



Improving Care for California's Older Adults: The Role of Community Health Centers and Public Hospital Systems

JUNE 2022



AUTHORS

Bobbie Wunsch, Rafael Gomez, Laura Hogan, and Marty Lynch

Contents

About the Authors

This report was prepared by Bobbie Wunsch, MBA, founder and partner; and Rafael Gomez, MPP; Laura Hogan, MPA; and Marty Lynch, MPA, PhD, senior health care consultants, with Pacific Health Consulting Group. **Pacific Health Consulting Group** provides management consulting services to public sector and community-based health care organizations. With a focus on managed care development and health care delivery service improvement in the California safety net, Pacific Health Consulting Group's clients include community health centers, state and local health agencies, public hospitals, local public Medi-Cal managed care plans, and other organizations that deliver or finance health care services.

About the Foundation

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

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

- 3 Introduction
- 4 The Changing Demographic and Safety-Net Landscape
- 6 Safety-Net Response to the Changing Landscape
- 8 Older Adult Population Needs and Service Models
- 10 Emerging Practices and Percolating Innovation
- 13 Clinical and Business Model Considerations
- 18 Looking Forward
- 19 Conclusion
- 20 Endnotes

Introduction

California's demographics are changing, with the proportion of the state's population age 50 or older increasing at a record pace. Older adults also represent the fastest-growing age cohort receiving care through California's safety-net provider system. As the state's population shifts, so do the care needs for the older adult population, particularly those with low incomes, many of whom are eligible for both Medicare and Medi-Cal (dually eligible enrollees). Dually eligible enrollees are more likely to experience multiple health and social needs compared to the general Medicare population; this complexity calls for tailored and highly coordinated services inside and beyond clinical settings.

While California's community health centers and public hospitals have long provided integrated care to adults, children, and families with low incomes, historically these care settings have not emphasized services specifically focused on older people with low incomes and complex medical conditions. Despite this gap, the community health centers and public hospitals that compose California's safety net are well positioned to provide coordinated, integrated care to this growing group of Californians, given these organizations' unique skill set and culture supporting comprehensive care for complex populations.

This report outlines potential strategies and opportunities to meet the emerging care needs of older Californians with low incomes, describes a range of policy initiatives launching in California that present new opportunities for improved care for this population, highlights findings from a literature review of practices and programs designed to improve access and quality for older adults, and summarizes perspectives and insights from interviews with community health center and public hospital system leaders around emerging approaches and challenges they face in serving older adults with low incomes.

Key Terms

This report includes information about multiple types of safety-net providers. *Safety-net providers* is an overarching term referring to public and nonprofit health care organizations that focus on low-income and vulnerable populations. The report refers to specific types of safety-net providers where relevant. *Community health centers* refers to Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes. Community health centers and FQHCs may be county-affiliated entities or community-based nonprofit entities. *Public hospital systems* include county-affiliated hospitals, FQHCs, and non-FQHC health centers and other programs or services.

While the term *older adults* is often used to refer to people age 65 or older, this report takes a broader view, focusing on adults age 50 or older, given the higher rates of chronic conditions at younger ages for people with low incomes served by safety-net providers. However, much of the data reported are specific to older adults age 60 or older, or 65 or older, and people enrolled in both Medicare and Medi-Cal (dually eligible enrollees). Information on adults age 45 to 64 is included in consideration of the changing needs of adults as they age. Adults of all ages experiencing homelessness, multiple chronic conditions, or functional impairments benefit from a similar set of services to people in the older adult population age 65 or older.

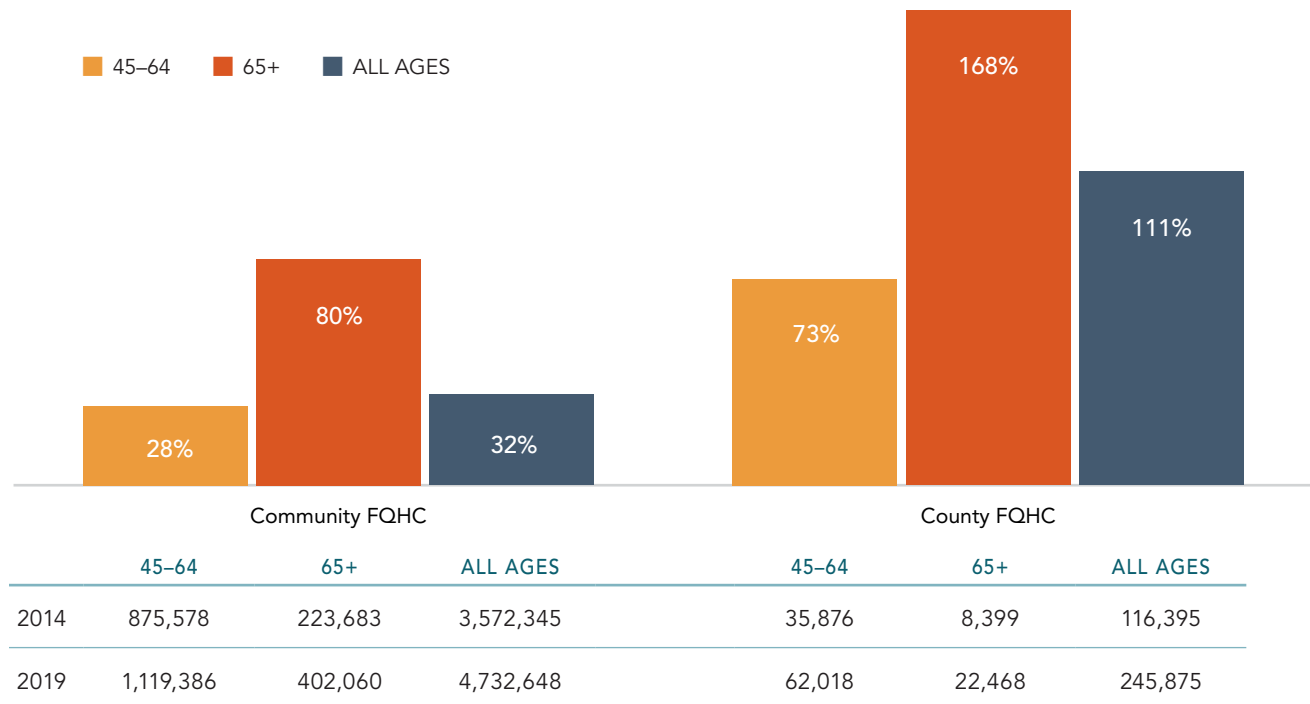
The Changing Demographic and Safety-Net Landscape

In 2020, there were 6.2 million adults age 65 or older in California representing about 15% of the state’s population; this group is projected to total 8.4 million, almost 20% of Californians, by 2030.¹ The increasing senior population is driven largely by baby boomers, who began to reach age 65 in 2011. The largest growth of seniors over the next two decades will occur among those age 85 or older.² This age cohort is projected to grow to almost two million by 2040.³ Currently, the majority of older adults in California are White; however, older Californians will rapidly become more ethnically and racially diverse, resulting in an older adult population that will be majority people of color by 2035.⁴

As part of this trend, the state’s population age 60 or older will be nearly one-third (29%) Latino/x and 16% Asian by 2030.⁵

California safety-net providers are increasingly caring for an aging and more complex patient population. Utilization data for both community and county FQHCs indicate that growth in the number of patients age 65 or older is already occurring.⁶ (See Figure 1.) While older adults still represent a smaller percentage of overall patients served compared to younger age groups, the rate of growth among older adult patients has outpaced these other age groups in recent years.⁷ Between 2014 and 2019, the percentage of community FQHC patients age 65 or older increased from 6.3% to 8.5% of the total patient population, an increase of 80%, compared to a 32% increase among total patients during that period.⁸ The increase among patients age 65 or

Figure 1. Percentage Increase in the California FQHC Patient Population, by Age, Community vs. County, 2014–19



Source: Author analysis of California FQHC data from the 2014 and 2019 “Health Center Program Uniform Data System (UDS) Data Overview,” US Health Resources and Services Administration (HRSA).

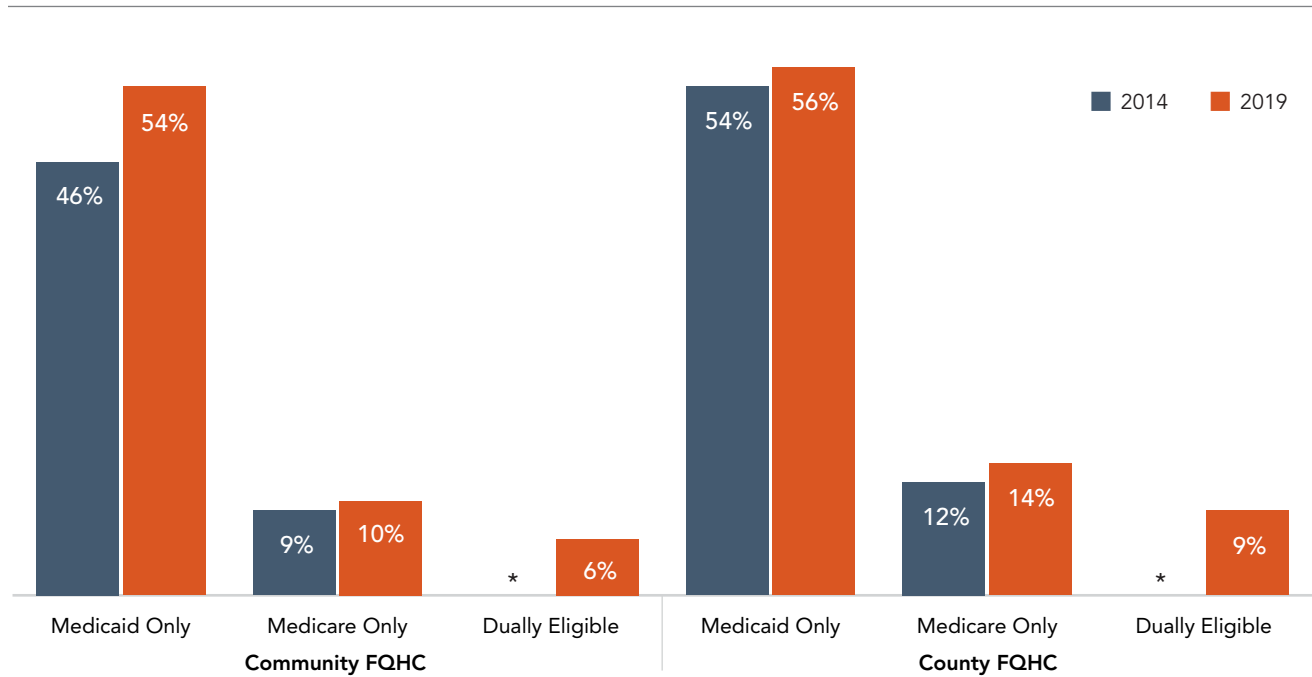
older was the highest among all adult age groups (including age 19 to 44 and age 45 to 64) and also higher than youth (age 18 or younger). While the proportion of patients age 45 to 64 has remained steady since 2014, community FQHCs in California now serve more than 1.1 million patients in this age group — almost one in four patients.⁹

The proportion of county FQHC patients age 65 or older also grew as a proportion of total patients over the five-year review period. In 2014, 7% of patients at county FQHCs were age 65 or older, and this increased to over 9% in 2019.¹⁰ (See Figure 1.) Additionally, in California’s public hospitals, inpatient discharges for patients age 60 or older increased from 21% to 28% between 2014 and 2019. Inpatient discharges with Medicare as the payer also increased from 11% to 18% during the same period.¹¹ As with FQHCs, the significant growth in the percentages of older adults receiving care in public hospitals is noteworthy and likely

reflects longer-term trends driven by demographics; however, the overall number of older adult patients remains relatively small.¹²

Patients eligible for both Medicare and Medi-Cal (dually eligible enrollees) represent the majority of FQHC Medicare patients. Nationally, the percentage of dually eligible enrollees served by FQHCs nearly doubled between 2002 to 2017, from 9.2% to 17.9%.¹³ In California, dually eligible enrollees total 1.58 million statewide.¹⁴ Nearly 6 in 10 (57%) FQHC Medicare patients receiving care in 2019 were dually eligible enrollees.¹⁵ In 2019, county FQHCs had a higher proportion of Medicare patients than community FQHCs (14% compared to 10%) and a higher proportion of dually eligible patients (9% vs. 6%), suggesting greater complexity within the county FQHC adult patient population. (See Figure 2.) Although FQHCs served only 16% of all dually eligible Californians in 2019, this rate varied dramatically by community; in 14 rural counties,

Figure 2. Proportion of California FQHC Patients Age 18+ with Medicaid and/or Medicare, Community vs. County, 2014 and 2019



* Data on dually eligible enrollees not available in 2014.

Source: Author analysis of California FQHC data from the 2014 and 2019 “Health Center Program Uniform Data System (UDS) Data Overview,” US HRSA.

community FQHCs provided care to 40% or more of the dually eligible population in each county.

Safety-net providers are well positioned to care for the multiple needs of dually eligible enrollees.

Dually eligible enrollees are nearly twice as likely to have three or more chronic conditions compared with Medicare-only enrollees. Diabetes, kidney disease, and heart disease are all significantly more prevalent among dually eligible enrollees, as are functional limitations and disabilities such as intellectual disability and mobility impairment.¹⁶ FQHCs also serve higher proportions of dually eligible patients with mental health conditions, substance use disorders, and disabilities than private providers.¹⁷ Although more likely to serve patients with complex needs, California FQHCs meet or exceed overall HEDIS (Healthcare Effectiveness Data and Information Set) performance measures for hypertension and diabetes control, two measures relevant for older adults.¹⁸

Bringing the strengths of safety-net providers more intentionally to the care of older adults may contribute to better health outcomes. Safety-net health care providers, including community health centers and public hospital systems, offer culturally adapted care; integrated physical, oral, and behavioral health services; and a history of support services to address social needs. These attributes may position these settings as high-quality providers for older adults based on their existing strengths. One area of potential opportunity is for community health centers and public hospital systems to serve as providers for Medicare Advantage (MA) health plans, including those specifically aimed at serving dually eligible enrollees (Dual Eligible Special Needs Plans, or D-SNPs). Currently, research shows a high prevalence of social needs among enrollees of MA plans but shows varied and often lower Medicare Star Ratings among MA plans serving dually eligible populations, and suggests that MA plans with better quality ratings include practices that address

both clinical and social needs and offer tailored services and supports.¹⁹ Because community health centers and public hospital systems already provide many of the kinds of integrated clinical and social care that can improve the quality and quality ratings of MA plans, they have the potential to fill an important provider role for MA plans (including D-SNPs) in the future.

Safety-Net Response to the Changing Landscape

The safety-net response to the changing landscape is varied and evolving. A scan of the field was conducted for this report including a review of literature and almost 30 interviews with community health center organizations and associations; public hospital systems including the affiliated county FQHCs; Medi-Cal managed care plan (MCP) leaders; state and federal agency representatives; and aging service and advocacy experts. Findings indicate important perspectives about how safety-net providers are responding to changing patient needs and the extent that these providers have considered, explored, or enacted adaptations to their service and business models.

There is a growing awareness among safety-net providers that patient mix is changing.

Among many safety-net primary care providers, panels of patients age 45 or older are growing while pediatric age groups are declining or stagnant. Even so, the implications of this trend and any action to modify business or operational models has been largely tempered by the overall higher numbers of younger patients and the lack of familiarity with older adult needs and service options. The expansion of specialized services for older patients may also be constrained by the concern that Medi-Cal enrollees who age in to Medicare eligibility may transition to another provider or health plan upon enrolling in Medicare.

Care for older adults is an emerging issue for safety-net associations. The California Primary Care Association and California Association of Public Hospitals and Health Systems indicate that addressing the specific needs of older adults with low incomes is not currently a top-tier strategic priority for members. Health centers, public hospital systems, and Medi-Cal MCPs alike are focused on implementation timelines for ongoing state policy initiatives while simultaneously needing to rebuild basic service delivery infrastructure impacted by the COVID-19 pandemic and, in some cases, climate-related events as well.

There are early signs of federal agency awareness and interest. Interviewees from the federal Bureau of Primary Health Care showed interest in and awareness of the increasing numbers of older adults served in the safety net. They are encouraging health centers to explore models for expanding staffing to increase support for older adults and aging populations, such as hiring geriatricians, piloting new strategies to address social determinants of health for older adults, and modifying payment models to increase quality and reduce cost for dually eligible older adults.

“We are working internally and with partners such as CMS [Centers for Medicare & Medicaid Services] to develop pilots for different populations, including the elderly. The movement towards value-based care could significantly increase support for currently nonreimbursable approaches to care coordination and other patient support services.”

— Jim Macrae, associate administrator,
Bureau of Primary Health Care

California policy initiatives are underway to increase integrated, whole-person care and to address social needs. Through a set of complementary initiatives and state budget proposals, older adults with low incomes will soon have access to an expanded and more coordinated continuum of services. There will be increasing numbers of older adults with Medi-Cal, not only due to demographic shifts, but also because Medi-Cal eligibility expanded to include undocumented adults age 50 or older in May 2022.

The pace and scope of change is ambitious. CalAIM (California Advancing and Innovating Medi-Cal) represents a set of interrelated initiatives, state policy changes, and budget resources in service of its goal to transform the Medi-Cal delivery system. The California home and community-based services spending plan totals \$4.6 billion (federal and state resources), funding efforts across six state departments to ensure older adults and people with disabilities have support to live safely in the community. Related policy changes and flexibilities, such as efforts to modernize payments to community FQHCs and flexible reimbursement for telehealth services, also may influence new models of care for older adults with low incomes.²⁰

Over the next five years, CalAIM sets the stage to expand managed care and to enhance supports for older adults with low incomes through a series of steps:

- ▶ Enhanced Care Management (ECM) and Community Supports launched in 2022 as a new benefit (ECM) and new optional services (Community Supports) through Medi-Cal MCPs, providing high-touch engagement for high-need Medi-Cal enrollees and addressing social needs.
- ▶ In 2023, dually eligible Californians will be enrolled in Medi-Cal MCPs statewide for Medi-Cal benefits.

- ▶ Skilled nursing facility care will be integrated as a Medi-Cal MCP benefit statewide beginning in 2023.
- ▶ Statewide availability of aligned Medi-Cal MCPs and Dual Eligible Special Needs Plans (D-SNPs, a type of Medicare managed care plan) to coordinate all Medicare and Medi-Cal benefits is proposed by 2026. (Rollout begins in seven counties in 2023.)

There is uncharted opportunity for community health centers and public hospital systems to meet the needs of California’s expanding older adult population. The convergence of demographic trends and policy initiatives aimed at improving coordination and quality of care for older adults offers a timely moment for these safety-net providers to consider opportunities and strategies to expand services and to improve care for older adults. Given the central role community health centers and public hospital systems already play as major providers to Medi-Cal MCP members, the potential growth of MCPs and D-SNPs for dually eligible enrollees represents an area of future change and opportunity.

Older Adult Population Needs and Service Models

Whether seeing significant growth in older adults or not, a common experience across most safety-net providers is an increasingly complex patient population. Meeting the needs of this population is an increasing focus for community health centers and public hospital systems. While perhaps not fully embracing the business and practice considerations specific to older adults with low incomes, interviewees did report increasing adaptations to serve adults with higher complexity, such as people experiencing chronic homelessness. Public hospital systems, in particular, have a long history of

servicing high proportions of complex adult patients and offer compelling clinical models to meet the needs of these patients. It is useful to consider how these programs can benefit older adults, given that the needs and service requirements of older adults overlap significantly with those of younger and more complex populations.

Older adults with low incomes present unique clinical and support service needs that raise multiple considerations for safety-net providers. This population can benefit from an increasing array of supportive services as they age, such as case management, community health worker assistance, screening and referrals to address social needs, eligibility and navigation support, and population-specific cultural practices. Given these types of service needs, care models organized to respond to whole-person needs are especially relevant for older adults. Comprehensive care models have historically been the bedrock of community health centers and public hospitals, making them uniquely positioned to care for older adults.²¹ Almost all FQHCs provide behavioral health services and dental services colocated with primary care, and many offer pharmacy and optometry services. Nationally, health centers increased behavioral health staff by 248% over the last 10 years, far outpacing increased staffing in other clinical positions.²²

Importantly, the clinical and support service needs of older adults shift along a continuum as patients age and become more frail. Common aspects of care where safety-net providers could evolve to better support older adults are highlighted in the sidebar “Older Adult Service Needs” (see page 9), and examples of how some California safety-net providers are beginning to address those needs are described in the next section, “Emerging Practices and Percolating Innovation.”

Older Adult Service Needs

- ▶ Longer appointment slots
- ▶ Increased need for physician visits, including from internal medicine physicians and geriatricians
- ▶ Chronic disease management
- ▶ Care management services
- ▶ Access to aligned specialty services, podiatry, cardiology, physical therapy, endocrinology, gastroenterology
- ▶ Aligned ancillary services, such as pharmacy and imaging
- ▶ Behavioral health services
- ▶ Dental services
- ▶ Polypharmacy / medication reconciliation
- ▶ Targeted support, such as transportation, isolation-reducing services, partnership with housing programs

Care model. As patients age or have more complex needs, the core primary care model must evolve, including who provides primary care, how services are structured, and how to expand care coordination, care management, and support services for social needs. Primary care for older adults becomes more physician dependent and may require longer appointment times due to the prevalence of multiple chronic conditions, cognitive impairment, and other disabilities.

Clinical services. Beyond primary care support, older adults require and use a more comprehensive range of clinical services. Dental and behavioral health services are a particular need among older adults with low incomes and are offered in most community health centers. A broad array of complementary clinical specialties, such as podiatry, cardiology, physical therapy, endocrinology and gastroenterology, behavioral health, dental services, medication reconciliation, and links to home

health and long-term services and supports are also important.

Support services. Care coordination for older adults is an essential and intensive service to support effective navigation across multiple providers addressing medical, dental, behavioral health, long-term services and supports, and social needs. As patients age, support services outside traditional health care are essential. Providers must organize a range of supports, whether through community partnerships or internal services, to meet the needs of older adult patients. These supports include services such as Medicare enrollment, transition and navigation support, transportation, programs to increase social connections and reduce isolation, services to address food insecurity, and support for housing and social services.

Service settings. The prevalence of functional or mobility limitations among older adults means that providers should consider the settings and facilities where they deliver care to this population. This may mean redesigning waiting rooms, exam rooms, and other clinic settings to be physically and socially welcoming for older adults. The equipment and facilities to accommodate older adults with limited mobility include powered, accessible exam tables and larger corridors and rooms for easy wheelchair use. Older adults can often benefit from the use of remote monitoring and telehealth services, although support may be required to use these services.

Market expansion. Some safety-net providers are examining the local Medicare marketplace to explore ways to retain patients and reach new patients. Providers describe scanning for the market penetration of Medicare Advantage (MA) and identifying local plans, determining the level of Medicare fee-for-service (FFS), assessing patient needs and market gaps, and developing a strategy that aligns MA contracting and patient recruitment. As adults age in to Medicare, they typically receive myriad and

confusing communications from government programs, health care systems, and health plans. Taking initiative to raise awareness that older adult patients can stay with their safety-net provider after Medicare enrollment, coupled with support for Medicare enrollment through trained staff and relationships with insurance brokers, are underutilized “low-hanging fruit” patient retention strategies for safety-net providers. The recent Medi-Cal expansion to undocumented adults age 50 or older is yet another factor for considering expansion of safety-net providers’ efforts to attract and retain older adults.

Emerging Practices and Percolating Innovation

Promising strategies and models of care tailored to older adults with low incomes have begun to percolate across the California safety net, building on the strengths and history of safety-net providers. Practices span the continuum of care for the most frail and vulnerable adults of all ages, to adapted primary care strategies for older adult patients with lower acuity and social needs. Given the demographic, health care utilization, and policy trends, planning for a deeper and broader response to the needs of older adults may be a strategic imperative for safety-net providers over the coming years.

The range of approaches described below highlights varying local context and organizational capacity to provide services along the continuum of needs for older adults.

Older adult clinics are not explicitly organized to serve the frail elderly; rather, they target both adults age 50 or older, as well as people with complex conditions. These programs include internal medicine or family practice physicians focused on the care of adults linked to aligned specialty services, social supports, care management, and facilities conducive to care for this population.

Preparing for Anticipated Growth of Older Adult Population

Marin Community Clinics (MCC) serves residents with low incomes in one of the fastest aging counties in California. In anticipation of the need to serve growing numbers of older adults with low incomes, MCC opened a clinic site explicitly designed to attract and serve adults age 50 or older. The new site pairs internal medicine with select specialty services, allows for longer appointment times, has waiting rooms and exam rooms and tables conducive to older adult needs, delivers targeted enabling services (e.g., transportation), and uses aligned site promotion and marketing strategy to appeal to the older adult community.

Geriatric clinics operate as separate, comprehensive primary care programs staffed by a team usually led by a geriatrician or internal medicine physician and designed to serve higher acuity older adult patients with longer appointments, specialized equipment and senior-friendly facilities, intensive case management, and other support services. Geriatric clinics can serve as a next step on the continuum of care after older adult clinics.

Care coordination and management linked to social needs and services — including population health management, risk-stratified empanelment, and multidisciplinary and home-based care approaches — are essential for older adult services. One payment source for these services is the Medicare Chronic Care Management (CCM) benefit, available within fee-for-service Medicare. CCM provides additional reimbursement to providers caring for people with two or more chronic conditions in recognition of the time required to assess needs, coordinate services, and provide education to support managing chronic medical conditions. CCM services can support addressing some clinical care coordination needs

for older adults but may not enable providers to fully meet social needs. While some FQHCs have chosen to operate CCM using in-house staff and resources, several community FQHCs noted that their health centers lacked the care coordination, staffing, and billing capabilities to advance CCM. They turned to an external vendor contract to deliver CCM and have been pleased and surprised with the interest in the program expressed by patients.

Embedded Care Coordination Services

Adults age 65 or older account for more than 20% of patients at the North East Medical Services (NEMS), an FQHC in San Francisco. NEMS operates an embedded care management model for older and higher-risk patients, including risk-stratified patient panels (by age and gender), an enterprise-wide population care management team, and complementary care coordination and behavioral health management teams. NEMS also offers PACE (Program of All-Inclusive Care for the Elderly) to enable nursing home-eligible patients to live in the community safely and independently. Looking forward, NEMS aims to expand remote patient monitoring and other technology-enabled solutions. They anticipate opportunities to leverage their in-house independent practice association (IPA) and pursue a limited Knox-Keene license to operate a health care service plan to widen resources and tools to care for their patients.

Medication reconciliation programs work to combat use of nonbeneficial medications and to identify potential medication interactions and side effects that can be especially dangerous for older adults. Older adults metabolize drugs at different rates than younger adults and are more prone to drug interactions, given multiple chronic conditions and, frequently, prescribing by multiple specialists. Through medication reconciliation programs, a health center pharmacist or primary medical

provider holistically reviews pharmaceuticals for older patients at least once per year. Patients are asked to bring in all medications to discuss how they are using each one, identify possible interactions between medications, and adjust dosages or change medications.

Enhanced technology is a growing and important component of care for older adults. Technology capacities include more fully using existing electronic health record patient portal and population management capabilities, expanding the use of remote monitoring to manage chronic health conditions without in-person visits, and targeted reliance on telehealth visits for older adults. Considerations related to training and support for older adults to make effective use of technology is considered best practice.

Medicare enrollment assistance that includes navigation and enrollment support as patients age into Medicare coverage is a growing practice in community FQHCs that helps patients and supports continuity of care, while encouraging the patient to remain with the FQHC. Health centers that define retention of patients aging in to Medicare as a goal find there is an increase in older adult patients and reimbursement that serves as rationale to invest in this assistance.

“That is one of the biggest problems with retaining our Medicare patients in community health centers. When our patients reach Medicare eligibility, we don’t do enough to retain them while the Medicare Advantage plans are aggressively marketing to them.”

— Kevin Mattson, CEO, San Ysidro Health

Medicare Enrollment and Retention

Several health center interviewees shared examples of strategies they are using to increase retention of patients as they age in to Medicare:

- ▶ Assign low-intensity but high-touch navigators to outreach, assist with enrollment support and provider selection, and periodically touch base during the first year of care following the Medicare transition.
- ▶ Conduct outreach and education, including “64th birthday” mailings, monthly on-site birthday parties and appreciation events, and events at neighborhood grocery stores to meet with on-site eligibility specialists or independent Medicare insurance brokers.
- ▶ Establish relationships to educate independent brokers about the health center and to provide space on-site for cooperative independent brokers to meet with patients.
- ▶ Expand training of staff benefit consultants to support Medicare enrollment for patients and Medicaid enrollment for those Medicare-covered patients not already on Medicaid.

Primary care at home can be beneficial for some older adults with chronic conditions and functional disabilities. Research indicates these programs fill gaps in care and can be cost-effective by reducing hospitalizations and skilled nursing care.²³ Primary care at home may also be an effective option for attracting and retaining disabled older adults with low incomes because the services are highly valued by patients. Primary care at home can be reimbursable if the patient cannot get to the clinic. In addition, providing these services may be part of an overall cost containment strategy under managed care or other risk-bearing arrangements where the health center benefits by reducing the overall cost of care.²⁴ LifeLong Medical Care and several other centers report operating a primary care at

home program using a team of physicians, nurse practitioners, and case managers, augmented with home-based palliative care when needed. Health centers also report providing health services to patients in skilled nursing facilities and other congregate housing settings.

PACE (Program of All-Inclusive Care for the Elderly)

PACE is a full-risk capitated program of comprehensive services to maintain independence for older adults who would otherwise require institutional care. With full financial risk, PACE can generate meaningful margins but can also expose the organization to potential losses. PACE is an entirely distinct line of business for safety-net providers requiring new facilities, services and providers, and administrative and business infrastructure that translates into start-up costs of several million dollars. The longer-tenured PACE programs at FQHCs report consistent program growth and positive financial margins. PACE may serve as a natural extension of the continuum of care for safety-net providers with large older adult, dually eligible populations. For smaller health centers lacking economies of scale to engage in PACE, partnerships with other FQHCs may be a pathway to provide PACE services. Expansion of PACE by FQHCs is underway throughout parts of Northern, Central, and Southern California.

Geriatric emergency rooms in hospital settings have adapted staff models, facilities, and care protocols, similar to models of separate pediatric and psychiatric emergency settings. Staff have geriatric training, use protocols to screen for cognitive impairment, and operate in a space designed for older adults by reducing ambient noise and distraction. This is an emerging practice intended to improve the experience and care for older adults whose chronic conditions can mean more frequent emergency room visits.

Clinical and Business Model Considerations

Most safety-net organizations have yet to invest in specific older adult services. While a few providers are setting the pace for fully integrated business and programmatic strategies to serve older adults with low incomes, others are at the start of assessing future options for programs, taking initial steps to expand services, or developing an understanding of the implications of changing community needs for their role as service providers.

Stepping more intentionally into care for older adults presents new business and financial considerations and potential opportunities. Safety-net providers have well-defined financial models that currently rely heavily on per visit Medicaid and Medicare prospective payment system (PPS) reimbursement for FQHCs and supplemental Medicaid financing for public hospital systems. Expanding to specialized care models for older adults with low incomes, including both dually eligible enrollees and adults with Medicare only, requires new calculations for productivity and reimbursement, an approach to risk and managed care arrangements, understanding of market share and patient recruitment, and analysis of the role and value of new or different lines of business.

Strategic foresight. A few safety-net providers have acknowledged the increasing numbers of older adult patients and recognize this trend will continue. For this group, it is clear that the safety net is well positioned to offer integrated social and clinical care and that there is strategic value in developing integrated financial, service, and business strategies at the organizational level to attract and retain older adults with low incomes. These providers have adopted varied approaches based on local context and organizational vision and demonstrate a willingness to leverage managed care and expand risk as a part of their older

adult strategy. For example, some providers are participating in risk-based contracts through IPAs to maximize value-based payments. A few health center organizations operate or are developing PACE services and incorporating clinical and long-term services and supports to allow those who would otherwise require institutional care to remain safely in the community. Others are contracting with Medicare Advantage (MA) plans, actively recruiting MA enrollees, offering Medicare enrollment support, and maintaining relationships with local health insurance brokers.

Expanding the Continuum of Care for Older Adults

AltaMed, based in Los Angeles, is a large FQHC serving more than 325,000 patients. AltaMed has long-standing experience delivering PACE services. Primary care for older adults, however, has been embedded within general medicine clinics and teams. More recently, internal leadership is taking a different view. “The fact is that we recognize that PACE is in a continuum. We want to be able to offer that middle part of the journey, which is why the senior clinic strategy becomes so critical,” says Lourdes Birba, vice president of Aging Services and Product Development. AltaMed is adapting its care model across the enterprise to incorporate longitudinal care management, transformed care teams, longer appointment times, and programmatic tiering based on need and complexity. AltaMed is initiating separate older adult medicine clinics at two sites, to be expanded based on experience.

Deliberate movers. A second group of safety-net providers is making steady progress to deepen and expand services for increasingly complex and aging patients. Interviewees in this group flagged incremental steps across a range of strategies to increase the number of older adults served, such as implementing older adult clinics, conducting a feasibility plan for PACE, expanding in-house specialty services, and hiring geriatric provider staff. In addition, interviewees mentioned steps to evaluate facility and equipment to match the needs of older adults, as well as strengthening knowledge and expertise to maximize billing, contracting, and financial performance. Some FQHCs are establishing MA contract relationships and Medicare Chronic Conditions Management (CCM) contracts for traditional (fee-for-service) Medicare patients. Still others are conducting outreach to patients aging in to Medicare.

Chronic Care Management

The far northern California communities served by Shasta Community Health Center (SCHC) have been home to more older adults than many other California communities. To meet local needs, the clinical model for SCHC leans more on physician providers than many FQHCs. Competing demands and constant workforce shortages have limited programmatic attention on older adults. In the last year, however, SCHC secured a contract with an outside vendor to manage the Chronic Care Management (CCM) program, a reimbursable care coordination benefit for Medicare FFS enrollees. The program, which has attracted significant patient participation, provides phone-based assistance and navigation. “The navigational aspect of this is what people are really welcoming. They are having difficulty connecting to some of the resources, and this helps,” stated Dean Germano, CEO of Shasta Community Health Center.

At the starting line. A third and larger group of organizations has yet to elevate the strategic importance of an older adult strategy or simply lacks the bandwidth to develop new capacities. Rural health centers interviewees noted they have historically served large older adult populations. For example, the majority of health centers in rural Northern California (12 of 15) report that 15% of total patients served in 2020 were age 65 or older.²⁵ But many of these organizations face multiple challenges and workforce shortages that make it more difficult to take significant steps to expand care or to implement new business strategies for older adults in the immediate future. Some acknowledged putting their efforts to increase older adult services on hold in the face of a steady stream of crises over recent years.

Many community health centers and public hospital systems recognize that it takes effort and planning to understand local trends, explore the business drivers, and develop the relevant organizational considerations before any strategy implementation for older adults with low incomes. Although the immediate future may be challenging, beginning a dialogue with community-based aging organizations, elder advocates, and community leaders may offer an opening for incremental steps forward. Interviewees also raised a partnership model with other safety-net providers as a viable option to address the lack of scale that is a barrier for some providers to sustain services for older adults with low incomes.

“FQHCs need to be looking at the demographics in their community to see how it is changing and to better understand what the demographics are showing. The second important thing is looking at their operations and capabilities to treat an older population.”

— Jim Macrae, associate administrator,
Bureau of Primary Health Care

Public hospital systems as clinical leaders. Public hospital representatives highlighted a long history of serving patients age 25 to 64 with multiple and complex needs. However, most of these interviewees indicated their organization does not have a corresponding strategic or business focus specific to older adults. In part, this is related to complex financing issues, discussed in the “Public hospital systems” subsection on page 17. Maximizing revenue through funding streams tied primarily to Medi-Cal, such as supplemental payments provided to hospitals serving a high proportion of Medicaid and uninsured patients, is a significant driver of the way services are delivered and impacts organizational strategy. Representatives from most public hospitals interviewed indicated they do not have MA contracts, and as a result, patients that age in to Medicare and enroll in an MA plan must change providers. Public hospital systems also recognize that supplemental payments are unsustainable, and they need a stronger, more secure financial footing — which could be fostered in part through changes to payer mix.

There are pockets of innovation, however. Interviewees noted that even without an articulated older adult business strategy, they maintain a small and steady role in older adult care and are clinically well suited to do more. Public health care systems often have expansive internal medicine and geriatric clinical staff and a track record serving adults with low incomes experiencing complex health and social needs, such as homelessness and serious mental illness. As integrated systems of outpatient, inpatient, primary, and specialty care, public hospitals can develop multiple elements of a continuum to attract older adults with low incomes, including many of the models described above. Some public hospitals, including Zuckerberg San Francisco General Hospital and Trauma Center, have participated in efforts to improve the quality and experience of older adults by developing geriatric emergency departments. Through training,

residency rotations, leadership opportunities, care management practices, and facility improvements, geriatric emergency departments provide age-friendly care and transition services after discharge from emergency care to reduce the number of hospital readmissions post-emergency.

Complex Care in Public Systems

Zuckerberg San Francisco General Hospital and Trauma Center (ZSFGH) has an ambulatory care service model in their clinics responsive to the needs of more complex populations, including older adults. This includes complex care management, behavioral health, and social workers. Susan Ehrlich, MD, CEO of ZSFGH, noted, “The services that we have already incorporated into our care model to address complex social, behavioral, and medical needs are critically important for older adults.” ZSFGH was also the only public hospital system interviewed that reported that it is on the path to becoming certified as having a geriatric emergency department.

Outpatient productivity and reimbursement. For FQHCs, traditional financial sustainability is rooted in Medi-Cal as the primary payer, relying on clinical productivity and a cost-based PPS rate sufficient to sustain needed services. FQHCs receive full Medi-Cal PPS rate reimbursement for dually eligible patients. Visits for Medicare-only patients are reimbursed at the Medicare PPS rate, which is less than the Medi-Cal PPS rate. Older patients present with more complex needs, resulting in lower clinical productivity and increased care coordination that PPS rates may not fully cover. According to interviewed health center leaders and available data, most FQHC patients age 65 or older are dually eligible, but this can vary by community. Rural health centers serve a broader segment of the older adult community than their urban counterparts, which means more Medicare-only patients.

Care models and services for older adults also present new opportunities for generating revenue. As the proportion of Medicare and dually eligible patients grows, health centers will be increasingly pushed to reevaluate reimbursement strategies, deepen Medicare billing and financial expertise, and leverage multiple revenue sources. Some options include:

- ▶ Implementing Medicare CCM to gain reimbursement for care coordination for older adults enrolled in FFS Medicare via an internal staffing or outsourcing model.
- ▶ Leveraging FQHC pharmacy revenue through the 340B Drug Pricing Program to enhance overall revenue, given that medication prescriptions are notably higher among older patients. The 340B Drug Pricing Program allows eligible health care clinics and hospitals to purchase outpatient drugs at a 20% to 50% discount and to reinvest savings into expanded clinical programs.
- ▶ Expanding MA contracts with competitive capitation rates and Star Rating quality incentives that strengthen sustainability. Some health centers are elevating their contracting and billing office expertise to understand and leverage these opportunities. With a large enough MA panel, health centers are in a better position to negotiate favorable MA contracts including risk-sharing arrangements.
- ▶ Forming a continuum of approaches with an overall revenue strategy. For example, older adult clinics or geriatric clinics may serve as meaningful sources for referrals into health center–led PACE programs. Within public hospital systems, outpatient clinics may serve as attractive feeders to specialty or hospital services. New lines of business, such as PACE, can present strong revenue generation that offset other outpatient losses.

Managed care and risk. The role of managed care in serving older adults with low incomes is expected to increase over time, as CalAIM requires Medi-Cal managed care plans to offer D-SNPs available to all dually eligible enrollees by 2026. Although the timeline may shift, the long-term intention of increasing enrollment in aligned Medi-Cal and Medicare plans appears clear. This represents a natural opportunity for safety-net providers already central in Medi-Cal managed care networks.

California’s diverse communities vary in the portion of their Medicare populations enrolled in MA and those remaining in FFS. Local prevalence of MA alongside provider interest and expertise in managed care risk defines the relevance of this marketplace for safety-net providers. Some providers are exploring aligned managed care and risk strategies for older adult services to incorporate the additional costs of care coordination into revenue and also to improve health outcomes. This includes using health center–controlled IPAs and networks to contract for Medicare lines of business, which can contribute positive net income that may be used for expanded and more flexible services for enrollees. Whereas Medicare accounts for a small subset of safety-net patients currently and thus often does not merit significant organizational attention and resources, the strategic importance of managed care and risk strategies may increase in safety-net systems as the number of Medicare patients grows and networks evolve.

Public hospital systems. Public hospital systems face unique challenges around Medicare reimbursement due to their dedicated resource streams. California public hospital operations and systems are designed to maximize Medi-Cal reimbursement, track and report supplemental payments provided to hospitals serving a high proportion of Medicaid and uninsured patients, and maintain their mission to serve primarily Medi-Cal and uninsured patients. Often these are not the same strategies required to participate at scale in Medicare risk-based reimbursement.

Likely in response to multiple factors, including supplemental payments and Medi-Cal waiver funding, historical service patterns, and internal strategic choices, California public hospitals have not prioritized services to dually eligible enrollees and other Medicare enrollees and often report no financial advantage in any available Medicare revenue options. Despite the dedicated clinical staff and history with socially complex patients, interviews did not reveal specific business or financial strategy to translate these existing strengths into a focused area of growth for the expanding older adult population. There are indications from some public hospital leaders that the time has come for modifying this position, as recent trends indicate rising percentages of patients age 60 or older. In addition, the current reliance on specialized funding streams, like supplemental payments, may decline as more older adults served by public hospitals are enrolled in managed care, and public systems are considering how a move to capitation will change operations and revenue streams. Diversifying their payer mix, including dually eligible enrollees, may provide more sustainable and stable sources of funding over time.

Changing the operational and clinical care models honed for success under current reimbursement policy will require lead time, different accounting supports, and perhaps a new context for defining

provider productivity. One public hospital leader noted they recently purchased cost-accounting systems that will track productivity and costs for the first time.

Interviewees spoke to internal shifts toward strategy to build expertise and systems that will retain dually eligible enrollees, initiate risk-based Medicare contracts, and tailor services to the needs of older adults with low incomes. Public hospital representatives also referenced the expansion of Medi-Cal to older undocumented adults as a shift that may spur rethinking of multiple dynamics.

Public hospital systems have financial expertise, administrative resources, and clinical depth that position them well for success. They also may have untapped resources for building new service models in underutilized facilities and campuses no longer in service and often in communities where older adults live.

Taking stock. Financial and risk strategies are undergoing change, and the resulting impact is not yet clear. In the near term, some health centers are likely to move from prospective payment systems to a new alternative reimbursement method, and the future of public hospital reimbursement is also under scrutiny. As California's safety-net care delivery landscape evolves in coming years, stakeholders concerned with providing high-quality health care and supports to older adults with low incomes should consider the following questions: How will future policy and reimbursement intersect with demographic trends and changing patient populations? How will safety-net providers succeed under new benefits and services while retooling billing and financial systems? And perhaps most important, how will multiple, simultaneous system changes impact the ability of providers to innovate and expand programs for the growing older adult population?

Looking Forward

This report documents demographic, health care utilization, and policy trends to elevate the growing need and opportunity to expand targeted and tailored care models for older adults with low incomes in community health centers and public hospital systems. There are multiple care models and service options to consider, and safety-net providers should explore them within the local health and social services context before proceeding. Below, four steps are outlined to guide analysis and decisions about various older adult services and alternatives.

Community assessment. Conduct a local scan and data analysis to gain an understanding of the existing continuum of services and to assess data about older adults with low incomes at the zip code level. This will offer a big picture view of the current size, projected characteristics and the associated needs of local populations of older adults and older adults with low incomes.

Business assessment. Research the current local health care market for older adults with low incomes, including the number of MA plans in the area and the provider networks associated with each plan. The findings will inform an analysis of financial and operational options. Learning about existing and planned D-SNPs is perhaps more challenging to uncover yet is critical to future revenue analysis. Identifying and developing relationships with other community organizations supporting older adults may offer insights into the needs and gaps in the current system. Finally, insurance brokers providing Medicare navigation may be another source of information about the patterns and business arrangements in place locally. Making sense of the organizational players and financial contracting options currently and into the future are important elements of assessing the overall opportunity.

Organizational capacity. A separate, internally facing assessment should consider organizational capabilities and gaps for various service models and scenarios. A careful assessment of the clinical, business, and strategic alignment that might be required to expand discrete program elements or launch totally new lines of business to serve older adults is likely a team exercise across multiple departments of the organization. It may require underlying assessment of workforce challenges, financial position, experience with risk-based contracts, and whether the organization has recently launched other strategic initiatives.

Phased approach. For many of the emerging practices identified, starting small and building expertise over time is a good practice. This approach can focus on services or programs that may be newly targeted to older adults but are within established organizational capacities, such as Medicare enrollment. Unless significant capital is available and a specific clinical and business strategy has been identified, options that expose the organization to risk, such as a PACE program, are best launched after a period of experience.

Conclusion

Community health centers and public hospital systems have an important role to play in the care of older adults with low incomes. California policy and rapidly changing demographics are key drivers of opportunity to supporting the integration of services needed for older adults to live safely in the community. The growing number of older adults served in safety-net systems offers a compelling case for health centers and public hospital to assess and expand services dedicated to older adults with low incomes by building on core capacities for complex clinical, behavioral, and social needs. Many safety-net providers have begun to respond with innovative practices that marry their strengths to the rapidly changing demographics and contribute positively to the care available for older adults. Primary care that incorporates technology and seamlessly links social supports is a logical fit for health centers.

An aging and diverse California calls for safety-net providers to respond and grow as critical providers of care for older adults with low incomes. Forging stronger alliances and shared purpose between advocates for older adults, policymakers, and health centers with interest in developing more extensive models of care may serve to accelerate progress. By working together, these stakeholders can ensure that the existing strengths of safety-net providers — such as cultural and language capacity, integrated medical, behavioral health, and oral health services, team-based models of care, and other services to address social needs — are employed to deliver a system that supports health and well-being for an older and more racially diverse California.

Endnotes

1. Jen Joynt, *Long-Term and End-of-Life Care in California, 2020: Is California Meeting the Need?*, California Health Care Foundation (CHCF), June 2020.
2. “**Facts about California’s Elderly**,” California Dept. of Aging.
3. *Long-Term and End-of-Life Care*, CHCF.
4. Nina Ebner and Nari Rhee, *Aging California’s Retirement Crisis: State and Local Indicators* (PDF), UC Berkeley Labor Center, October 2015.
5. “Appendix G,” in *California State Plan on Aging, 2017–2021* (PDF), California Dept. of Aging.
6. “**Office of Medicare Innovation and Integration: Data and Information**,” California Dept. of Health Care Services (DHCS), last updated February 2022; Amber Christ and Georgia Burke, *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, CHCF, September 2020; and author analysis of 2014 and 2019 **Health Center Program Uniform Data System (UDS) Data Overview** from the US Health Resources and Services Administration. While UDS data from 2020 were reviewed for this report, due to the multiple impacts of the COVID-19 pandemic on health care use and delivery in 2020, this report presents 2014–19 data as a more reliable comparison period for analysis of trends.
7. Author analysis of UDS data.
8. Author analysis of UDS data.
9. Author analysis of UDS data.
10. Author analysis of UDS data.
11. Author analysis of California hospital patient discharge data from 2014 and 2019 from “**Hospital Inpatient - Characteristics by Facility (Pivot Profile)**,” California Health and Human Services Open Data Portal.
12. Author analysis of California hospital discharge data.
13. Sandra Decker, “**CHCs and the Health Care Safety Net - Dual Eligibles and Those Medicaid-Eligible Due to Disability Are Most Likely to Use Community Health Centers**” (APPAM 42nd Annual Fall Research Conference, online, Nov. 11–13, 2020).
14. “Office of Medicare Innovation and Integration,” DHCS.
15. Author analysis of UDS data.
16. Christ and Burke, *Primer*.
17. Tara A. Lavelle et al., “**Utilization of Health Care Services Among Medicare Beneficiaries Who Visit Federally Qualified Health Centers**,” *BMC Health Services Research* 18, no. 41 (Jan. 25, 2018).
18. Author analysis. Diabetes: Diabetes population with HbA1c under control (HbA1c ≤ 9%); Hypertension: Hypertension population with blood pressure under control (≤ 140/90 mmHg); California HEDIS: Statewide Medi-Cal managed care weighted average performance measure results; FQHC source: author analysis of UDS data; and HEDIS source: *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* (PDF), vol. 1, Main Report, DHCS, June 2020.
19. Melony E. Sorbero et al., *Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies*, RAND Corp., 2018; and Charron L. Long et al., “**Health-Related Social Needs Among Older Adults Enrolled in Medicare Advantage**,” *Health Affairs* (Millwood) 41, no. 4 (Apr. 2022): 557–62.
20. *Time to Modernize Payment to Health Centers: How Old Rules Jeopardize Patients During the COVID-19 Pandemic*, CHCF, June 2020.
21. *Community Health Center Chartbook*, National Association of Community Health Centers (NACHC), 2021.
22. *Chartbook*, NACHC.
23. Christine Ritchie et al., *Medical Care at Home Comes of Age*, CHCF, January 2021; and Sarah Klein, Martha Hostetter, and Douglas McCarthy, *An Overview of Home-Based Primary Care: Learnings from the Field*, Commonwealth Fund, June 2017.
24. Ritchie, *Medical Care at Home*.
25. Author analysis of UDS data.