FEBRUARY 2021

CHCF Issue Brief

Holding On: How California's Health Centers Adapted Operations and Care for Patients During the Pandemic

California's Federally Qualified Health Centers (FQHCs)[1] are a critical part of the health care safety net, providing care for communities of color, people experiencing homelessness, and others who do not have regular access to health care. It is vital that health centers are financially and operationally stable so they can continue to effectively meet the needs of the patients who rely on them for primary care, behavioral health, and dental services.

At the start the COVID-19 pandemic, California's health centers were already facing financial challenges that had put them on uncertain ground, with significant reductions in operating margins between 2016 and 2019. Once the pandemic hit, face-to-face primary care visits and corresponding reimbursements dropped precipitously. This paper identifies several key factors that enabled California's health centers to manage the financial strain exacerbated by the pandemic while continuing to serve patients at a time when accessing health care involved new and unanticipated challenges.

Introduction

FQHCs have played a critical safety-net role in California since the 1960s. According to data submitted by health centers to the federal Health Resources and Services Administration (HRSA), 5.6 million patients were served at 1,963 sites across the state in 2019.[2] Of the 5.6 million patients, 3.6 million were covered under Med-Cal, the state's Medicaid program. The California Office of Statewide Health Planning and Development's 2019 Annual Utilization Report shows that 92% of patients served in FQHCs are non-White, 67% have incomes at or below 200% of the federal poverty level, and 34% have a primary language other than English.[3]

The COVID-19 pandemic caused serious disruptions in care delivery throughout the country. In-person visits declined at California health centers by more than 4 million between April and December 2020, a reduction of 20% compared to the same period in 2019.[4] In the early days of the pandemic, health centers were forced to make major operational changes that focused on meeting the most urgent community needs.

In the summer of 2020, Aurrera Health Group and Capital Link were commissioned by the California Health Care Foundation to release a series of three reports that will provide a comprehensive window into the financial and operational impact of the pandemic on California's FQHCs. The first report, *California Federally Qualified Health Centers: Financial and Operational Performance Analysis, 2016–2019*, released in November 2020, analyzed the key financial and operating trends of the sector from 2013 through 2019, and identified several areas of declining financial performance that preceded the pandemic.[5]

This paper, the second in the series, analyzes the financial impact of the COVID-19 pandemic on California health centers from March through December 2020, based on a range of publicly available as well as proprietary data, as further described in the "Data Sources and Methodology" section. It also identifies several key factors that enabled California's health centers to manage the financial strain caused by the pandemic, enabling them to continue to serve patients at a time when access to health care was being curtailed due to stay-at-home orders. These findings are informed by interviews conducted in fall 2020 by Aurrera Health Group with FQHC executives and other health center experts.

In addition to exploring short- and immediate-term responses to the pandemic and the corresponding reductions in revenue, experts also shared thoughts about COVID-19-related implications for the future of care delivery and reimbursement, and ways that health

centers should anticipate and plan for future recessions. An exploration of these long-term considerations and opportunities will be presented in the third and final report in the series.

Existing Financial Environment and Vulnerability Assessment

At the start of the COVID-19 pandemic, California health centers were already facing financial challenges that put them on uncertain ground. The most recent financial and operational performance analysis by Capital Link found that California FQHCs experienced a significant decline in operating margins between 2016 and 2019 — from 6.5% to 2.5% at the median.[6] This decline was largely due to expenses growing more quickly than revenue. For example, personnel-related expenses grew from 70% of revenues in 2016 to 75% by 2019.[7] At the same time, cash reserves declined, totaling 77 days cash on hand for the median California FQHC in 2019 — the lowest level achieved over the four years. Especially concerning, one-quarter of health centers had less than 28 days cash on hand at the end of fiscal year 2019.

By mid-March 2020, California's FQHCs were beginning to feel the financial effects of the pandemic. Visits had declined precipitously, resulting in $853 million in estimated lost revenue between April and December 2020 (see Table 1). At the same time, health centers were incurring additional costs related to the pandemic, including for the purchase of personal protective equipment (PPE), equipment and licenses for a rapid transition to telehealth, and facility modifications to enable safer execution of routine and pandemic-related care.

Capital Link estimates that California FQHCs incurred a total of $512 million in COVID-19-related expenses between April and December 2020.[8] Together, lost revenue and COVID-19-related costs equaled an estimated $1.36 billion through year-end 2020 — 19% of their entire 2019 budgets, which totaled just over $7 billion.

After taking into account $834 million in federal relief funding received by the California FQHCs between April and December 2020 (as detailed later in this paper), the estimated net losses sustained by the health centers equaled almost $531 million. For the average California FQHC, net losses between April and December 2020 drained 27 days of cash from its balance sheet. The majority of centers were left with very low levels of cash by year-end — with months of the pandemic still ahead in 2021.

Table 1. Net Losses Due to COVID-19, California FQHCs
April to December 2020 (9 months)

Lost Revenue	$853,268,299
COVID-19-Related Costs	$511,590,479
Total Lost Revenue and Costs	**$1,364,858,778**
Federal Relief Funding	$834,057,832
Net Gains (Losses)	($530,800,946)
Average Days' Cash Drain	27

Source: Capital Link's analysis of sources cited in "Data Sources and Methodology" section.

Absent the federal relief funding discussed below, the financial strain would likely have been untenable for most health centers. Even with the relief funding to date, it seems likely that most health centers will need several years of significant operating surpluses or additional funding streams to fully recover from losses sustained during the pandemic.

FQHC Strategies to Mitigate Financial Losses During the Pandemic

In response to the significant and necessary reduction in face-to-face visits during the first nine months of the COVID-19 pandemic, California FQHCs were able to pivot to meet patient needs. For patients who needed an in-person visit to address an acute care need, health centers reconfigured physical space and workflows to ensure patient and staff safety. Some programs were completely restructured. For example, Hill Country Community Clinics moved wellness services "beyond the four walls" of the health center and provided virtual peer support, more outdoor activities, and care packages delivered to people's homes, thereby supporting patients who needed contact and might otherwise be isolated during the pandemic.

A major takeaway from the expert interviews was that reliance on the current prospective payment system (PPS) reimbursement structure created significant risks when responding to the COVID-19 pandemic. Under PPS, reimbursement for primary care visits is contingent on the occurrence of an in-person visit. Alternative models of care delivery have historically not been reimbursable nor incentivized.

California health centers employed a range of immediate loss-mitigation strategies during the first months of the COVID-19 pandemic. The strategies varied in level of effort, but taken together, they sustained health centers through 2020 as the pandemic continued. Strategies included:

- Embracing and investing in telehealth
- Reassigning and furloughing staff
- Spending down reserves
- Closing sites temporarily
- Generating quick cash
- Tapping into COVID-19-related federal support
- Leveraging partnerships

Embracing and Investing in Telehealth

Before the COVID-19 pandemic, discussions about a shift toward more consistent and extensive use of telehealth were generally dismissed based on concerns about how challenging the change would be for providers, patients, and payers alike. However, the sudden and unexpected nationwide shutdown caused by COVID-19 resulted in a widespread, necessary, and immediate shift to the use of telehealth across the country. Between April and December 2020, 53% — 8.4 million out of 15.9 million — of all health care visits were conducted virtually (including video- and telephone-enabled telehealth) at California FQHCs. One CEO pointed out that over two weeks, they "flipped from a model that was about 8% telehealth to 80% telehealth."

Due to federal flexibilities[9] and the emergency order of the California Department of Health Care Services allowing telehealth visits to be reimbursed through the PPS system during the pandemic, FQHCs were able to:

- Use new and widely available technologies to meet with patients virtually
- Receive the same payments under Med-Cal whether care was provided over the phone or through video
- Provide telehealth to Medicare clients via phone without the use of video technology and at any site — including the client's home
- Use nurse practitioners to provide telehealth services without the medical supervision of a physician

These policy modifications have broad and long-term applicability. All FQHC executives interviewed for this brief acknowledged that the ability to shift to telehealth so quickly came as a surprise but allowed them to continue providing services. In the case of behavioral health care, the accessibility of telehealth during the COVID-19 pandemic improved no-show rates. For Bay Area health centers, one executive pointed out that telehealth as an option for behavioral health services resulted in "a net plus . . . we went from about 25% no-show for behavioral care to pretty close to zero." For patients who embrace the opportunity to connect with providers virtually, convenience is a key component of patient-centered care.

While the California budget has given indication that telehealth will be compensated to some degree, the details are still unclear. Health center leaders emphasized that while they are encouraged by this, it is important that reimbursement and subsequent policy changes support equitable access to telehealth.

Shifting to telehealth and video visits on a long-term basis will take some effort. Experts cited the need to reconsider workflows, staff responsibilities, and physical space to facilitate providing care remotely. Most noted that the use of telehealth did not improve efficiency and in fact, required more time for staff to determine appropriate care in advance of the visit. Additionally, interviewees noted that some patients do not have the digital literacy skills needed for successful video visits. Health center leaders in rural areas where high-speed internet is limited have been particularly challenged by the transition to telehealth. However, one expert pointed

out that telehealth has allowed health centers to reach people they have not before, creating long-term potential for improving access to care, ultimately facilitating the goal of reducing health disparities.

More than ever, California health centers are ready to make changes to facilitate more flexible and patient-centered models of care, which may include the ongoing promotion of telehealth and video visits in certain circumstances, even after the pandemic ends. Payers and policymakers would also need to acknowledge the validity of this model to ensure financial sustainability. In the words of one expert, health centers long for more predictability about revenue, and desire to get off the "hamster wheel" where only face-to-face encounters with a licensed provider are reimbursable.

Reassigning and Furloughing Staff

COVID-19-related guidelines limiting physical contact severely impacted delivery of services that require face-to-face visits, leaving FQHCs in the difficult position of determining how to keep staff on payrolls. Given the difficulty in recruiting and retaining staff during even the best of times, letting staff go because of the pandemic is particularly problematic in the long term. It is likely that patients will have care needs that were neglected during COVID-19, which could cause an increase in demand for primary care. There are already signs that people are delaying important care. As of June 30, 2020, an estimated 41% of US adults reported having delayed or avoided medical care during the pandemic because of concerns about COVID-19, including 12% who reported having avoided urgent or emergency care.[10] Simultaneously, Medi-Cal enrollment is projected to grow.[11] Given the significant role that health centers play in providing care to Medi-Cal enrollees and this potential increase in primary care demand, maintaining health center capacity should be a priority for the state. Without staff to see these patients, access to care could be impeded.

While dozens of health centers resorted to staff furloughs,[12] many interviewees noted that they went to great lengths to keep their staff intact, redeploying them to other critical tasks during the pandemic. Dental assistants and staff at school-based health centers were most impacted by shutdowns, as their services could not be offered remotely. Rather than furloughing these staff, La Clínica de la Raza reassigned staff to conduct COVID-19 testing. Support staff became patient screeners. Hill Country Community Clinic reassigned dental staff to backfill medical staff who were not able to come in physically to the clinic. Peach Tree Health transitioned some of their behavioral health staff to be outreach and social workers, providing follow-up and check-in care to clients that providers believed may be isolated or neglected during the pandemic. While the time spent was not always reimbursable, the new assignments meant keeping staff on payroll.

As part of its pre-COVID-19 strategy to redesign care delivery, San Mateo County clinics restructured the medical assistant and front-desk staff roles. Instead of rooming patients and taking vitals as part of a patient visit, medical assistants now focus on prevention and population health management. They conduct outreach to patients about well-child visits, mammograms, and other screening reminders. Front-desk staff now have care coordination responsibilities. These redefined roles helped San Mateo clinics respond quickly to a new care model during the COVID-19 pandemic. By quickly reassigning staff, health centers were able to avoid extensive furloughs and layoffs by redirecting resources to address the more immediate needs of clients, while at the same time reducing the impact of service disruptions on revenue.

Spending Down Reserves

Though FQHCs quickly pivoted to provide remote patient care through telehealth, the significant reduction in patient visits forced them to tap into financial reserves. As indicated in Table 1 above, Capital Link estimates that California's FQHCs sustained operating losses totaling almost $531 million between April and December 2020, even after accounting for federal relief funding.

Covering this level of loss greatly impacted cash reserves, requiring the average health center to drain their reserves by 27 days. Given that the median California FQHC had 77 days cash on hand and the bottom 25th percentile had 28 days of cash at fiscal year-end 2019, a cash drain of 27 days means that many health centers are entering 2021 and the next phase of the pandemic with dangerously low levels of cash on hand. Given that visit levels are likely to be depressed going forward and health centers

will continue to incur COVID-19-related costs until the pandemic recedes, these minimal reserves will continue to constrain their operations in 2021 and could lead to deeper furloughs or other loss of capacity for the system.

In the words of one executive, "We decided we would use our reserves to ride it out . . . even though there was a lot of financial heartburn — for people on the front lines and the staff, they didn't have to feel like we were losing ground. We were losing ground, but we had already committed that whatever happened, we would ride it out."

Closing Sites Temporarily

According to weekly data analyzed by Capital Link, California FQHCs closed an average of 242 sites per week between April and December 2020, representing 13% of sites in the state. Without patients, it was unreasonable for both financial and safety reasons to keep clinics staffed at full capacity. However, site closures did not eliminate financial losses since most site costs are still fixed in the short term. Not only is this a short-term fix with minimal financial benefit, closing clinics, even if only temporarily, can have a significant negative impact on patients. Representatives of San Mateo clinics observed that limiting access to ambulatory care resulted in serious implications for the county's hospital emergency department. They noted that they had never seen as many people in diabetic ketoacidosis as they had seen in the last few months and were astounded by what people had deferred during this period. While clinics were hastily transitioning to telehealth, people invariably fell through the cracks, and even with telehealth access, there are still patients who for a variety of reasons need to be seen in person. The impact of COVID-19 is likely to have significant health effects for Californians with low incomes for some time to come.

Generating Quick Cash

In the first months after COVID-19 hit, many health centers focused on improving immediate cash flow, including locking cash flow (postponing plans and eliminating new spending) in hopes of ensuring financial viability. The need to infuse cash into the system prompted Peach Tree Health to pursue reconciliation of past accounts receivable with the state, an exercise often postponed during normal times.

Several health centers pursued a short-term strategy that, while not a permanent solution, demonstrated the seriousness of COVID-19-related circumstances. California allows for converting existing licensed primary care clinics to "intermittent clinics" — sites owned by the main clinic organization but operated at a separate location. This conversion allows FQHCs to bill at the higher reimbursement rate of the primary site. While rules regarding the intermittent site must be followed (not operating more than 40 hours per week, for example), leveraging this flexibility has been a relatively simple strategy with immediate financial benefits.

Tapping into COVID-19-Related Federal Support

As estimated by Capital Link, Table 2 summarizes the major sources of federal support that health centers in California were able to access between April and December 2020, totaling $834 million. Four major sources contributed to this support: (1) HRSA, through three grant allocations administered by the Bureau of Primary Health Care; (2) US Department of Health and Human Services' Provider Relief Fund, including a "General Distribution" and a "Rural Distribution;" (3) telehealth grants awarded by the FCC (Federal Communication Commission); and (4) loans through the Small Business Administration's Paycheck Protection Program, eligible for forgiveness subject to certain conditions that most health centers should be able to meet.[13]

Table 2. Federal Relief Funding Available to California Health Centers, April to December 2020 (9 months)

▶ HRSA	
▶ H8C[14]	$13,842,902
▶ H8D[15]	$193,072,106
▶ H8E[16]	$102,794,295
▶ US Dept. of Health and Human Services, Provider Relief Fund	
▶ General Distribution[17]	$94,890,209
▶ Rural Distribution[18]	$18,379,034
▶ FCC Telehealth Grants[19]	$7,559,979
▶ Paycheck Protection Program Loans[20]	$403,519,307
Total Relief Funding	**$834,057,832**

Note: Calculation assumptions for estimated funding sources are described in the "Data Sources and Methodology" section.

All interviewees articulated that they took advantage of these grant opportunities to mitigate the impact of the pandemic on patients and revenues. In addition to the federal relief funding, some health centers have been able to tap into funding and/or PPE through various charitable sources, local and national relief organizations, and counties. For example, Community Medical Centers, based in Stockton, took advantage of all federal opportunities to avoid furloughing staff, but in doing so needed to hire a grant manager to keep track of the multiple funding streams available during the pandemic.

Some organizations, such as the California Primary Care Association (CPCA), also made short-term emergency loans available, in collaboration with several partners. The CPCA COVID-19 Response Loan Fund awarded eight low-interest loans totaling $5.65 million and eight technical assistance companion grants totaling $240,000 to FQHCs. Interviewees noted that the CPCA funds are being used for renovations to existing facilities to deal with COVID-19 requirements, including plexiglass, automated doors, and touchless faucets, in addition to other changes to allow for better social distancing. In some cases, funds are going toward maintaining key staff and avoiding layoffs due to lost revenues during the pandemic. While loans are an important mechanism for short-term cash flow relief, borrowers are expected to repay them. For this reason, they do not play the same role as grants in mitigating the financial consequences of the pandemic.

Leveraging Partnerships

FQHCs found value in their relationships with health plans when attempting to minimize losses due to the pandemic. L.A. Care has between 335,000 and 350,000 Medi-Cal members who have a primary care home in Los Angeles community health centers. These health centers are paid on a capitated basis, which means they were paid during the pandemic even when patient census was down. In order to improve health center cash flow, L.A. Care prepaid its 2020 pay-for-performance (P4P) payments in April 2020, based on what they had paid out in 2019, and determined they would then reconcile these payments at the end of the year. FQHCs that earned less in P4P than they received in advance will be able to keep the funds, and those that earned more in P4P will receive additional funds. Other Medi-Cal health plans have accelerated claims payments to health centers to help mitigate cash flow challenges.

Several experts cited the importance of existing partnerships during the pandemic. Community Medical Centers worked quickly to launch (and pivot to telehealth) a new partnership that was already being planned before the pandemic. In partnership with the local community college, which has over 2,700 students who live at or below 200% of the federal poverty line, Community Medical Centers opened a student health center on campus. Since the community college is not holding classes in person, before opening the health center, they began seeing students virtually and have also offered in-person COVID-19 testing and flu shots. They plan to open the physical space in early 2021.

Looking to the Future

Despite entering 2020 already facing financial challenges, health centers have been nimble and creative in the face of the pandemic, delivering care in new ways to meet patient needs during an extraordinary time.

With the ongoing pressure the pandemic is placing on the state's health care delivery systems and the corresponding financial challenges faced by FQHCs, health centers will need to continue to be creative. COVID-19 has presented an opportunity to further explore opportunities to strengthen operations and garner long-term support from multiple stakeholders to continue health centers' essential community health care role.

A more detailed, nuanced analysis by type of health center (region, size, rural vs. urban) is currently being conducted to better understand each group's unique opportunities and challenges in the current environment.

In addition, policy actions can speed health centers' ability to recover from the financial shocks of the pandemic and ensure they can continue to provide essential access to care. As the state considers how to prioritize health equity, California's health centers have a vital role to play. The experiences of health centers during 2020 highlighted in this brief point to those policy solutions. These

include extending reimbursement for telehealth beyond the pandemic and reforming the PPS system to allow health centers to provide more flexible care beyond just in-person visits.

A deeper exploration of these operational changes and policy considerations will be provided in a final report to be published in spring 2021.

Data Sources and Methodology

The data analysis contained in this report is based on information from the following sources:

- Audited financial statements of FQHCs (both Section 330s and Look-Alikes) as reported by fiscal year.
- Uniform Data System (UDS) reports as submitted annually by FQHCs by calendar year to the Health Resources and Services Administration (HRSA).
- HRSA's Data Warehouse for the number of California FQHC sites and the size of COVID-19 grants issued to each California FQHC.
- HRSA's Health Center COVID-19 Survey, including weekly responses from health centers from April 4, 2020, through January 1, 2021.
- US Department of Health and Human Services (HHS) Data Warehouse for the amount of Provider Relief Fund (PRF) General Distribution issued to each California FQHC health center:
  - General Distribution estimated at 2% of 2019 Net Patient Service Revenue.
- HHS Data Warehouse for the amount of each PRF Rural Distribution issued to each rural California FQHC health center:
  - Rural Distribution based on FQHC site addresses mapped by RUCA (rural-urban commuting area) codes 4 to 10, with a fixed amount of $103,253 per rural site.
- FCC telehealth grants as published by the FCC on July 8, 2020.
- Small Business Administration (SBA) Paycheck Protection Program (PPP) loan amounts for each eligible California FQHC:
  - Based on surveys of health centers in several states conducted by Capital Link and the National Association of Community Health Centers (NACHC) between April 13, 2020, and June 9, 2020, and
    - For non-survey respondents, the SBA PPP loan amount was calculated for eligible health centers (those with 2019 UDS FTEs less than 450), from FY 2019 Audited Financials: Salaries & Related Expenses, divided by 12 and multiplied by 2.5.
    - If a health center's FY 2019 audit was not available, the loan amount was calculated as follows: Total Revenues (from 2019 UDS) multiplied by the California FY19 median for Personnel-Related Expense as Percentage of Operating Revenue, as calculated from the FY19 audits. The result was then divided by 12 and multiplied by 2.5.
- COVID-19-related expenses include costs of purchasing PPE, telehealth implementation, and facility modifications related to COVID-19. They were estimated on a per-patient per-month basis, based on data collected from health centers in multiple states by NACHC and Capital Link between March and October 2020.

Financial audits were collected directly by Capital Link to create the data set for California health centers. The comparative national health center data set was developed from Capital Link's proprietary database of health center audited financial statements.

Health center financial health and performance were calculated for all California FQHC Section 330 and Look-Alikes (including public entity FQHCs) for which financial audits were provided to Capital Link. The number of audits included in the data set varies each year, as Capital Link continues to add audits to its database as they become accessible. The health center data set examined for the current analysis is outlined as follows:

Table 3. Number of Audits, California FQHCs
2013–19 (fiscal year)

FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
134	145	155	163	164	167	157

Table 4. Number of UDS Reports, California FQHCs
2013–19 (calendar year)

2013	2014	2015	2016	2017	2018	2019
164	182	198	200	197	200	202

About the Authors

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About the Foundation

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

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Endnotes

1. FQHCs are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. They include federally funded health centers known as "Section 330 grantees" and those that meet certain federal requirements, but do not receive federal grant funding, known as "Look-Alikes." This document includes FQHC public health system clinics and refers to all types as "health centers."
2. *2019 UDS Resources*, Health Resources & Services Administration (HRSA), n.d.
3. *2019 Pivot Table - Primary Care Clinic Utilization Data*, California Health and Human Services Open Data Portal, accessed December 2020.
4. Capital Link estimate based on weekly data submitted by health centers to HRSA beginning in April 2020. See Table 1 for a summary of the financial and operational impacts of COVID-19 on California FQHCs from March through December 2020.
5. *California Federally Qualified Health Centers: Financial and Operational Performance Analysis, 2016–2019* (PDF), Capital Link, 2020.
6. *California FQHCs*, Capital Link.
7. This finding was also bolstered by interview responses from health center leaders who cited workforce competition and increasing labor costs as their biggest concern before the pandemic.
8. See "Methodology" section herein for a description of sources and methods used to develop estimates for this analysis.
9. "Policy Changes During COVID-19," US Dept. of Health and Human Services, n.d.
10. Mark É. Czeisler et al., "Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020," *Morbidity and Mortality Weekly Report* 69, no. 36 (Sept. 11, 2020): 1250–57, doi:10.15585/mmwr.mm6936a4.
11. Shannon McConville, "Predicting the COVID-19 Medi-Cal Enrollment Surge," Public Policy Institute of California Blog, June 5, 2020.
12. "California Health Center COVID-19 Survey Summary Report," latest data from January 29, 2021, HRSA, n.d., accessed February 10, 2021.
13. Some centers may have also received funding through HRSA's Uninsured Claims Program, funded through the Families First and PPHCE Acts, which covers testing and treatment for uninsured patients. Because of overlapping eligibility criteria with other sources of federal funding, and difficulty in accessing these data in a systematic way, the authors have not separately accounted for funding from this source.
14. Through COVID Supplemental Appropriations passed into law on March 4, 2020, HRSA made "H8C" grants totaling $100 million to Section 330–funded health centers nationally. The grants were made via a formula to cover the costs of responding to COVID-19 and for maintaining or increasing grantee capacity. Awards were made on or around March 27, 2020, to cover costs incurred within one year of award, unless otherwise extended.
15. Through the CARES Act passed into law on March 27, 2020, HRSA made "H8D" grants totaling $1.32 billion to Section 330–funded health centers nationally. The grants were made via a formula to cover the costs of responding to COVID-19 and for maintaining or increasing grantee capacity. Awards were made on or around April 7 and 8, 2020, to cover costs incurred within one year of award, unless otherwise extended.
16. Through the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA) passed into law on April 24, 2020, HRSA made "H8E" grants totaling $600 million to Section 330–funded health centers and Look-Alikes nationally. The grants were made via a formula to cover costs to purchase, administer, and expand capacity for testing to monitor and suppress COVID-19. Awards were made on or around May 7, 2020, to cover costs incurred within one year of award, unless otherwise extended.
17. The Provider Relief Fund, administered by Health and Human Services, was originally funded in the CARES Act ($100 billion), expanded in PPPHCEA ($75 billion), and further expanded by the Consolidated Appropriations Act, 2021 ($3 billion). Beginning in April 2020, it reimburses eligible health care providers for health care–related expenses or lost revenues that are attributable to coronavirus through July 31, 2021. Through December 2020, health centers have received several rounds of "General Distributions" totaling approximately 2% of 2018 net patient revenue.
18. A portion of the PRF was distributed to certain providers in rural areas beginning in May 2020. Funds were distributed to eligible sites, totaling approximately $103,253 per site.
19. Funded through the CARES Act ($200 million nationally), the FCC made 30 awards between April and July 2020 to California FQHCs for devices and services related to telehealth.
20. Administered by the Small Business Administration, Paycheck Protection Program Loans were made available to businesses with fewer than 500 employees beginning in April 2020 through the CARES Act (many large FQHCs were not eligible). The program was extended and expanded through the PPPHCEA. The loans, which are forgivable if borrowers meet certain criteria, were meant to incentivize small businesses (including nonprofits) to retain staff on their payrolls. Additional funding and requirements related to this program were added through the Consolidated Appropriations Act of 2021, but it is unlikely that health centers will be eligible for this round of funding.