RESEARCH LETTER

Changes in In-Person, Audio-Only, and Video Visits in California's Federally Qualified Health Centers, 2019-2022

Federally qualified health centers (FQHCs) provided outpatient primary care to approximately 30 million low-income individuals in 2021.[1] Prior to March 2020, FQHCs rarely received reimbursement for telehealth services delivered into patients' homes. However, pandemic-related regulatory waivers allowed many payers to reimburse FQHCs the same rate for in-person, audio-only, and video visits. Most visits delivered by California FQHCs in 2020 were audio only.[2] Little is known about the evolution of audio-only visits as FQHCs gained experience with video visits. We describe visit trends among California FQHCs from 2019 to 2022.

Supplemental content

Methods | This study builds on prior analyses of an initiative to support telehealth implementation and presents new data through August 2022.[2,3] Federally qualified health centers submitted aggregated data on billable in-person and telehealth (video and audio-only) visits from February 2019 to August 2022.

We estimated linear regression models of visits, controlling for the number of patients seen in the FQHC each year and FQHC and month fixed effects. After estimation, we produced adjusted monthly visits by visit type (in-person, video, and audio-only) allowing for pairwise comparisons of months. We present changes in total visits for primary care and behavioral health comparing February 2020 (prepandemic) to August 2022 (pandemic) and highlight adjusted visit rates by visit type focusing on the pandemic period only (April 2020 to August 2022). Statistical significance was defined as a 2-sided $P < .05$. Analyses were conducted using Stata version 17.0 (StataCorp) and the study was declared exempt by RAND's institutional review board.

Results | Thirty multisite FQHCs that served 1.3 million patients in 2021 provided data (**Table**). Per 1000 patients, total adjusted primary care visits increased by 8.5% from February 2020 to August 2022 (from 252.94 to 274.47 visits; difference, 21.52 [95% CI, 15.22-27.83] visits; $P = .06$), and total behavioral visits increased 23.3% (from 41.53 to 51.22 visits; difference, 9.69 [95% CI, 3.45-15.92] visits; $P = .004$) (**Figure**).

For primary care, in-person visits per 1000 patients increased between April 2020 and August 2022 (from 69.19 [95% CI, 61.02-77.36] visits to 195.86 [95% CI, 186.22-205.50] visits); audio-only visits decreased (from 154.81 [95% CI, 145.76-163.85] visits to 58.79 [95% CI, 48.13-69.46] visits), and video visits increased (from 8.77 [95% CI, 0.0-8.99] visits to 19.81 [95% CI, 11.50-23.96] visits). For behavioral health, in-person visits per 1000 patients increased between April 2020 and August 2022 (from 10.02 [95% CI, 7.18-12.85] visits to 19.17 [95% CI, 16.32-22.02] visits), audio-only visits decreased (from 37.85 [95% CI, 34.63-41.07] visits to 20.15 [95% CI, 16.92-23.39] visits), and video visits increased (from 3.95 [95% CI, 0.00-5.03] visits to 11.89 [95% CI, 8.99-15.01] visits). Audio-only visits peaked in April 2020 for primary care and in March 2021 for behavioral health. For primary care, the proportion of in-person visits increased from 29.7% to 71.4%, audio-only visits decreased from 66.5% to 21.4%, and video visits increased from 3.8% to 7.2%. For behavioral health, the proportion of in-person visits increased from 19.6% to 37.4%, audio-only visits decreased from 74.2% to 39.3%, and video visits increased from 7.7% to 23.2%.

Table. Characteristics of Participating Health Centers[a]

Characteristics	Participating health centers, No. (%) (N = 30)
Type of health center	
FQHC	24 (80.0)
FQHC lookalike[b]	3 (10.0)
Public hospital FQHC	3 (10.0)
Region in California	
Northern	7 (23.3)
Central	6 (20.0)
Southern	17 (56.7)
Total unique patients in 2019	
≤9999	3 (10.0)
10 000-49 999	17 (56.7)
50 000-99 999	8 (26.7)
≥100 000	2 (6.7)
Patient characteristics, mean (SD), %	
Racial or ethnic minority[c]	80.1 (21.5)
Medicaid or dual eligible	63.4 (10.8)

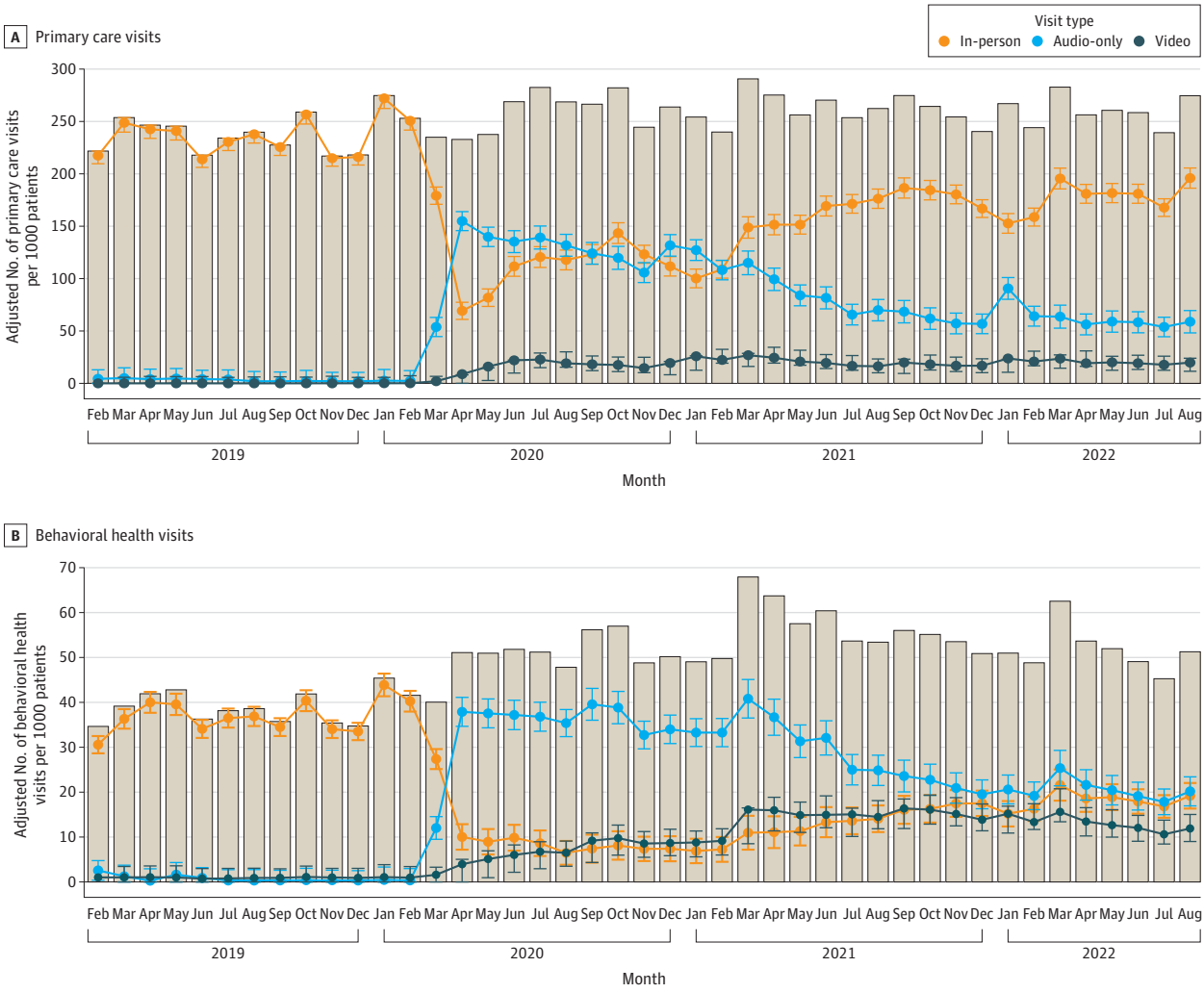
Abbreviation: FQHC, federally qualified health center.

[a] Data are presented for the 30 health centers that participated in data collection through August 2022 and exclude 11 health centers (26%) that contributed data in prior publications covering February 2019 to August 2021 and dropped out due to reporting burden. The current cohort of 30 health centers is similar to the original cohort (n = 41) on key characteristics, including size, location, and patient demographics.

[b] FQHC lookalikes are community-based clinics that meet the requirements of the Health Resources and Services Administration Health Center Program but do not receive Health Center Program funding.

[c] Racial or ethnic minority was defined as individuals who self-identified as Alaska Native, American Indian, Asian, Black or African American, Hispanic or Latino, Native Hawaiian, Pacific Islander, other non-White race, or more than 1 race. Race and ethnicity data are reported to the Health Resources and Services Administration annually as part of mandatory reporting and are shown here to provide detail on the patient populations served by FQHCs in the sample.

Figure. Adjusted Primary Care and Behavioral Health Visits per 1000 Patients, by Visit Type, February 2019 to August 2022



Bars represent the adjusted mean total visits per 1000 patients (adjusting for clinic and month fixed effects using a generalized linear model with a log link and gamma function). The denominators varied based on the period: for each year, we used the total number of unique patients seen per clinic per year, except for 2022, for which we used the unique patients seen in 2021. The adjusted visits by visit type sum to the total number of visits and were derived after estimation; whiskers indicate 95% CIs. Primary care visits were defined as visits delivered by primary care clinicians, including physicians (internal medicine, pediatrics, and family practice), nurse practitioners, and physician assistants. Behavioral health visits were defined as visits delivered by specialty behavioral health clinicians credentialed by the health center. For behavioral health, 2 health centers were excluded because they did not deliver behavioral health visits throughout the entire study period. During the pandemic period (April 2020 to August 2022) across all federally qualified health centers in the sample, there was a mean of 301 052 visits per month for primary care and 34 031 visits per month for behavioral health.

As of August 2022, 16 FQHCs (53%) had never adopted video visits or had phased them out completely, and 4 (13%) had discontinued audio-only visits for primary care. For behavioral health, 7 FQHCs (25%) had no video visits and 6 (21%) had discontinued audio-only visits.

Discussion | More than 2 years into the COVID-19 pandemic, 1 in 5 primary care visits and 2 in 5 behavioral health visits were audio only in this sample of FQHCs in California. Although audio-only visits decreased over time, FQHCs continued to deliver audio-only visits in high volume, likely because of their role in improving access. Within primary care, the decline in audio-only visits from the early pandemic peak appears to coincide with the return of in-person visits rather than growth in video visits. Study limitations include that only FQHCs in 1 state were tracked.

California FQHCs increased or maintained their visit volume with the transition to telehealth despite workforce loss.[4] Telehealth likely improved the productivity of remaining staff.[5]

Many FQHCs implemented promising practices to expand video visits, and video visits increased over time, particularly for behavioral health. Nonetheless, FQHCs continued to rely on audio-only visits, likely due to clinician- and

patient-related barriers to video telehealth.[3] In 2022, California Medicaid granted FQHCs permanent payment parity for audio-only visits.[6] Thus, FQHCs do not have a financial incentive to limit audio-only visits, and they are likely to remain widespread in coming years. More research is needed on the effectiveness of audio-only visits to inform their use in safety net settings.

Lori Uscher-Pines, PhD, MSc
Colleen M. McCullough, MPA
Jessica L. Sousa, MSW, MPH
Sarita D. Lee, BS
Allison J. Ober, PhD
Diana Camacho, MPH
Kandice A. Kapinos, PhD

Author Affiliations: RAND Corporation, Arlington, Virginia (Uscher-Pines, Kapinos); RAND Corporation, Santa Monica, California (McCullough, Lee, Ober); RAND Corporation, Boston, Massachusetts (Sousa); California Health Care Foundation, Oakland (Camacho).

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Corresponding Author: Lori Uscher-Pines, PhD, MSc, RAND Corporation, 1200 S Hayes St, Arlington, VA 22202 (luscherp@rand.org).

Author Contributions: Dr Uscher-Pines had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Concept and design: Uscher-Pines, Ober, Camacho, Kapinos.
Acquisition, analysis, or interpretation of data: Uscher-Pines, McCullough, Sousa, Lee.
Drafting of the manuscript: Uscher-Pines, Sousa, Lee, Kapinos.
Critical revision of the manuscript for important intellectual content: All authors.
Statistical analysis: McCullough, Lee, Kapinos.
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Supervision: Uscher-Pines, McCullough.

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Data Sharing Statement: See the Supplement.

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Reconciliation Payments in the Bundled Payments for Care Improvement Advanced Program and Reductions in Clinical Spending Needed for CMS to Avoid Financial Losses

The Bundled Payments for Care Improvement Advanced (BPCI-A) program is designed to encourage reductions in clinical spending and generate financial savings for the Centers for Medicare & Medicaid Services (CMS). Participating hospitals and physician groups select from inpatient and outpatient bundles of care "episodes" that last from an index encounter to 90 days after discharge. For each bundle, participants are assigned a target price for episode spending. Participants receive positive reconciliation payments (bonuses) if spending is below their target or owe negative reconciliation payments (penalties) if spending exceeds their target. For CMS to avoid financial losses, reductions in clinical spending must equal or exceed the sum of reconciliation payments paid to participants.

Supplemental content

CMS does not publicly report data on reconciliation payments. Little is known about the magnitude of reconciliation payments and the implications for CMS savings. This study examined the magnitude of reconciliation payments and clinical spending reductions necessary for CMS to break even in the first 4 performance periods of the BPCI-A.

Methods | Data on target prices, case volume, and reconciliation payments for hospitals and physician groups participating in the BPCI-A for performance periods 1 (beginning October 1, 2018) through 4 (ending December 31, 2020) were acquired through a Freedom of Information Act request. Adjustments to reconciliation payments based on quality performance and accountable care organization participation were incorporated in performance periods 1, 2, and 3. While these adjustments were not available for performance period 4, this should have had no material effect on results (ρ = .99 between adjusted and unadjusted reconciliation in performance period 1). To capture CMS spending expectations if the BPCI-A had not been implemented, mean target prices were inflated by the 3% discount rate embedded in program rules and weighted by bundle episode volume. To estimate the reduction in clinical spending required for CMS to break even, we divided mean reconciliation payments per episode by CMS expectations of spending per episode if the BPCI-A had not been implemented (eMethods in Supplement 1). Analyses were performed at the participant-performance period level and conducted using Stata version 17.0 (StataCorp).

Results | Hospital participation increased between performance periods 1 (712 hospitals; 146 697 episodes) and 4 (753 hospitals; 97 633 episodes), while physician group participation decreased (from 495 physician groups [116 963 episodes] to 388 physician groups [58 000 episodes]) (**Table**). Reconciliation payments were $313.0 million (95% CI, $275.7 million to $350.4 million) in performance period 1 (hospitals, $221.3 million; physician groups, $91.7 million); $284.8 million (95% CI, $252.8 million to $316.7 million) in performance period 2 (hospitals, $179.9 million; physician groups, $104.8 million);