakes trade when they signed on to the Affordable Care Act. They agreed to massive cuts in federal aid that defrayed the cost of caring for the uninsured. In exchange, they would gain tens of millions of newly insured customers.”[46]

Another interview with the CEO of Stronger Hospital in Cook County, Chicago, conveyed no desire to return to pre-ACA ways as well. The interviewer said that this hospital is one of the busiest in the nation and handles most of the city's gunshot victims. They summarized the situation by stating “The vast majority of patients here used to be uninsured, and the county-run hospital struggled to take care of all of their medical and mental health needs. Those patients

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[43] PBS NewsHour, “Hospitals Worry an ACA Repeal Could Harm Their Financial Health,” *PBS NewsHour*, February 2017, http://www.pbs.org/newshour/bb/hospitals-worry-aca-repeal-harm-financial-health/.

[44] Ibid.

[45] Ibid.

[46] Ibid.

now have Medicaid coverage because of the Affordable Care Act, and the Cook County hospital system has gained $200 million in new revenue to cover their services, breaking even for the first time ever."[47] The CEO expressed no desire to return to the way things were when they served a mostly uninsured population.

LITERATURE REVEIW

Challenge in Getting Sufficient Physician Participation in Medi-Cal

Researchers conducted surveys in 2011 and 2013 that assessed California physicians' participation in Medi-Cal. The California Healthcare Foundation reported on these surveys in 2014 and explained the results, analyzed findings, and discussed the survey's implications for healthcare delivery to Medi-Cal patients. The report explained that the The Health Services and Resources Administration advises that there need to be 60 to 80 full-time primary care physicians participating in Medi-Cal for every 100,000 enrollees.[48] The study found that low payment rates for physicians participating in Medicaid deter physicians from accepting those patients. In 2012, participation of primary care physicians in the Medicaid program was very low compared to other states; California had the second lowest percentage of primary care physicians accepting new Medicaid patients, and the third lowest Medicaid primary care physician payment rate. Medicaid agencies have flexibility in terms of physician reimbursement rates for Medicaid services, which results in much variation of these rates between states.

The study also found that community health centers and other safety net providers may

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[47]Ibid.
[48] Coffman et al., "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?"

not have sufficient funding to provide Medicaid patients with timely appointments and resources. A lack of timely appointments was shown to result in more hospitalizations, higher costs, and sicker patients, illustrating the importance of private providers accepting Medi-Cal recipients. Of the primary care physicians who responded to the 2013 survey, 64% were serving Medi-Cal patients and 90% were serving Medicare patients, showing that physician participation rate is much lower in Medi-Cal than Medicare.[49] Facility-based physicians, such as emergency room physicians, radiologists, and anesthesiologists, were most likely to have Medi-Cal patients at 82%, due to the fact that emergency rooms and providers involved in emergency services must treat patients regardless of insurance type. A major reason for these hospitalizations are mental health diagnosis, and only 47% of the surveyed psychiatrists had Medi-Cal patients.[50]

FQHC Expansion Due to the ACA

The California Healthcare Foundation conducted a Regional Markets Study of healthcare markets across California. The study investigated how Californian FQHCs have been able to expand their capacity and services due to the implementation of the ACA and other policy factors, and discussed that this push for expansion comes from the need for more services, as the ACA resulted in millions more Californians being covered by Medi-Cal. [51]

The study explains the importance of FQHCs and what they have been able to accomplish in terms of increasing primary care resources and improving access to behavioral health, social services, and other specialty care. Between 2011 and 2014, FQHCs in California increased their sites by one third, increased their clinical workforce by almost a third, and

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[49] Ibid.
[50] Ibid.
[51] California Health Care Foundation, "Stepping Up to the Plate."

allowed for a one quarter increase in patient visits.[52] Besides physical expansion, expansion of resources has greatly contributed to their increasing ability to serve their clientele. Many FQHCs anticipated that with more eligible patients would come more competition between safety net clinics, and therefore expansion and improvement of services was a necessity. They determined that they had to prepare to be "providers of choice, not last resort."[53]

The study discussed that this competition could prove positive for patients by giving them a choice in provider and forcing FQHCs to improve their services to appeal to their patients. Although this anticipation of competition resulted in some positive changes, most FQHC directors determined that after Medicaid expansion they simply had a much larger client based and did not see increased competition between providers[54].

Health Clinics Deliver Care Cost-Effectively

A presentation by the Health Resources and Services Administration explained studies done by various institutions addressing the cost efficiency of federally funded health centers (HCs). In these studies, HCs refers to FQHCs as well as Health Center Programs Grantees, which are health centers that receive federal grants but are not eligible for the same Medicaid and Medicare reimbursement as FHQCs.[55]

Researchers at University of Irvine conducted a study looking at a population insured under Medicare and comparing the cost of those patients receiving care at HCs, private physician offices, and outpatient clinics. Results showed that all services for these patients cost less at HCs,

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52 Ibid.
53 Ibid.
54 Ibid.
55 Health Resources and Services Administration, "Are Health Centers Cost Effective? A Review of Recent Research on Health Center Cost of Care," July 2015, https://bphc.hrsa.gov/datareporting/pdf/healthcentercosteffectiveslides.pdf.

while for primary care services physician offices cost slightly less. This study determined that HCs provide lower total annual cost services than physician offices and outpatient clinics, with savings largely due to non-primary care services.[56]

Research by the University of Chicago also found that HC patients overall had lower expenses across all services. This study looked at matching groups of Medicaid beneficiaries across 13 states receiving all kinds of care in HC and non-HC settings.[57] In some states primary care use and/or spending was higher in HCs, as well as higher emergency use in one state. However, overall use and spending across all of these services was lower among patients at HCs.[58]

Medicaid Beneficiaries Face Challenges in Receiving Timely Appointments

A study by the U.S. Department of Health and Human Services in December 2014 determined that many Medicaid managed care providers could not offer timely appointments to enrollees.[59] This study examined availability of providers to schedule appointments for managed care patients, and found that slightly over 50% of providers could not offer appointments to enrollees. This included 35% who were on the provider list but could not be located, 8% who were on the list but informed they were not participating, 8% who were not accepting new patients. Although the median wait time was two weeks, 25% of providers offering appointments

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56 Dana B. Mukamel et al., "Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings," *Health Services Research* 51, no. 2 (April 2016): 625–44, doi:10.1111/1475-6773.12339.

57 Robert S. Nocon et al., "Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings," *American Journal of Public Health* 106, no. 11 (November 2016): 1981–89, doi:10.2105/AJPH.2016.303341.

58 Ibid.

59 Office of the Inspector General, "Access to Care: Provider Availability in Medicaid Managed Care" (Department of Health and Human Services, December 2014), https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

had waiting times of more than 1 month, and 10% were not open for more than 2 months.[60] This study was completed prior to the full expansion of ACA provisions and reflects the quantity of Medicaid enrollees and Medicaid providers from 2014.

Impact of the ACA on Hospital Closures and the California Healthcare Market

A study from the journal *Health Affairs* found that hospital closures did not have a significant impact on health outcomes.[61] The study aimed to explore the impact of hospital closures on patients health outcomes, because with payment changes brought about by the ACA it was determined that some hospitals may be forced to close. The study looked at 195 hospital closures from 2003 to 2011 and found no significant change in annual mortality rates in areas that underwent one or more hospital closures.[62]

A study from The Brookings Institute analyzed implementation of the ACA to figure out how it has affected state healthcare markets and the successes seen in implementation. The study focused on California and Michigan as states that had expanded Medicaid, and North Carolina and Texas that did not expand Medicaid.[63] The study looked at competition within state markets, expansion efforts made by the states, and regulations put in place to help or hinder navigator efforts that aim to make health insurance enrollment easier. In California the uninsured population was decreased by 50% after Medicaid expansion, largely attributed to an active navigator program which increased enrollment, consistent negotiations about premiums with

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60 Ibid.

61 Karen E. Joynt et al., "Hospital Closures Had No Measurable Impact On Local Hospitalization Rates Or Mortality Rates, 2003–11," *Health Affairs* 34, no. 5 (May 2015): 765–72, doi:10.1377/hlthaff.2014.1352.

62 Ibid.

63 Michael Morrisey et al., "How Has Obamacare Impacted State Health Care Marketplaces?" (Brookings Institute, February 2017), https://www.brookings.edu/research/how-has-obamacare-impacted-state-healthcare-marketplaces/.

insurers, and other active purchasing strategies.[64] California was the first state to create a state insurance marketplace and has taken advantage of opportunities to expand through the ACA. The state insurance marketplace, Covered California, allows the government to negotiate rates, work with insurers, and standardize benefits. The 2017 market reflects participation of 11 insurers, which is more competition than other states. However, large insurers have been reporting losses due to their participation, and UnitedHealthcare dropped out of the market in the first year. There is current uncertainty about what the next enrollment periods' market will look like due to undetermined federal healthcare policy.[65]

Improved Delivery of Care with the §1115 Medicaid Demonstration Waiver

A study by the California Association of Public Hospitals analyzing the §1115 Medicaid Demonstration Waiver of 2010-2015 explains the waiver's successes and addresses what could occur with the Medi-Cal 2020 waiver. In 2010 this waiver provided funding and allowed for the implementation of the Delivery System Reform Incentive Program (DSRIP) and the Low Income Health Program (LIHP).[66] The drive to obtain this waiver and implement these programs illustrated California's leadership role in ACA reform and the state's focus on expanding care. These programs were taken on by California's 21 public health care systems (PHS), which are representative of 15 regions of California and include county-affiliated systems and University of California medical centers.

The study discussed that each project funded by the waiver has set goals for improving

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[64] Ibid.
[65] Ibid.
[66] California Association of Public Hospitals and Health Systems and California Health Care Safety Net Institute, "California's Delivery System Reform Incentive Program: Success to Build On," October 2015, http://caph.org/wp-content/uploads/2015/10/CA-DSRIP-2010-2015-Successes-to-Build-On.pdf.

care, and incentive payments were only received by the public health care systems if the goals were met. These projects had many objectives, including a shift to focus on preventative care rather than a reactive model that focused on treatment, tracking health status of patients through improved coordination and registries, and assisting patients with self-management goals. Specifically these goals were reached in the following measures; over 680,000 patients have been assigned a primary care team at a clinic; 11 organizations implemented disease management registries to better coordinate care and added over 1 million patients; 7 organizations expanded primary care capacity and increased the number of patients seen by 18.5%.[67] Additional milestones include topics such as patient safety, care coordination, health outcomes, and emergency room visits. The study determines that great strides have been made in effective and improved delivery of care, but that this momentum must continue with the new Medi-Cal 2020 Waiver in the next five years in order to maintain improved outcomes.

METHODS

This paper will employ a mixed methods approach, using both quantitative and qualitative data to explain and address the role of FQHCs in delivering health care to Medi-Cal beneficiaries. Data was gathered from interviews with professionals working for FQHCs in Los Angeles, as well as demographic information gathered from government websites. The interviews consisted of meetings with professional staff at two different FQHCs in Los Angeles; Community Health Alliance of Pasadena, also called ChapCare, and AltaMed Medical and Dental Group.

Interviews

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[67] Ibid.

Participants in these interviews included Steven Abramson, Director of Development and Marketing for ChapCare, and Erica Jacquez, Associate Vice President of Government Relations for AltaMed. Participants were asked open-ended questions concerning expansion of their organizations, funding structures, community outreach, and health care services. The list of interview questions can be found in Appendix A. Informed consent forms were used to inform the participant of the purpose of the study as well as their rights and options for data publication. Interviews were held over the phone, with the researcher taking notes that included both summarized data and direct quotes.

Steven Abramson is the Director of Development and Marketing for ChapCare. ChapCare opened its first clinic in 1998 that offered primary care services to Pasadena residents. In 2001 they opened a dental clinic, and achieved FQHC designation by 2004[68]. Through grants that they were eligible for as an FQHC, ChapCare opened two additional centers in Pasadena, and beginning in 2012 they were able to expand multiple centers into El Monte/South El Monte with ACA funding . ChapCare now operates eight clinics that are located throughout Pasadena, Monrovia, and El Monte/South El Monte, and has expanded to include specialty services such as pharmacy, behavioral health, health insurance enrollment assistance, optometry, HIV specialty care, radiology, and pediatric care[69] Over 51% of their board of directors is composed of community members of various backgrounds and career paths, aligning with FQHC leadership guidelines. As a FQHC, they serve the communities of San Gabriel Valley and accept patients regardless of insurance status or ability to pay. In 2016 they saw 15,145 patients at all clinics, resulting in 70,351 patient visits that year. Their patients are 60% Latino, 18% Caucasian, 17%

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[68] Community Health Alliance of Pasadena, "History & Mission | ChapCare," 2017, https://www.chapcare.org/who-we-are/history-mission/.

[69] Community Health Alliance of Pasadena, "Medical Services | ChapCare," 2017, https://www.chapcare.org/our-services/medical-services/.

Black, and 5% Asian/Pacific Islander. 69% of patients are enrolled in Medi-Cal, while 5% have Medicare, 6% have private insurance, and 20% are on county programs or are uninsured[70].

Erica Jacquez, Associate Vice President of Government Relations, was interviewed about AltaMed. AltaMed opened a free clinic in the 1970s in East Los Angeles, and quickly became a Community Health Center with grant funding from the Urban Health Initiative[71]. In the 1980s a second clinic was opened, and services such as a Substance Abuse Treatment Program and transportation services were introduced. 1996 saw an introduction of PACE clinics, providing a Program of All-Inclusive Care for the Elderly, and as of 2017 AltaMed operates eight of these specialty clinics[72]. Through the 2000s AltaMed expanded services and opened clinics throughout East Los Angeles as well as Boyle Heights, El Monte, West Covina, and downtown Los Angeles, and expanded to Orange County as well to encompass Santa Ana, Huntington Beach, and Anaheim. During this time they were also able to develop specialty services such as behavioral health, an HIV mobile unit, dental care, ophthalmology, lactation services, pharmacy, health education, and senior services[73]. AltaMed is now California's largest FQHC, with 43 sites throughout Los Angeles County and Orange County that deliver over 950,000 patient visits annually. They provide targeted resources for their Latino and multi-ethnic communities and host a large number of bilingual staff and providers[74].

Demographics

In terms of quantitative data, charts and figures will show physician quantities throughout

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[70] Community Health Alliance of Pasadena, “Key Statistic | ChapCare,” 2017, https://www.chapcare.org/who-we-are/key-statistics/.

[71] AltaMed Health Services Corporation, “AltaMed | History,” 2017, http://altamed.org/altamed_overview/history.

[72] Ibid.

[73] AltaMed Health Services Corporation, “AltaMed | Overview,” 2017, http://www.altamed.org/programs_and_services/overview.

[74] Ibid.

Los Angeles, trends in physician's patients, numbers of enrollees across different types of insurance, and patient trends across various health service providers. This data was collected through census.gov, city government websites, and websites for DHCS, Department of Public Health, and Medi-Cal.

The qualitative data will include a number of components such as government documents, participant observation, and interviews. The documents are both scholarly articles and governmental reports, gathered from government websites and scholarly databases and concerning Medi-Cal, ACA expansion, Medi-Cal 2020, FQHCs, delivery of care to Medi-Cal beneficiaries, and budget information. General information about these topics, given in the background section, will be the base of information used to explain and justify conclusions reached at the end of this paper.

FINDINGS

This paper examines healthcare resources that are available to those on Medi-Cal, specifically the services provided by Federally Qualified Health Centers. Through interviews with professionals at health centers in Los Angeles, analysis of literature around FQHCs and healthcare, and charts and graphs showing the changes in Medi-Cal enrollment and providers, this section will analyze how FQHCs are able to serve their populations as well as the challenges that these centers face.

Quantitative and qualitative data was collected from various government websites and health organizations and foundations. These sources provided clear quantitative information about patients and providers, as well as qualitative information surrounding reasons for shortage of providers. Some data describes changes over time while other data gives a picture of the

current healthcare landscape.

Qualitative data was collected from interviews with Steven Abramson, Director of Development and Marketing from ChapCare, and Erica Jacquez, Associate Vice President of Government Relations from AltaMed. There were patterns and themes seen in the responses of both of these interviews and overall they addressed how their organization serves their specific community. These themes included the following:

- Both organizations work with their communities through community outreach. They keep up to date on policies and practices and work with other organizations in an attempt to inform policy.
- They had many services and resources available to their patients prior to the ACA, but with the implementation of the ACA they were able to increase revenue because they were being reimbursed for services through insurance, which allowed them to expand and more comprehensively serve the community.
- Through the ACA they were able to create more jobs within their organization, which led to increased resources and the ability to do more outreach in order to get people covered.
- Both organizations stay informed and involved with current policies affecting their organization and population. Jacquez talked specifically about the state loan repayment program which has given the incentive for motivated members of their community to become a part of the AltaMed provider workforce. ChapCare discussed following updates about payment reforms that are in process at both federal and state levels, and discussed that advocating for those reforms will be hugely important in maintaining and improving their workforce and therefore improving patient outcomes.
- Both organizations discussed at length their desire to ensure that people are getting the

best care possible and that their organization is addressing the needs of their community.

Neither interview addressed specific problems within their organization, although Abramson did talk broadly about policies and funding reform that could help or hurt their organization as a whole. The interviews supported information outlined in the background section, including increased health insurance enrollment with the implementation of the ACA, and increase of funding and grants available to FQHCs with the ACA. It is important to note that these reforms and policies at the federal level through the ACA were able to benefit local FQHCs across the country, and to realize that in its implementation these resources and grants that were supposed to be widely available were attainable and allowed small FQHCs to expand. Abramson's insight in to increasing competition with private providers corroborated the research that determined that incentives for both private and public providers to accept Medi-Cal increased with the ACA.

Medicaid's Expansion to Serve a Larger and More Diverse Population

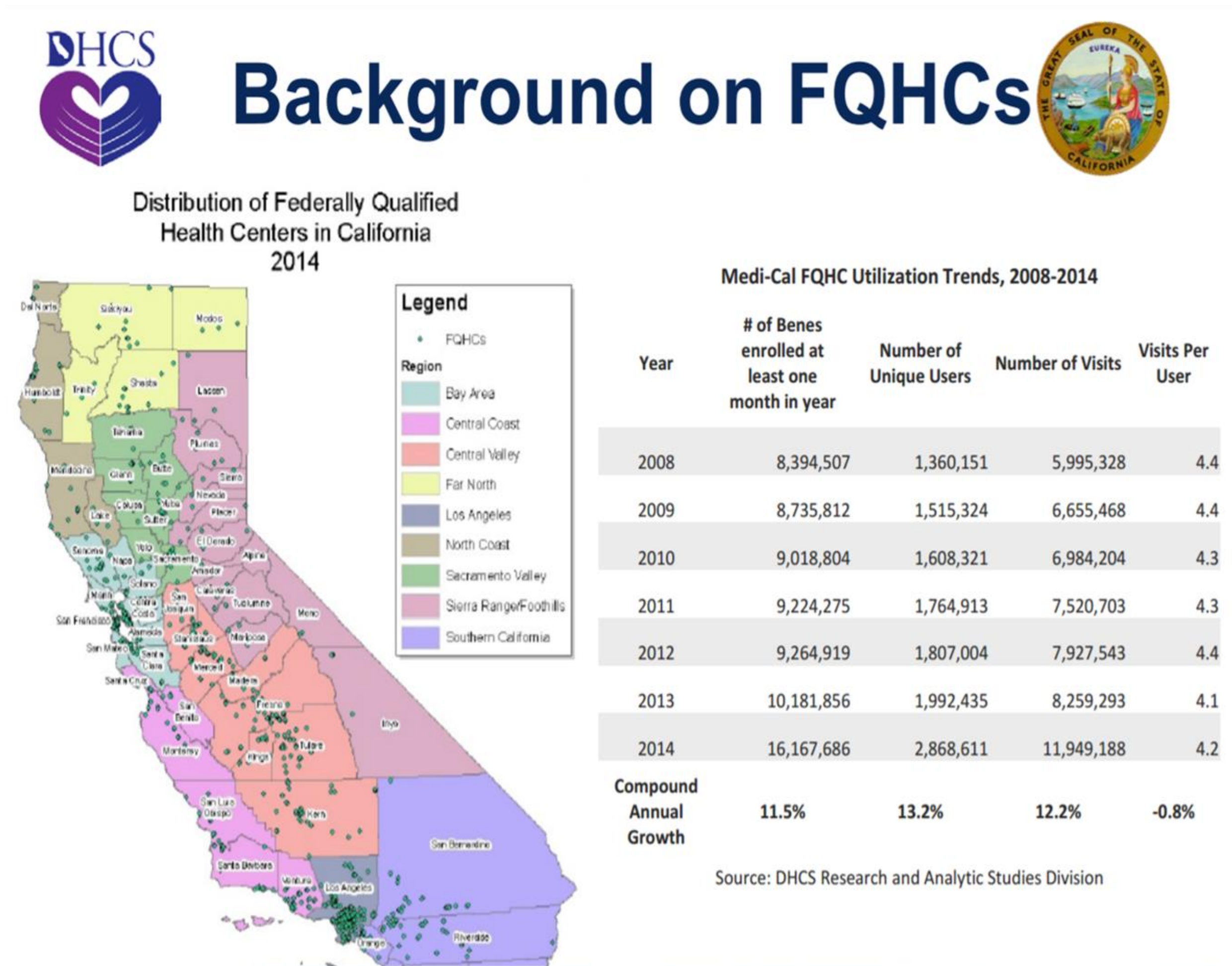
With the implementation of the ACA, Medicaid expanded to include nonelderly adults up to 138% of the federal poverty level, pregnant women, children, the disabled, and refugees, given certain qualifications[75]. By changing public health insurance coverage to include millions more people, the demographic trends and the needs of the Medicaid population also changed dramatically. Demographics can offer insight to trends seen in the population and can indicate specialized resources that a population might need. Information about language preferences and health outcomes can illustrate specific services that would be useful to a population, and should

[75] Centers for Medicare and Medicaid Services, "Affordable Care Act."

inform decisions about services offered by health centers.

Los Angeles County boasts a diverse group of residents. As FQHCs are open to all members of their community, it is important for the centers to have an understanding of their population's health and demographic trends in order to address their needs.

Background on FQHCs[76]
Figure 1



Year	# of Benes enrolled at least one month in year	Number of Unique Users	Number of Visits	Visits Per User
2008	8,394,507	1,360,151	5,995,328	4.4
2009	8,735,812	1,515,324	6,655,468	4.4
2010	9,018,804	1,608,321	6,984,204	4.3
2011	9,224,275	1,764,913	7,520,703	4.3
2012	9,264,919	1,807,004	7,927,543	4.4
2013	10,181,856	1,992,435	8,259,293	4.1
2014	16,167,686	2,868,611	11,949,188	4.2
Compound Annual Growth	11.5%	13.2%	12.2%	-0.8%

From Figure 1 it is clear that Los Angeles hosts a large number of FQHCs compared to the rest of the state. It is important that these health centers understand the unique qualities, characteristics, and needs of their diverse Los Angeles population.

[76] Ryan Witz, "Federally Qualified Health Center Alternative Payment Methodology Pilot," July 2016.

Los Angeles County Resident Language Trends[77]
Figure 2

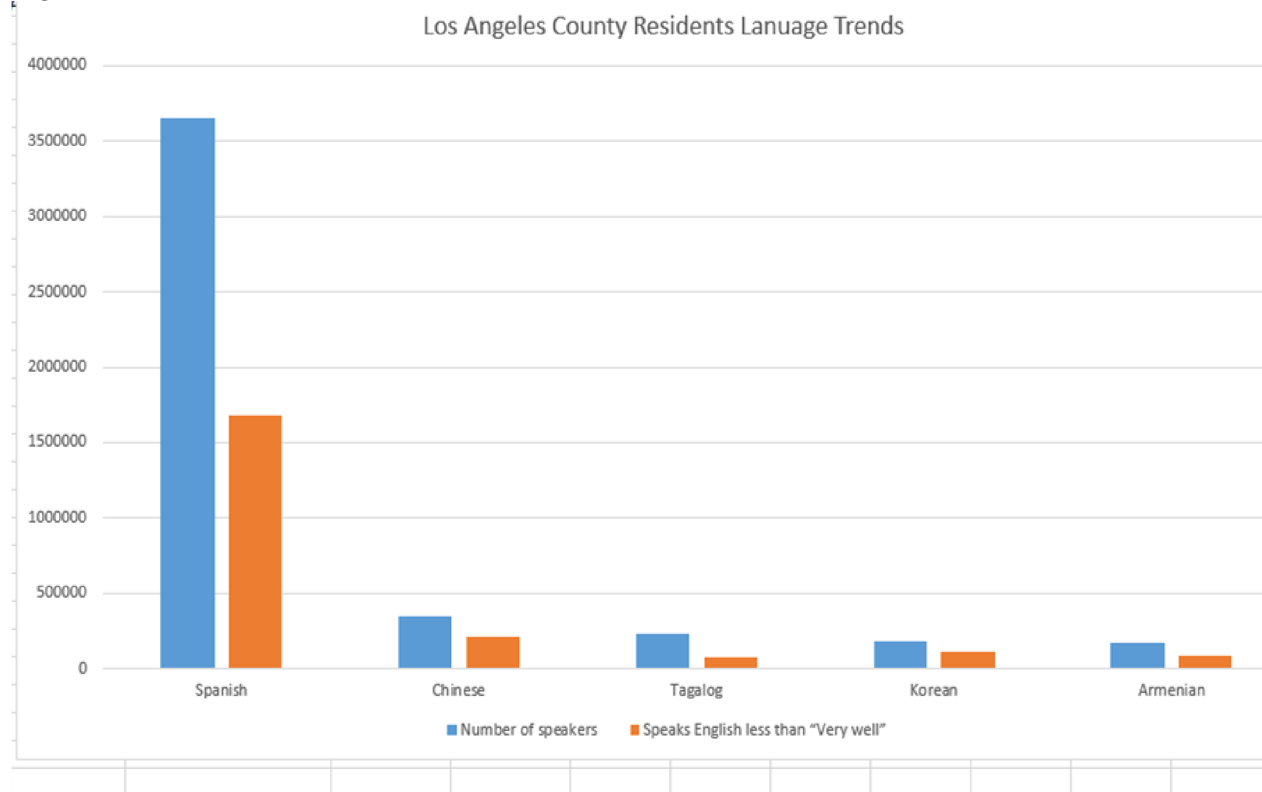
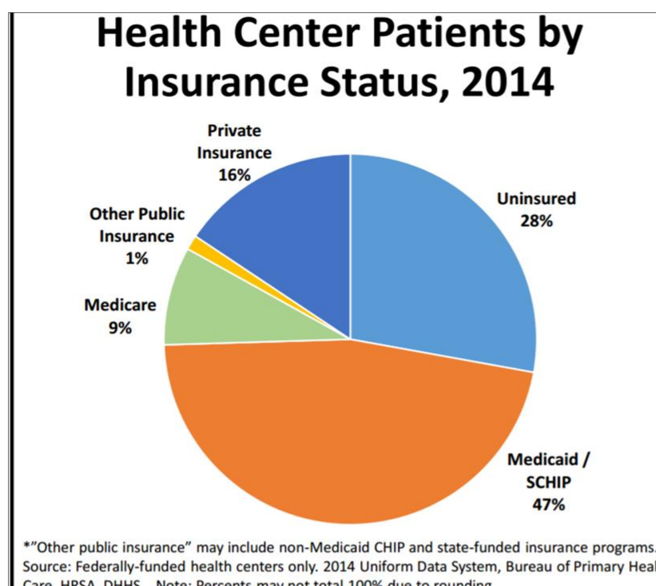


Figure 2 illustrates the trends seen in language throughout Los Angeles County. These are the results of the American Community Survey asking individuals what language they speak at home ("Number of speakers") and asking about their English-speaking level with the options "very well", "well", "not well", or "not at all". Within each group encompassing a certain language spoken at home, about 50% of people in each of these groups speaks English "less than very well". Among at-home Spanish speaking residents that percentage is 45.9%, 59.8% among Chinese speakers, 33% for Tagalog, 61.7% for Korean, and 51% for Armenian speaking residents. It is possible that people who speak a different language at home and speak English

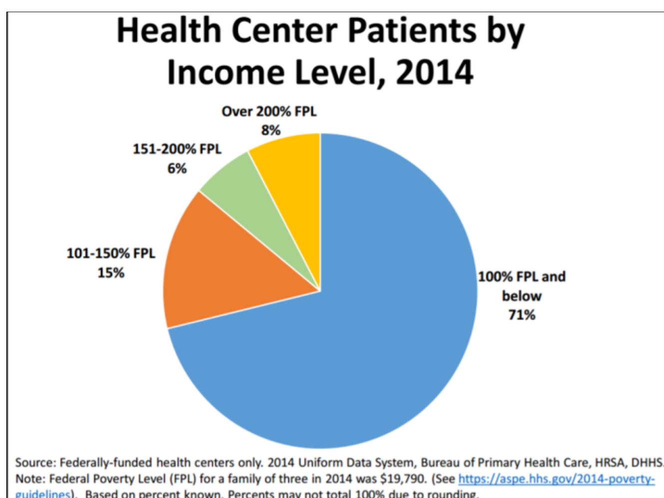
[77] US Census Bureau, "Detailed Languages Spoken at Home and Ability to Speak English," 2015, https://www.census.gov/data/tables/2013/demo/2009-2013-lang-tables.html.

"less than very well" would benefit from receiving medical services in their home language.



Health Center Patients by Income Level, 2014[78]

Figure 3



Health Center Patients by Insurance Status, 2014[79]

Figure 4

Figures 3 and 4 offer a look at national trends for those who use FQHCs. It can be seen from Figure 3 that 71% of FQHC patients live at or below the federal poverty level. Figure 4 illustrates the fact that FQHCs nationally are mainly serving those on public insurance, and are an important resource for the uninsured as well.

The Role of the ACA in Expanding Access to Healthcare

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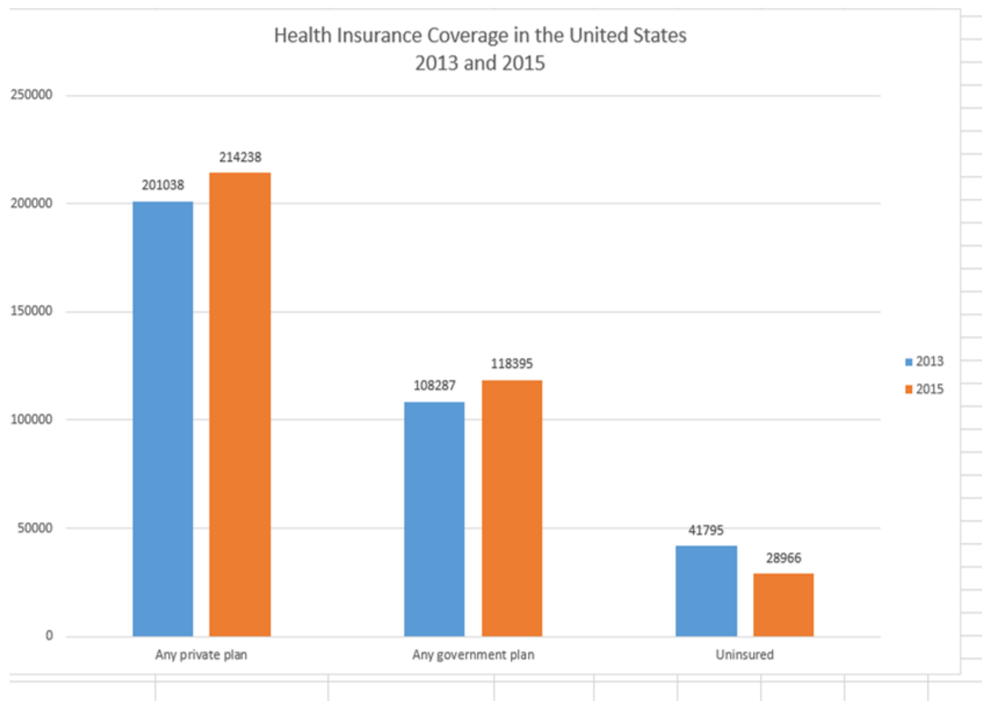
[78] National Association of Community Health Centers, "America's Health Centers."

[79] Ibid.

With the implementation of the ACA, the amount of people enrolled in both private and public insurance increased, as seen in Figure 5. The ACA included provisions to expand both private and public insurance enrollment; expansion of Medicaid allowed for increases in public insurance enrollment, while subsidies available to those purchasing their own insurance resulted in increases in private enrollment.

Health Insurance Coverage in the United States, 2013 and 2015[80]

Figure 5



[80] Jessica C. Barnett and Marina S. Vornovitsky, “Health Insurance Coverage in the United States: 2015,” September 2016, https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf.

Number of Medi-Cal Eligibles in Los Angeles County[81]
Figure 6

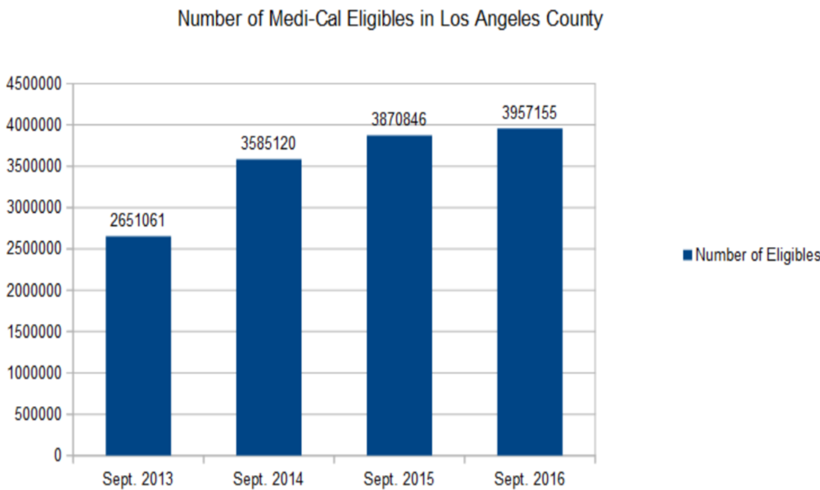


Figure 6 uses data from the California Health and Human Services Open Data Portal to illustrate increasing levels of Los Angeles Country residents who are eligible to enroll in Medi-Cal. This chart shows the number of eligibles increasing by over 1 million from September of 2013 to September of 2016. It can be determined that having more individuals that are eligible for Medi-Cal results in more people enrolling in this insurance,which consequently necessitates an increased need for healthcare services.

Both AltaMed and ChapCare determined that increased healthcare enrollment had a positive effect on their patients and on their clinics. With the ACA they were able to increase Medi-Cal enrollment and grow their patient population, which resulted in increased revenue to fund expansion of specialty services.

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[81] Medicaid, "Medicaid and CHIP Total Enrollment Chart," December 2016, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report highlights/total-enrollment/index.html.

Ability of FHQCs to Expand Services Due to Opportunities Through the ACA

There are many factors that allowed AltaMed to expand to fit the needs of their client population. With the ACA they were able to increase Medi-Cal enrollment and grow their patient population. They expanded to fit to needs of their community, and through increased funding and they had the resources to continue to address community needs through service expansion. Due to the needs of these new populations, as well as increased funding from grants, AltaMed expanded services to include HIV resources, behavioral health programs, obesity prevention, lactation services, and pharmaceutical services.[82] AltaMed has "grown in leaps and bounds in the past years because of the need and ability of our organization to deliver quality care without exception in culturally competent manner."[83]

The ACA was also helpful in expanding the workforce of AltaMed and the workforce of health centers overall. Extra funding and grants created thousands of jobs in the healthcare field and allowed AltaMed to develop a resource center, making it simpler for people to get help enrolling in health insurance and accessing care. The state loan repayment program is also an important program that ensures the continuation and quality of the workforce[84].

Abramson also discussed how the ACA offered opportunities for ChapCare to expand services. He explained that the ACA had $11 billion allocated in federal Access Point Grants to open new health centers and expand services, wherein a center applies and pick an area of need based on certain criteria[85]. ChapCare has successfully benefited from these grants; prior to 2008 they had one health center, expanded to three around 2010, and now operate eight clinics. They

[82] AltaMed Health Services Corporation, "AltaMed | Overview."
[83] Erica Jacquez, AltaMed, February 3, 2017.
[84] Ibid.
[85] Steve Abramson, ChapCare, February 3, 2017.

have been successful in getting three Access Point Grants, meaning six years total of operating funds. Additional operational money gives the clinic time to build up and set up new locations, and within the grant it is an option to ask for this money to cover costs of opening new clinics[86]. This operational money was used to open the Vacco site, Garvey site, and Peck site, meaning that all expansion to serve the El Monte community was made possible from these new Access Point Grants. Other expansion grants that allowed ChapCare to increase specific services include Behavioral Health, allowing them to go from one licensed clinical social worker to four, Oral Health, allowing expansion of dental services at their Lincoln location, and a grant to expand HIV services. These are all competitive grants but ChapCare has been successful in securing almost all that they have applied for[87].

Another aspect of ChapCare's ability to expand is due to the increased number of insured patients that they've seen thanks to the ACA, resulting in increased revenue for the clinic. Most of the clients that they are serving post-ACA are now insured; prior to the ACA only about 25% of their patients had insurance[88]. The uninsured patients were on a sliding fee, but there were no guarantees about ChapCare getting reimbursed for those services. With people insured they have a billable source of revenue, which allowed ChapCare to improve the quantity and quality of their services. They have invested heavily in outreach for insurance enrollment as it is clear that patient's resources will improve when they are insured. Post-ACA ChapCare's patient insurance rate is around 80%, and with more repayment there can be increased funds for the clinic and therefore improved services for the population[89].

As stated earlier, a PBS interview also offered a look at increased funding and revenue

[86]Ibid.
[87]Ibid.
[88]Ibid.
[89]Ibid.

that benefitted their population. The CEO of Vista Health System in Waukegan, Illinois, explained that having more insured patients has improved reimbursement rates and allowed them to invest in new equipment and take on hundreds of new employees. Under the ACA 900,000 Illinois residents gained insurance, and if this is lost the hospital executives are estimating a loss of 95,000 jobs.[90]

The PBS interview with health center administrators also offers a look at funding structure. President of the Cook County Board of Commissioners says that, with an increasingly insured population, there has been an opportunity to decrease local taxes that were funding medical care for the poor. He explains that "the burden on local taxpayers to fund the Cook County Health System has dropped by $300 million since the health law went into effect", and "repealing the law could force local governments to raise taxes. For us, it's a $300 million hole in our budget. So, there aren't a lot of options, other than raising more revenue. It's a nightmare for us."[91]

Some budget assessments on a state level indicate that California is still adjusting to the new Medi-Cal population and attempting to correctly allocate funds for this population. The analysis of the Governor's 2017-2018 budget includes assertions that the previous fiscal year General Fund spending on Medi-Cal was adjusted upward by $1.8 billion due to a cost miscalculation of the Coordinated Care Initiative, and a need to pay prescription drug rebates owed to the federal government. The analysis also determines that if the increase of the Medi-Cal caseload is higher or lower than projected, state spending could be affect by tens of millions of dollars.[92] Additionally, with the continued phase-out of the federal government's share of

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[90] PBS NewsHour, "Hospitals Worry an ACA Repeal Could Harm Their Financial Health."
[91] Ibid.
[92] Legislative Analyst's Office, "Analysis of the Medi-Cal Budget 2017-2018," March 2017, http://www.lao.ca.gov/reports/2017/3612/medi-cal-budget-030917.pdf.

Medicaid caseload expenses, states will be adjusting to cover these populations in the coming years. At the time of the 2017-2018 budget creation, it was and still remains unclear what action the new federal administration will take to change federal Medicaid funding and assistance to the states[93].

The Challenges of Provider Incentives and Provider Shortage for Medi-Cal Patients

The State Loan Repayment Program (SLRP) aims to increase medical and behavioral health providers in designated California Heath Professional Shortage Areas. These designations allow health centers to be eligible to become FQHCs, and therefore the FQHCs are eligible to participate in SLRP in order to increase providers in areas needing more resources. AltaMed discussed the use of this program in helping them maintain adequate numbers of providers to serve their population and its success in offering providers incentives to work for FQHCs.

When asked about troubles with provider retention and incentive based on what was seen in the literature, Jacquez said that AltaMed "advocated for the state loan repayment program, which gives us the ability to attract many providers. This program gives enough incentive to hire employees who are motivated and are already a part of the population that they serve, ensuring a culturally competent provider population."[94]

Abramson offered an interesting look at issues with provider retention at ChapCare. He described that, prior to the ACA, community health centers were often serving the uninsured population. However, with an increase in the insured population, community clinics are now competing with private hospitals and clinics for patients and providers; at Kaiser, for example, they are beginning to serve Medi-Cal patients. These private practices have higher payment

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[93] Ibid.
[94] Jacquez, AltaMed.

structures, and based on this knowledge ChapCare has recently base-lined their salaries to be more competitive. ChapCare has also engaged in the "Optimal performance project", wherein outside professionals assess what the providers are doing, how they feel, and give recommendations on improving structure and health care delivery. ChapCare is taking many steps to improve experiences for their providers and ensure that they are staying competitive with private practices.

Figure 8 uses data from the California Health and Human Services Open Data Portal to illustrate shortages in primary care providers in different service areas throughout Los Angeles County. A chart defining these services areas can be seen in Appendix B. Based on federally determined Medical Service Study Areas (MSSA), the data set gave information about whether there was a shortage in primary care, mental health, or dental care, the number of full time physicians for that discipline, the shortage in terms of number of providers based on the provider-population ratio, as well as the percent of that population under 200% of the federal poverty line. The information was distilled into the following chart showing the number of full time primary health care providers in that particular MSSA within Los Angeles County and the shortage in that same MSSA.

Primary Care Health Professional Shortage Los Angeles[95]
Figure 8

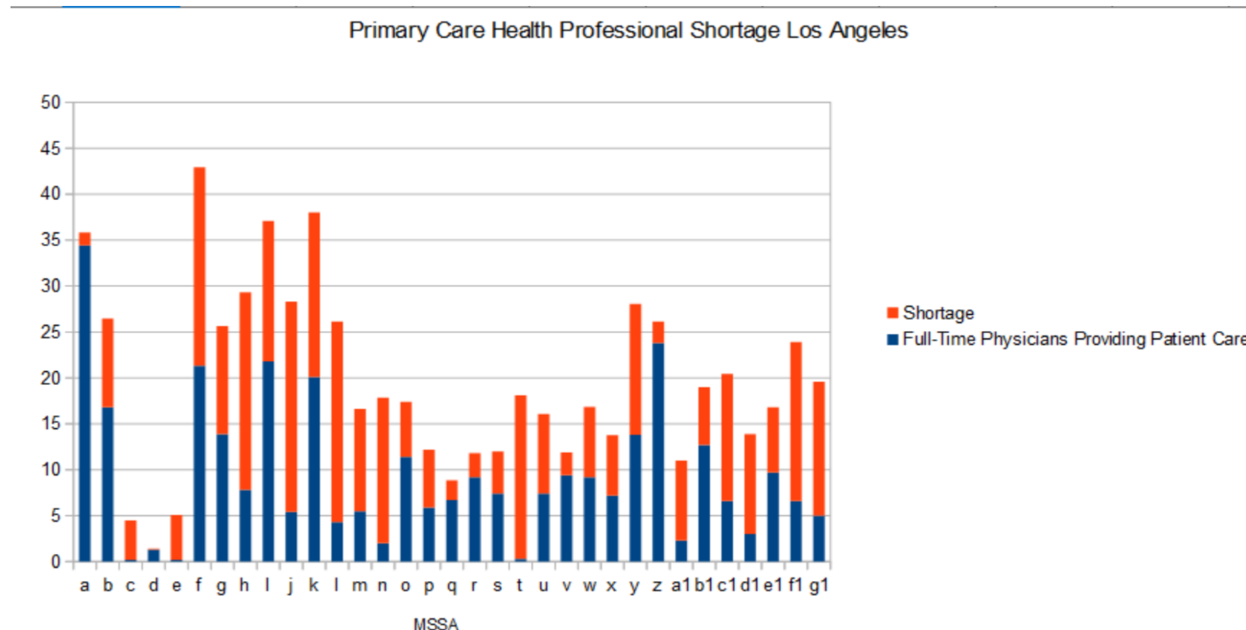


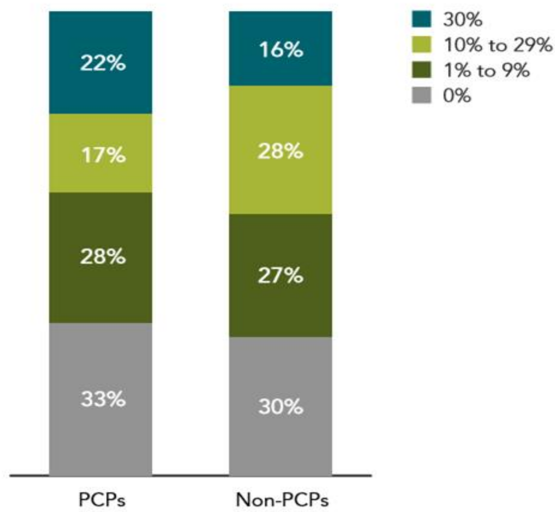
Figure 8 confirms that there is a shortage of primary care providers in many areas in Los Angeles County, something that was seen in the literature but not discussed in interviews. The service areas in the data set, however, did not include Pasadena or North East Los Angeles, and El Monte is the only MSSA included in this data that is served by ChapCare. ChapCare's very recent expansion into El Monte could be looking to fill that gap, and may result in less shortage as those clinics become more established.

[95] California Health and Human Services, "Primary Care Health Professional Shortage Areas," *Open Data Portal*, 2017.

Figure 9 shows that in 2013, 33% of primary care physicians had no Medi-Cal patients, 28% had 1-9% Medi-Cal patients, 17% had 10-29%, and 22% had 30% or more Medi-Cal patients.

Concentration of Medi-Cal Patients Among Physicians:PCP vs. Non-PCPs, 2013[96]

Figure 9



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[96] Coffman et al., "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?"

California Physicians with Any and 30% or More Medi-Cal Patients [97]
Figure 10

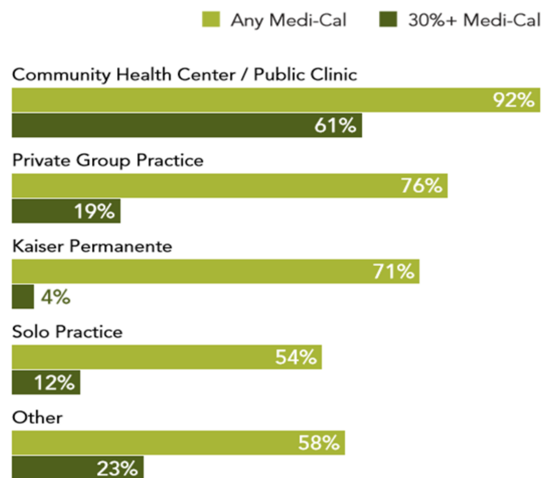

Figure 10 depicts California physicians who have Medi-Cal patients, separated into those with

[97] Ibid.

any Medi-Cal patients and those with 30% or more Medi-Cal patients. It shows these rates as they vary between community heath centers/public clinics, private group practices, Kaiser Permanente, solo practices, and other. In Figure 10 it can been seen that providers at community health centers and public clinics, which include FQHCs, are more likely to have Medi-Cal patients than private group practices and private hospitals. This reiterates the importance of these public health clinics and a lack of private providers serving this population.

California Physicians with Any Medi-Cal Patients and 30% or more Medi-Cal Patients[98]
Figure 11

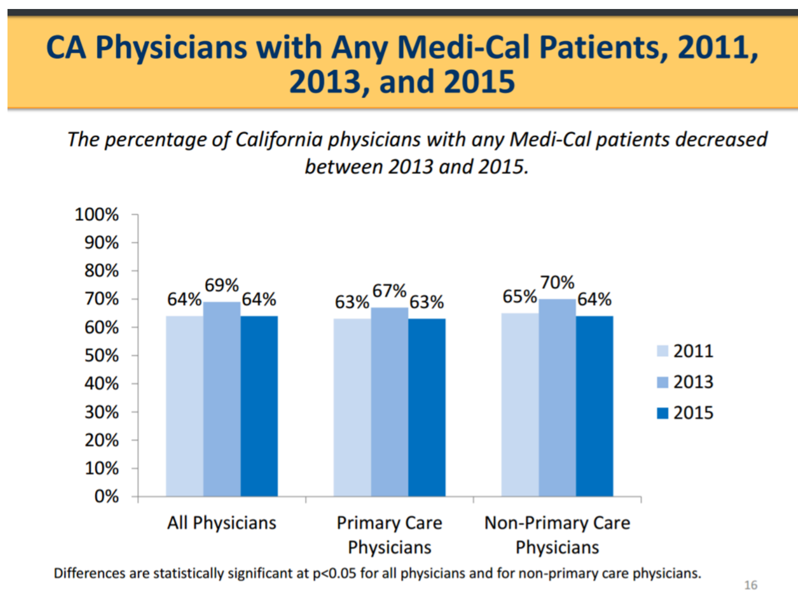

Figure 11 indicates that the percentage of California physicians accepting Medi-Cal has decreased at a statistically significant level from 2013 to 2015. This includes primary care physicians and non-primary care physicians.

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98 California Health Care Foundation, “Stepping Up to the Plate.”

Reasons for Limiting Number of Medi-Cal Patients in Practice, 2015[99]
Figure 12

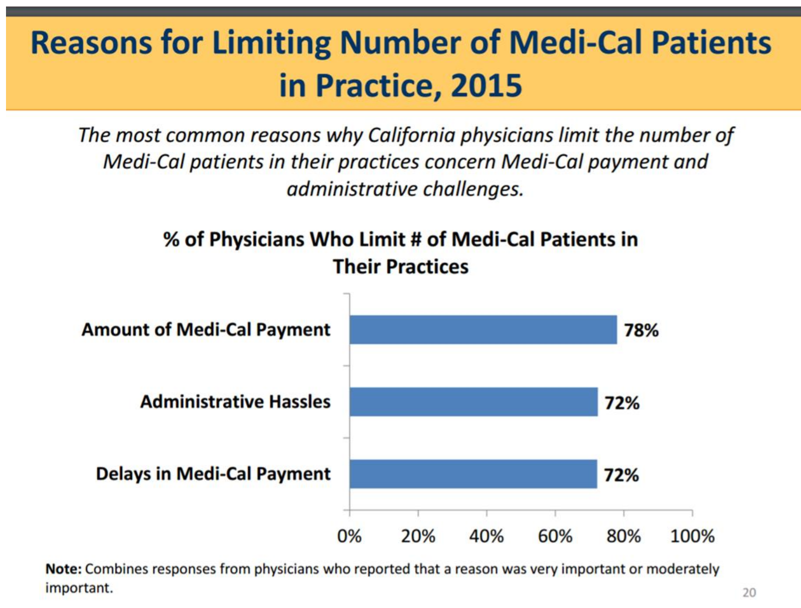

Figure 12 examines reasons for physicians not taking as many Medi-Cal patients, with the most popular responses concerning payment levels and program administrative difficulties.

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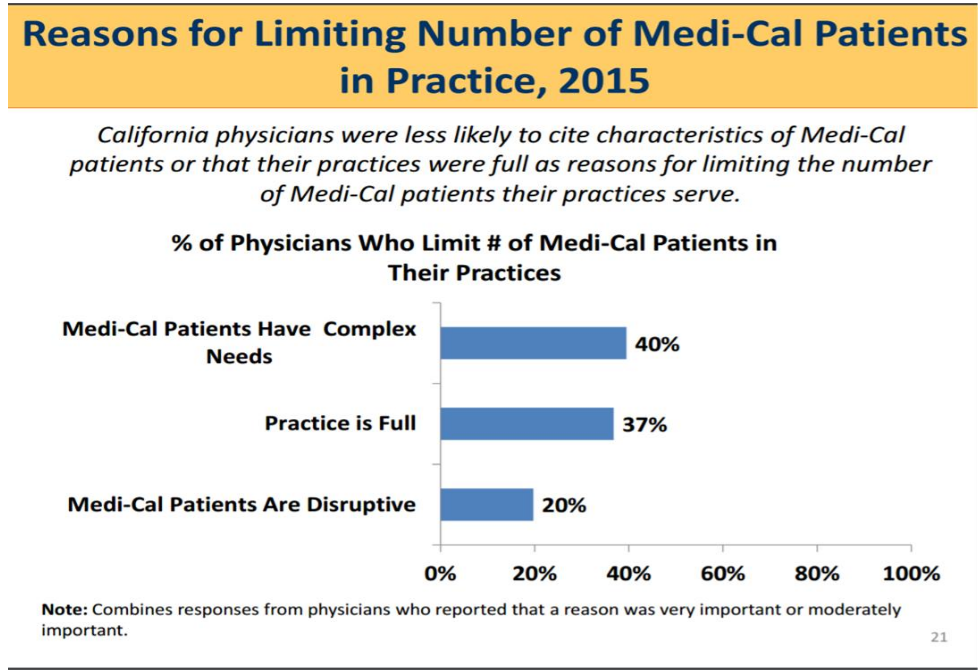
[99] Ibid.

Reasons for Limiting Number of Medi-Cal Patients in Practice, 2015, cont.[100]
Figure 13



[100] Ibid.

Figure 13 continues to explore reasons for providers limiting their number of Medi-Cal patients, indicating that 40% of those surveyed are concerned about complex needs of this population, while concerns about their practice being full or about patients being disruptive are both below 38%.

The previous figures indicate that the percentage of California physicians accepting Medi-Cal has decreased at a statistically significant level from 2013 to 2015. This includes primary care physicians and non-primary care physicians. It can also be seen that Medi-Cal enrollment has largely been increasing, and these numbers make it clear that the number of providers is not keeping pace with the increase in patients. Figures 12 and 13 provide some possible reasoning for this decrease, with the main concerns being lack of adequate payment and administration difficulties. Ideally the provider incentive programs discussed in the interviews and background would be curbing this decrease in providers, but these results may indicate that further incentives are needed in order to maintain adequate numbers of providers for Medi-Cal patients.

While the ACA created the opportunity for public insurance to be more widely available and attempted to incentivize providers to accept public insurance, it also increased enrollment in private insurance through subsidies. The increase in those on private insurance also demands an increase in providers for that population, so providers who chose to increase their patient population may be likely to accept more privately-insured patients.

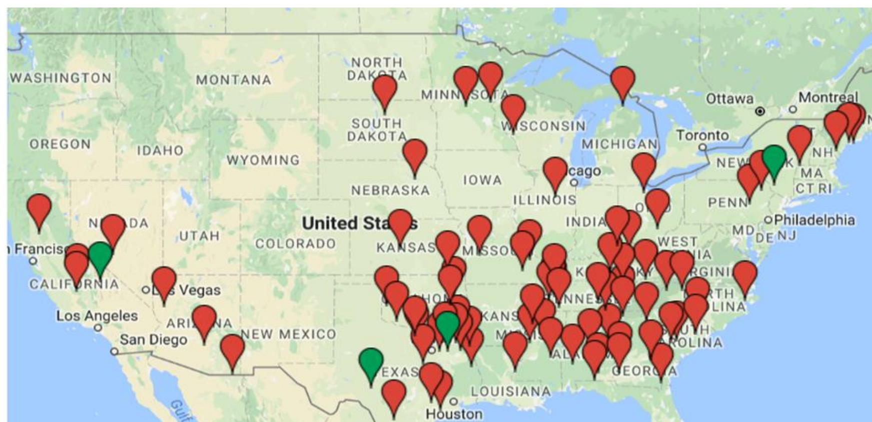
Although some of the literature and the interviews determined that increased incentives have allowed for an adequate number of providers to serve the Medicaid population, the charts and figures show that many areas are still not meeting federally-determined proportions of providers, that private providers are not accepting adequate levels of Medicaid patients, and that

lack of sufficient payment rates is a large reason for low numbers of providers.

FQHCs Filling a Gap in Service and Offering Cost Effective Solutions

From the aforementioned PBS interview concerning the closure of rural hospitals, the importance of FQHCs can also be seen. Rural hospitals across the country have faced closure since 2010, especially in states without Medicaid expansion, as seen in Figure 14. While these hospitals have been closing, however, the number of government funded health centers has grown, and many have expanded their patient population and improved their services. The Health Resources and Services Administration determined that between 2008 and 2015, the number of new health centers throughout the country increased by 27% and the number of patients served by health centers increased by 42%, or around 7.2 million additional patients.[101]

80 Rural Hospital Closures: January 2010-Present[102]
Figure 14



Rural Health Clinics- 2015[103]

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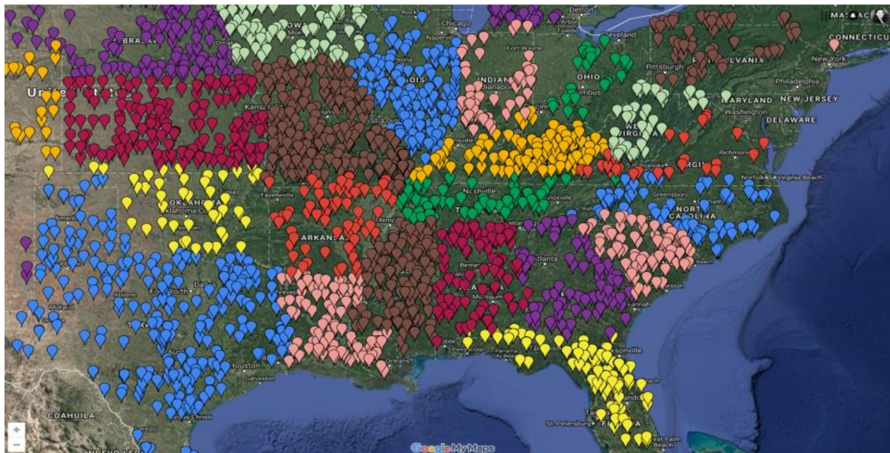
[101] Health Resources and Services Administration, "Health Center Program: Impact and Growth," 2017, https://bphc.hrsa.gov/about/healthcenterprogram/index.html.

[102] Cecil G. Sheps Center for Health Services Research, "80 Rural Hospital Closures: January 2010 - Present," *University of North Carolina at Chapel Hill*, 2017, http://www.shepscenter.unc.edu/programs-projects/rural health/rural-hospital-closures/.

[103] National Association of Rural Health Clinics, "Map of Rural Health Clinics in US," 2015, http://narhc.org/map of-rhcs-in-us/.

Figure 15



The ACA effects on states that assisted with Medicaid expansions and states that did not can be seen through Figure 14 and Figure 15. The ACA improved financial situations for government-funded health centers by increasing insurance enrollment which led to greater funds to cover medical services, because rather than serving a largely uninsured population they are now seeing publicly insured patients. Even in areas without integrated Medicaid expansion, individuals and health centers were able to look to federal funds in order to improve access to services. In the PBS interview it was mentioned that rural hospitals had always struggled to stay open due to fewer patients and thin financial margins. However, in states that assisted with Medicaid expansion, many rural hospitals were able to recover from low patients numbers when they saw an increased in the number of insured individuals, while states without Medicaid expansion have seen dozens of closures.[104] These cases illustrate the importance of federal and state assistance for health clinics, especially in rural areas that already may be facing provider shortage due to hospital closures and lack of state support for the Medicaid population.

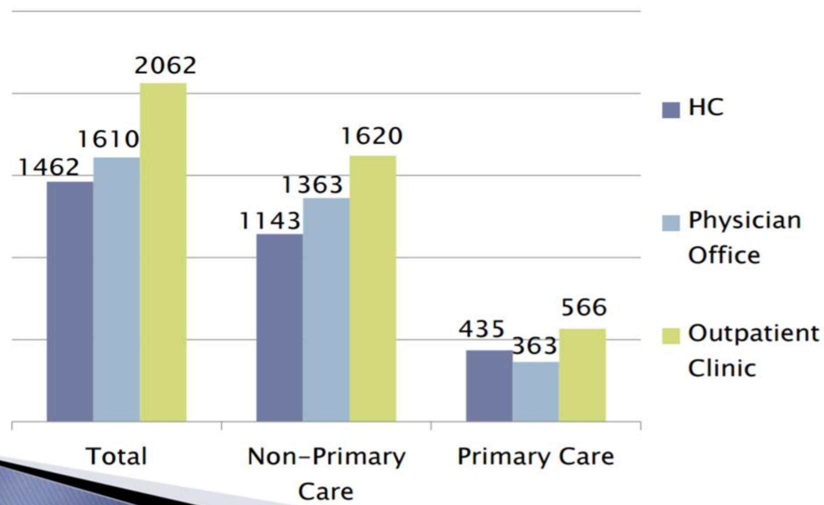
[104] PBS NewsHour, “Hospitals Worry an ACA Repeal Could Harm Their Financial Health.”

Aforementioned studies determined that having the Medicaid and Medicare population served at federally funded health centers may be less expensive than these populations seeking care elsewhere. From Figure 16 it is shown that the cost of care for Medicare and Medicaid patients were lower at HCs, while for primary care services physician offices cost slightly less.

Results: Median Predicted Costs Non-Aged >65[105]

Figure 16

[105] Health Resources and Services Administration, "Are Health Centers Cost Effective? A Review of Recent Research on Health Center Cost of Care."



Main Findings: Health Center vs non-Health Center[106]

Figure 17

[106] Ibid.

Main Findings: Health Center vs non-Health Center

Summary: *Health Center patients had lower use and expense across all services*

	Non-Health Center	Health Center	% Difference
Primary Care			
Visits	8.2	7.6	-7%
Spending	$1,845	$1,430	-23%
Other Outpatient Care			
Visits	15.7	12.2	-22%
Spending	$2,948	$1,964	-33%
Rx Drug Spending	$2,704	$2,324	-14%
Emergency Room			
Visits	1.3	1.2	-11%
Spending	$244	$216	-11%
Inpatient			
Admissions	0.25	0.19	-25%
Length of stay	1.1	0.8	-26%
Spending	$2,047	$1,496	-27%
Total Spending	$9,889	$7,518	-24%

37

From Figure 17 it is determined that in some states primary care use and/or spending was higher in HCs, as well as higher emergency use in one state. However, from Figure 18 it is clear that overall use and spending across all of these services was lower among patients at HCs.

HC vs non-HC, By State

↑ **HIGHER** use/cost at HCs | ↓ **LOWER** use/cost at HCs | No Significant Difference

Service	Outcome	AL	CA	CO	CT	FL	IA	IL	MS	NC	TX	VT	WV
Primary Care	Use		↓	↓	↑	↓		↑	↓	↓	↓		↓
	Spending	↓	↓	↓		↓	↓	↑	↓	↓	↑		↓
Other Outpatient	Use		↓	↓	↓	↓				↓	↓	↓	↓
	Spending	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
Prescription	Spending			↓		↓	↓	↓			↓		↓
Emergency	Use		↓			↓	↓	↑			↓		↓
	Spending		↓	↓		↓	↓						↓
Inpatient	Admits		↓		↓	↓	↓	↓	↓				
	LOS		↓		↓	↓	↓	↓					
	Spending		↓		↓	↓	↓	↓					
Total	Spending	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓

Summary: *While specific findings by service vary across states, all states had lower total spending for HC patients*

39

HC vs non-HC, By State[107]

Figure 18

[107]Ibid.

Medi-Cal 2020 and the Wrap Cap Pilot Improving Healthcare Delivery

In June 2016 an informational meeting about the Medi-Cal 2020 demonstration waiver was held in Los Angeles.[108] The meeting discussed specific programs and reforms that will be able to take place due to the renewed waiver, and that the programs will expand and develop services to target specific groups that may be high-need. Among important programs is the Drug Medi-Cal Organized Delivery System, which will create new services to assist with treatment and management of patients with substance use disorders. New measures will require physical and mental health care to be more coordinated, and recovery support visits will now be billable services as a way of monitoring and assuring health improvement. These new measures are made to work with managed care organizations, and therefore will create more resources for health centers to access when referring patients to specialty care.[109]

The Whole Person Care Pilot is also an important program targeted to expand resources for certain populations. This will include development of a central agency that organizes and coordinates care for Medi-Cal beneficiaries who fall into the following "high-risk" categories; homeless, mental health diagnosis, re-entry, substance use, and medical complications. The agencies will work with primary care providers and managed care plans to connect the patient with specialty resources in order to improve care coordination. This will benefit health centers and primary care providers by assisting with referrals and case management and taking a holistic approach to addressing patient's needs.[110] These programs and resources will be extremely beneficial to the Medi-Cal population if they are implemented and executed in an effective way.

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[108] Deborah Kelch, Wesley Ford, and Clemens Hong, "Implementing Medi-Cal 2020 in Los Angeles" (The California Endowment, Los Angeles, July 27, 2016).

[109] Ibid.

[110] Ibid.

These programs allow for the possibility of improved and expanded services to help manage high-need populations, and would benefit health centers by assisting with case management and care coordination.

Community outreach as well as policy awareness are important ways that AltaMed serves their population. They focus on government relations and have many community stakeholders, do work on and stay up to date about ACA policies, have connection and presence with elected officials, and help advocate for issues both statewide and federally[111]. They recently campaigned around propositions such as the tobacco tax in order to look out for their community and ensure that local policies are beneficial to those they are serving. They also recently participated in a homelessness roundtable to work on the issue of homelessness and development of resources and policies to serve that population. In general they work to support and promote legislation that focuses on healthcare disparities, including topics such as insurance rates, workforce development, civic engagement, and voter registration. They also get feedback from their community about their opinions surrounding policies and programs. In terms of current policy, they are continuously working on the §1115 Medicaid Demonstration Waiver, or Medi-Cal 2020 waiver. The Whole Person Care pilot is something they'll be pursuing in order to expand services to their population and coordinate care[112].

Abramson outlined ChapCare's specific goals in terms of improving and expanding services to their population. He also discussed these goals in relation to the currently undetermined future of healthcare, and how they can be reached even in the event that some of their patients lose insurance in the upcoming years[113].

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[111]Jacquez, AltaMed.
[112] Ibid.
[113] Abramson, ChapCare.

ChapCare is focused on expanding targeted services to populations such as pediatrics and prenatal care. They are working on engaging in pay for performance programs, where there are clinical outcomes based goals and incentives for improving health outcomes. They also have to actively negotiate by focusing on cost reduction and ensure that through their contracts they are getting the best deals for services and maximizing health service innovations. This will allow them to improve population management for high-cost populations114.

Abramson also discussed payment reform in detail, referring to the aforementioned Wrap Cap pilot that aims to implement alternative payment methodology for California FQHCs. This reform would result in clinics receiving more payment up front which would allow the organization to invest[115]. It calls for bonuses based on health outcomes, making payment more outcomes-based than based on number of visits. It will also eliminate maximum payments per person per day, and will allow for payment of two kinds of visits in one day. This can result in same day medical and behavioral health visits, and will decrease the likelihood of patients being lost to follow up. At ChapCare specifically, patients who are being seen for a medical appointment but express need for a mental visit are handed over to a behavioral health specialist when possible, but those visits cannot be reimbursed and may take time away from that providers work. Being able to address different concerns while the patient is physically at the clinic will likely be beneficial to patient health[116].

Possibility of ACA Repeal Harming Health Center Revenue and Healthcare Delivery

ChapCare's Steve Abramson spoke briefly about the future of healthcare. He determined

[114]Ibid.
[115]Ibid.
[116]Ibid.

that if the ACA is repealed, revenue streams will be lower, because less people will be insured and the clinic may not be reimbursed for certain services[117]. Additionally, an increase in the number of uninsured will be observed in both public and private insurance, due to a repeal of the insurance subsidies coupled with no mandate for people to buy insurance. He estimated that about 72% of people in California received subsidies on the health insurance marketplace. If the federal administration converts Medi-Cal to block grant program, the state would either cover less people with the most benefits possible, or more people with less benefits[118].

The aforementioned PBS interview determined that the ACA shifted the healthcare delivery model for hospitals by giving financial incentives to decrease emergency room visits and increase primary care and management of chronic conditions. It was explained that, prior to the ACA, hospitals would generate revenue from Medicare patients making emergency room visits, and therefore hospitals did not have the incentive to reduce these visits. Dr. Kenneth Polonsky of University of Chiago medicine explained that if these incentives are taken away, many patients will have to return to skipping preventative care and possibly going straight to the emergency room because they may not have health insurance and have limited ways to receive care.[119]

RECOMMENDATIONS

Millions more people now have health insurance and access to care. Many FQHCs and other federally funded health centers have been able to expand further to serve their population,

[117] Ibid.
[118] Ibid.
[119] PBS NewsHour, "Hospitals Worry an ACA Repeal Could Harm Their Financial Health."

but continue to face challenges working within the health care delivery system. Additionally, the future of insurance eligibility, government assistance for health centers, and availability of grants and waivers are currently undetermined.

Recommendations in this section are based on the prior discussions and research and serve to address the needs of patients, providers, and communities.

Federal

The future of healthcare delivery and insurance is unclear, as legislation aiming to repeal and replace the ACA is currently being crafted and debated. While it is likely that many aspects of healthcare will change, the following recommendations serve to address possible policy decisions and defend certain legal provisions included in the ACA.

In drafting a new health delivery and health insurance plan, the federal government should keep the following ACA provisions: insurance mandate, Medicaid expansion, insurance subsidies, and taxes.

Maintain Insurance mandate

Any new or updated federal healthcare plan should maintain the insurance mandate. This ensures that individuals will buy in to the health insurance market regardless of their health status. Without this mandate it is possible that people will buy insurance only once they need an expensive medical treatment, and if the majority of those insured need expensive treatments then insurance companies could easily lose money[120]. Without insurance, literature shows that individuals turn to emergency services, which drives up the cost to the individual and the cost to

[120] Margot Sanger-katz, "Why Keeping Only the Popular Parts of Obamacare Won't Work," *The New York Times*, November 2016, https://www.nytimes.com/2016/11/15/upshot/why-keeping-only-the-popular-parts-of-obamacare-wont-work.html.

hospitals and health centers[121].

Maintain Medicaid Expansion

The new healthcare plan should maintain the Medicaid Expansion option. The current federal government has expressed interest in phase out federal funding that was helping states instigate and manage Medicaid expansion. In states where the state government has taken a lot of action and responsibility, such as California, this may not severely harm them. However, in states where Medicaid expansion was recently developing or hasn't occurred, that would be extremely detrimental[122]. Federal aid for Medicaid has for decades been dependent on how much medical care those enrollees used in the state. The GOP would change this and put a cap on the amount of aid based on how many people qualify for Medicaid. Critics say that this will force states to phase out coverage for poor people and limit medical services, as was the case pre-ACA[123]. In the interview with Abramson he also voiced this concern, stating this would likely result in fewer resources for more people or more resources for fewer people[124].

Maintain Insurance Subsidies

The new healthcare plan should continue to offer insurance subsidies. People who were buying insurance in high-cost markets were eligible for higher subsidies, because insurance costs and cost of living vary dramatically based on location. This meant that the available amount for the subsidy would fluctuate with changing costs. The GOP is looking to decrease these subsidies and to make subsidies dependent on the person's age that would be in the form of a tax credit, for

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[121]Elaine Cox, "Why Do We Continue Using the ER for Care?," *US News & World Report*, December 2015, http://health.usnews.com/health-news/patient-advice/articles/2015-12-14/why-do-we-continue-using-the-er-for-care.

[122]Noam N. Levey and Lisa Mascaro, "Republicans Unveil Plan to Repeal and Replace Obamacare amid Conflicting Pressures," *Los Angeles Times*, March 6, 2017, http://www.latimes.com/politics/la-na-pol-house-gop-obamacare-20170306-story.html.

[123]Ibid.

[124]Abramson, ChapCare.

people who are not covered through their employer[125]. This is connected to the idea that older people have more medical needs, and models have shown that younger wealthier people will be better off under this system. This does not account for varying health plan costs in richer and poorer areas of the country and could quickly price individuals out of the market, and some research indicates that this will be detrimental to older populations[126] Other research determined that this will be more harmful to younger populations, but it is generally agreed that decreasing subsidies will result in negative impacts for different parts of the population[127]

Maintain ACA Taxes

The new healthcare plan should maintain new taxes that were implemented under the ACA. The ACA increased various taxes, including taxes on insurance companies, medical technology manufacturers, the wealthy. The federal government has expressed desire to cut all of these taxes, which will result in a significant tax cut for the wealthy and for insurers. It is argued that this will allow insurers to charge lower premiums, although lower premiums are not mandated.[128]

State

Conduct Outreach, Educate Providers and Encourage Involvement in Loan Repayment Programs

Providers of FQHCs should take advantage of loan repayment programs that aim to

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[125]Gary Claxton, Cynthia Cox, and Larry Levitt, "How Affordable Care Act Repeal and Replace Plans Might Shift Health Insurance Tax Credits," *The Henry J. Kaiser Family Foundation*, March 11, 2017, http://kff.org/health-reform/issue-brief/how-affordable-care-act-repeal-and-replace-plans-might-shift-health-insurance-tax-credits/.

[126]AARP, "AARP Opposes Healthcare Bill," March 2017, http://www.aarp.org/politics-society/advocacy/info-2017/aarp-opposes-healthcare-bill.html.

[127]Margot Sanger-katz, "Republican Health Proposal Would Redirect Money From Poor to Rich," *The New York Times*, February 16, 2017, https://www.nytimes.com/2017/02/16/upshot/republican-health-proposal-would-redirect-money-from-poor-to-rich.html.

[128] Levey and Mascaro, "Republicans Unveil Plan to Repeal and Replace Obamacare amid Conflicting Pressures."

alleviate some student debt and provide FQHCs with dedicated providers. FQHCs could engage in community outreach at local colleges and universities with nursing and doctoral programs in order to educate potential providers about the importance of FQHC work and payment benefits that they could experience working for a FQHC. This may encourage local providers to give back to the community that they are a part of in a way that is beneficial to themselves and local patients, and could result in a larger workforce for FQHCs. The following programs are available in California to providers at FQHCs, and more detailed information about the programs and eligibility can be found in Appendix C.

State Loan Repayment Program

This program offers repayment of loans for primary care providers who commit to a two-year full-time or four-year part-time employment in a federally designated Health Professional Shortage Area.

Steven M Thompson Physician Corps Loan Repayment Program

This program encourages providers to practice in a Health Professional Shortage Area (HPSA) or Primary Care Shortage Area (PCSA) in California. It allows allopathic or osteopathic physicians or surgeons practicing in one of these areas to have certain educational loans covered, given a commitment to serve this area for three years.

California Dental Association Student Loan Repayment Grant

This grant, by the California Dental Association, repays educational loans for select dental school graduates. This grant may be of particular interest as dental services have been more recently expanded by some FQHCs in Los Angeles.

Engage in Projects and Policy Discussions About Waivers and Programs

California FQHCs should engage politically with the current Medicaid waivers and

government programs that will benefit their populations. This includes the Medicaid 1115 waiver, or Medi-Cal 2020, as well as the Wrap Cap pilot. These programs will offer more resources to the Medi-Cal population and will instigate payment reform that will be tied to positive patient outcomes. They will also work on improved monitoring of patient outcomes and care coordination to improve the management of patient care. FQHCs should educate administration about these programs, engage in meetings and focus groups that discuss their progress and implementation, and stay updated about involvement in upcoming phases of the project. Information about upcoming meetings and involvement with these programs can be found in Appendix D.

Participate in Medicaid expansion

All states should participate in Medicaid expansion. This will directly affect the healthcare access of their rural populations. With Medicaid expansion, most rural community health clinics can become FQHCs, making them eligible for enhanced reimbursement through Medicaid, and therefore increase their revenue which would lead to expanded and improved services. This will also promote job growth in these rural areas and therefore benefit both patients and employees.

CONCLUSION

This paper explains the necessity of FQHCs in serving the Medicaid population as well as the benefits associated with care provided at FHQCs. It compiles multiple studies and sources showing the cost-saving benefits of FHQCs, the broad range of services provided by these centers, the changes brought about in these centers after the ACA, and the necessity of FHQCs among certain populations.

The importance of FQHCs and federally funded health centers is especially clear in rural areas. While rural hospitals have struggled to serve scattered rural populations for a while, even in states without Medicaid expansion rural health centers have been able to expand their caseloads and their services. Some rural hospitals in states with Medicaid expansion have also been able to handle increasing caseloads and benefit from more insured patients.

Interviews with professionals at FHQCs in Los Angeles offer insight to specific work that individual organizations are doing to serve their population, and show how these organizations reflect and sometimes diverge from conclusions reached in current literature. Detailed information about the ACA, its implementation, provisions affecting health centers, and the future of healthcare also serve to reiterate how laws, policies, and programs can help or hinder services for the Medicaid population. The compiled information serves to address the importance of FHQCs in serving Medicaid populations that may have limited resources and rely heavily on services provided at these centers. They also serve populations such as the uninsured or those on local insurance programs that may have even fewer resources.

The research also compiles information about waivers and pilot programs looking to improve health outcomes for certain populations. FQHCs can benefit from these programs that will allow them to develop payment reform, engage in care coordination, increase resources, and improve patient outcomes.

The first step in improving health outcomes on community, state, and national levels was reforming healthcare. Although it is currently unclear how federal healthcare policy will continue to develop and change, it is clear that the ACA expanded resources and health services for certain disadvantaged populations. With millions more individuals having insurance coverage, the next step is continuing to expand resources and improving health delivery. Data has shown that many

health centers have been able to expand services, and that current programs and waivers are looking to further expand services and improve healthcare delivery by bringing about structural developments and payment reform.

Background information, research, and program analysis paved the way for timely and important recommendations that aim to preserve the work that FHQCs currently do, expand services and outcomes that should be improved, improve health care delivery, and preserve federal programs that have proven useful.

Further research could include analysis of all FHQCs in the Los Angeles area to determine what specialty services are being provided, what health outcomes are being monitored, how patients feel about available services, and how providers feel about providing care at these centers. Research could offer a further look in to resources and programs available to these Los Angeles centers, as well as provide more detailed demographic information to assist the health centers in understanding their population.

Appendix A

The following list of questions was sent to organizations that were interviewed and provided a structure for each interview. The interviewees were informed that the questions could be changed as desired by them and their organization

Interview Questions

How do you think your organization effectively provides health care resources to your patient population?

How has your health center been able to expand with the implementation of the PPACA?

What does your community outreach look like?

Where do you think federal or state funding falls short; are some of your resources and services limited due to funding?

Where do you think there are gaps in your service?

In your experience, is provider retention a problem in FQHCs?

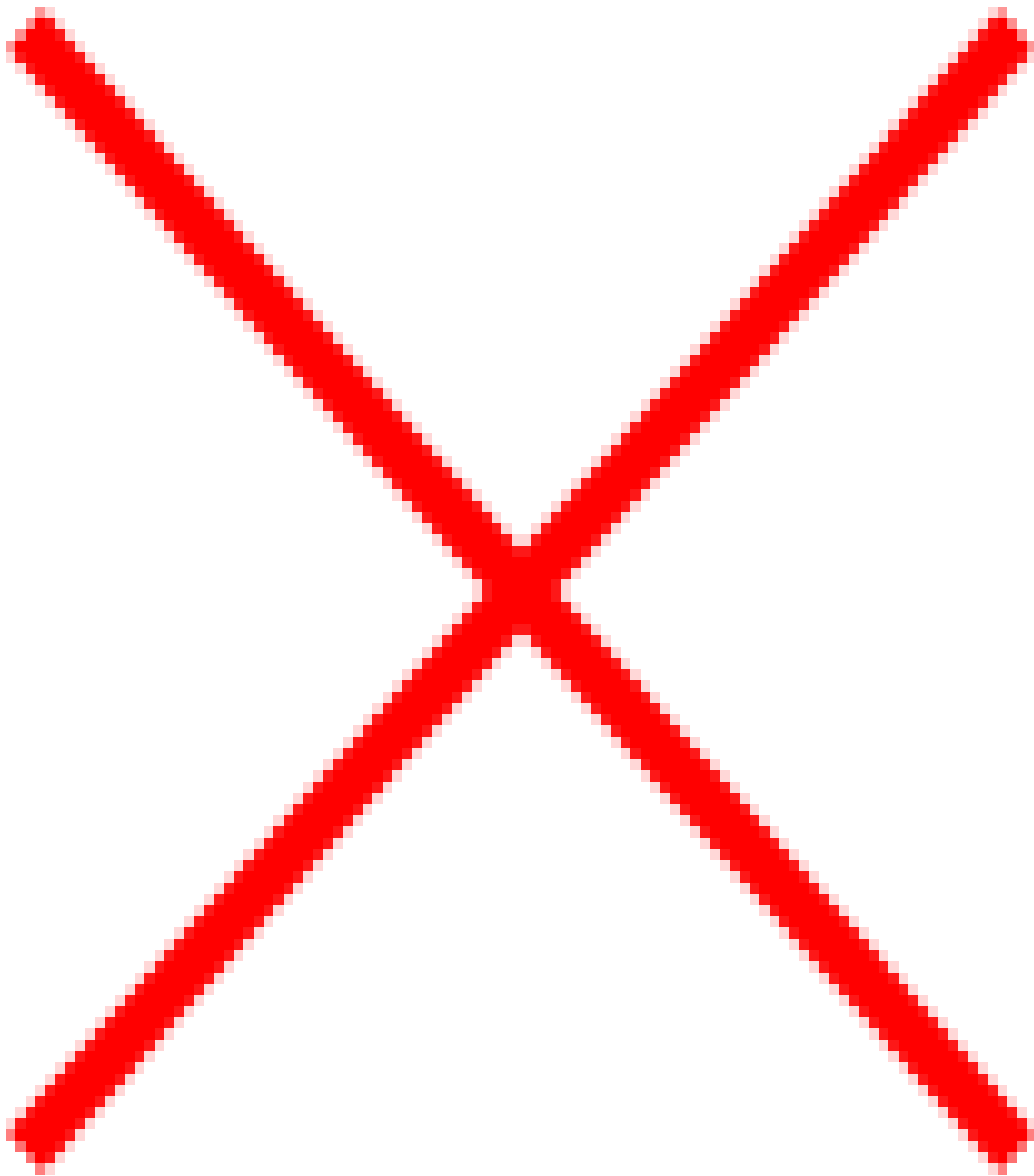
Do you encourage providers to participate in any state loan repayment programs as a way to maintain your provider population?

How do you see policies of the new presidential administration affecting your resources and you client base, if any predictions can be made at this point?

Are there specialty services specific to your population that you don't think are found at other centers (such as language services, insurance enrollment programs, etc)?

Appendix B

The following is a key for Figure 8, page 38, detailing the Medical Service Study Areas seen in the figure that are facing physician shortage.



Appendix C

State Loan Repayment Program

The State Loan Repayment Program (SLRP) works to increase the number of healthcare providers in federally designated California Health Professional Shortage Areas (HPSAs)[129]. It

[129] Office of Statewide Health Planning and Development, "California State Loan Repayment Program," 2017, https://www.oshpd.ca.gov/hwdd/slrp.html.

brings providers to these HPSAs who serve two years full-time or four years part-time at participating health centers. The SLRP offers repayment for certain educational loans, and the health center site matches the federal award with non-federal contributions[130].

The program website can be found at https://www.oshpd.ca.gov/hwdd/slrp.html. Questions regarding the program can be sent to SLRP@oshpd.ca.gov.

The 2017 provider application is open August 1-October 1, 2017, and can be found at https://calreach.oshpd.ca.gov/Login2.aspx?APPTHEME=CAOSHPD.

Steven M. Thompson Physician Corps Loan Repayment Program

The Steven M. Thompson Physician Corps Loan Repayment Program works to increase the number of allopathic and osteopathic physicians and surgeons in federally designated California Health Professional Shortage Areas (HPSAs)[131]. Physicians and surgeons can receive up to $105,000 for repayment of education loans when they serve as full-time providers in a HPSA for at minimum of three years[132].

The program website can be found at http://www.oshpd.ca.gov/hpef/Programs/STLRP.html.

The 2018 provider application will open early December 2017 and be due late February 2018, and can be found at https://calreach.oshpd.ca.gov/Login2.aspx?APPTHEME=CAOSHPD.

California Dental Association Student Loan Repayment Grant

The California Dental Association Student Loan Repayment Grant provides funds for those with a DDS or DMD degree to practice in a California Dental Health Professional Shortage Area or an otherwise determined underserved area for three years[133]. Applicants must have graduated from an American Dental Association accredited dental school within the last three years[134].

The program website can be found at http://www.cdafoundation.org/grants-awards/student-loan-repayment-grant

The 2017 provider application will be open May 1-July 31, 2017, and can be found at http://www.cdafoundation.org/grants-awards/student-loan-repayment-grant

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[130]Ibid.
[131]Office of Statewide Health Planning and Development, "Steven M. Thompson Physician Corps Loan Repayment Program," 2017, http://www.oshpd.ca.gov/hpef/Programs/STLRP.html.
[132]Ibid.
[133]California Dental Association Foundation, "Student Loan Repayment Grant," 2016, http://www.cdafoundation.org/grants-awards/student-loan-repayment-grant.
[134]Ibid.

Appendix D

Involvement in Medi-Cal 2020 Demonstration

Details about the Medi-Cal 2020 Waiver Demonstration can be found at http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx.

Questions and comments can be directed to 1115Waiver@dhcs.ca.gov.

The next Stakeholder Advisory Committee meeting is on Wednesday, May 17, 2017 from 10 am to 3:30 pm at 1414 K Street, Sacramento, CA 95814. Other upcoming meetings are on July 19, 2017, and October 19, 2017, and updated information can be found at http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx.
Questions about the Stakeholder Advisory Committee can be directed to SACinquiries@dhcs.ca.gov.

Involvement in the Wrap Cap Pilot

The California Wrap Cap Pilot, or Alternative Payment Methodology (APM) Pilot, is slated to start after January 1, 2018 according to the Department of Health Care Services (DCHS)[135]. For further information, DCHS contact Ryan Witz can be reached at Ryan.Witz@dchs.ca.gov.

The California Primary Care Association holds a Wrap Cap Workgroup on a monthly basis where members can participate in a voluntary demonstration and gain further information about the Wrap Cap Pilot[136]. For information about participating in the Wrap Cap Workgroup, Andie Patterson can be reached at andie@healthplusadvocates.org.

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