

medicaid and the uninsured

August 2010

Community Health Centers: Opportunities and Challenges of Health Reform

Introduction

The enactment of comprehensive health reform¹ will bring about important changes to the health insurance and health care delivery systems. Community health centers² will play a role in implementing many health reform provisions and in providing access to care for millions of Americans who will gain health insurance coverage under the law. To meet this new demand for services, particularly in underserved areas, the health reform law makes a significant investment in the expansion of health centers and also introduces important changes in health care delivery while strengthening efforts to improve community and population health.

Health reform brings major shifts in the health insurance status of health center patients. Increasing access to affordable insurance, coupled with the law's emphasis on greater clinical integration and health care innovation lays the groundwork for far-reaching changes over time in how health centers deliver care and develop affiliations with other providers as well as with community-wide prevention efforts. The transformation has already started. Most health centers once operated independently, but the advent of Medicaid managed care (which depends on networked providers) coupled with the growth of information technology has led to the formation of at least 83 health center networks.³ These networks allow multiple health center grantees to integrate financial and in some cases clinical services as well as develop their service capacity on a regional basis.⁴ Similarly, the growing proportion of patients with significant physical and mental health conditions, as well as the aging of the population, has led health centers to deepen the range of services they furnish and enter into increasingly comprehensive service delivery arrangements.

Despite coverage expansions and improvements to the health system, health reform will leave an estimated 23 million persons without access to affordable coverage, so health centers will likely continue to play a central—and perhaps increasingly critical—role in caring for the uninsured. The experience of health centers in Massachusetts following implementation of that state's landmark health reform law has demonstrated that as coverage has expanded, health centers have served an increasing proportion of the state's uninsured residents.⁵

This policy brief reviews the opportunities and challenges facing community health centers as a result of health reform. Following an overview, we describe how reform affects the growth trajectory of the health center program and the evolving role of health centers in a health care system poised to undergo significant transformation.

Overview

Initially established in 1965 by the Office of Economic Opportunity (OEO) as a War on Poverty demonstration program with roots in the civil rights movement,⁶ today's federally funded health centers reflect a national investment of considerable proportions targeted to increase access to care among underserved and medically disenfranchised populations. In 2008, 1,080 health centers operating in more 7,500 sites provided primary and comprehensive health care to more than 17.1 million people.⁷ An additional 100 "look-alike" health centers meeting all federal health center requirements but not receiving a federal grant under §330 of the Public Health Service Act served an estimated one million additional patients.

Community Health Centers: Fast Facts

Patient population	17.1 million
Health center grantees	1,080
Service sites	7,500
Total patient visits	66.9 million
Medical visits	49.9 million
Dental visits	7.3 million
Mental health/substance abuse visits	4.0 million
Enabling and other professional service visits	5.8 million

Source: GWU analysis of 2008 UDS

Organized as non-profit clinical care providers and operated in accordance with comprehensive federal standards, health centers are defined by four key characteristics:⁸

- Serve medically underserved populations;
- Provide a comprehensive range of "primary" health care services;
- Adjust charges for care based on patient income; and
- Governed by a community board, the majority of whose members are health center patients.

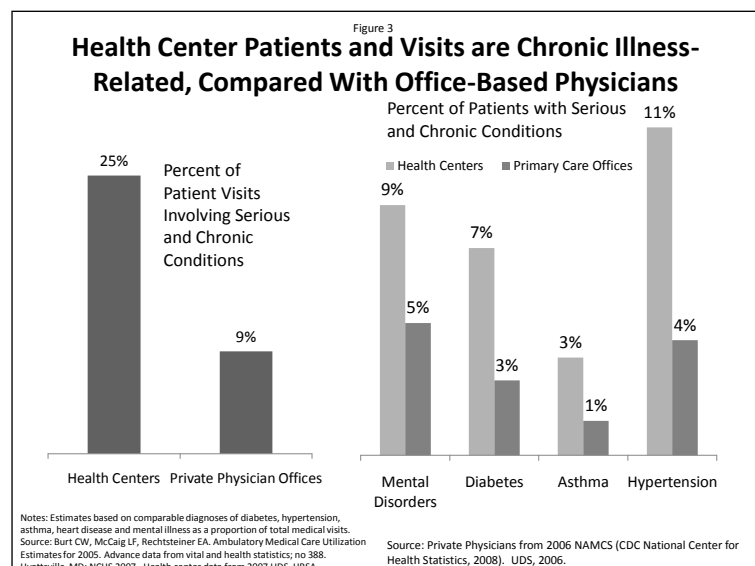
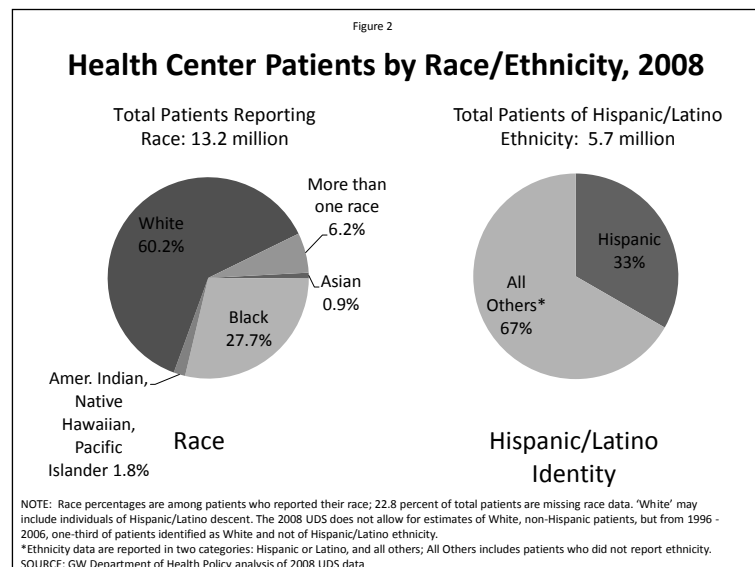
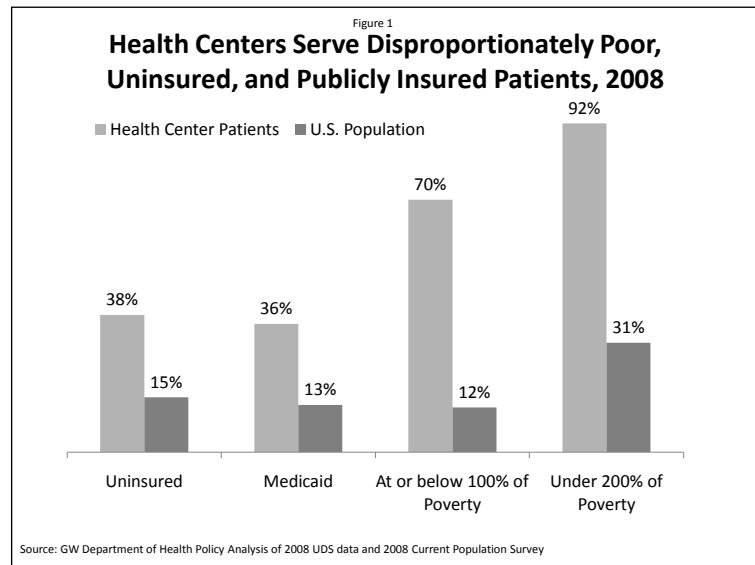
Health centers are a key clinical presence in their communities. In 2008, health centers employed 51,187 medical, dental and mental health/substance abuse staff. The National Health Service Corps (NHSC), which provides scholarship and loan repayment support in exchange for service in urban and rural communities identified as experiencing a shortage of primary health care services, is an important source of clinical staffing for health centers. From 2003 through 2008, health centers employed approximately 5,350 full-time equivalent (FTE) clinicians supported by the NHSC, and health centers represent the single largest NHSC placement site.⁹ Given their location in the nation's most medically underserved urban and rural communities, health centers are also a source of jobs and community enrichment, with a high rate of return into local health economies.¹⁰

Health Center Patients

Anchoring the safety net in many communities, health centers play an important role serving low-income, uninsured, and publicly insured patients. Compared to the U.S. population, health center patients are nearly six times as likely to be poor, two-and-a-half times as likely to be uninsured, and nearly three times as likely to be enrolled in Medicaid. Uninsured patients represent 38 percent of all health center patients. Together, uninsured and Medicaid patients account for almost 75 percent of health center caseloads (Figure 1).

Health center patients are disproportionately members of racial and ethnic minority groups. In 2008, of the patients for whom data on race was available 40 percent were racial minorities. Further, one-third of all patients, many of whom reported their race as White, were of Hispanic/Latino ethnicity (Figure 2). Health center patients are also more likely to live in rural areas (44 percent of health center patients, compared with 21 percent of the population) and to be younger and female; in 2008, children comprised 36 percent of all health center patients while nearly three in five patients were female.¹¹

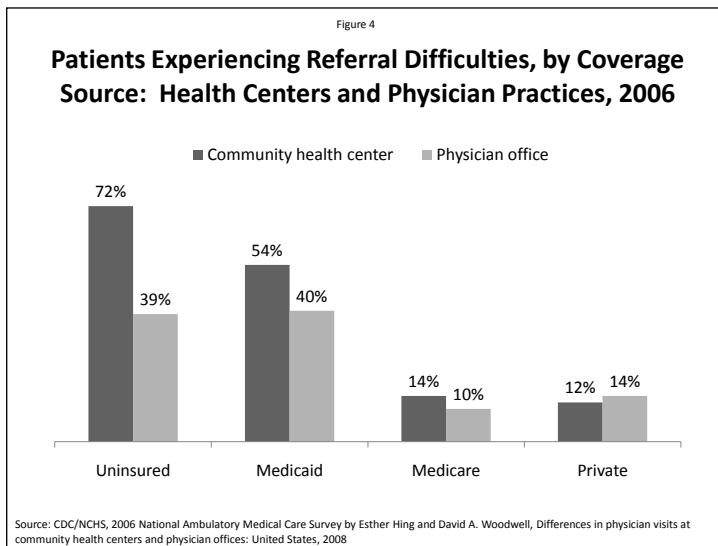
Compared with patients receiving care from private physicians, health center patients are nearly three times more likely to seek care for serious and chronic conditions (Figure 3). At the same time, health center patients, with the exception of health center patients with private insurance, are more likely to experience referral difficulties compared to similar patients treated in



private physicians' offices (Figure 4). Key factors that explain these barriers may include the greater referral difficulties in the case of uninsured and Medicaid-insured patients generally coupled with the far higher volume of health center patients who require referral.

Health Centers' Patient Care Role

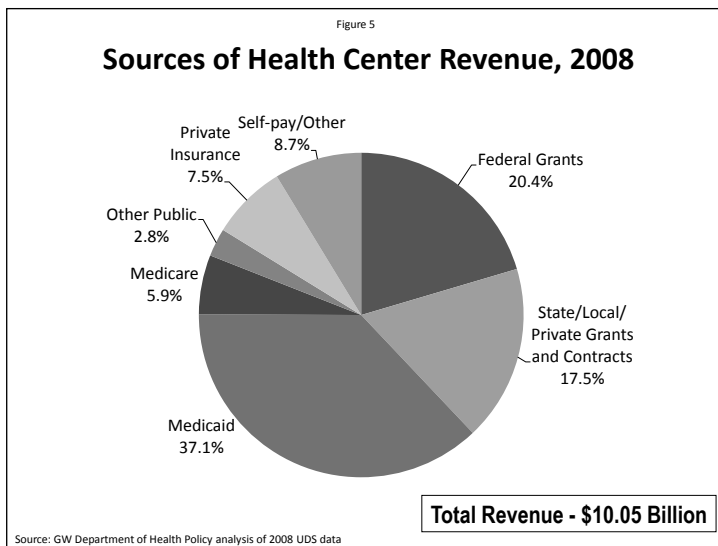
Health centers play an important role in reducing health disparities and promoting population health by providing high quality care.¹² Of particular note has been health centers' performance in the area of preventive health care. Research suggests that low-income, Medicaid and uninsured patients are more likely to receive preventive services at health centers than in other settings.



Beyond medical services, virtually all health centers offer supportive services such as case management, health education, and translation services. As such, health centers can address the full spectrum of their patients' needs, enabling them to serve as medical homes. Because of health center's operational structure as well as their comprehensive approach to patient care, patients served by health centers have annual per-patient medical expenditures lower than patients served in other settings.¹³

Health Center Funding Structure and Sources

Federally funded health centers derive their revenues from multiple payers including public and private health insurance as well as federal, state and local grants and contracts (Figure 5). Once a key source of funding for health centers, Public Health Service Act grants have declined in importance over the years and in 2008 accounted for just 18.3 percent of all health center revenues. By contrast, Medicaid payments accounted for 37 percent of all health center revenue that year, 2.5 times their relative importance in 1985. This growth reflects both Medicaid eligibility expansions that began in the 1980s, as well as changes to coverage of and payment for Medicaid services furnished by federally qualified health centers.¹⁴



Enacted in 1990, the policy and payment changes for federally qualified health center (FQHC) servicesⁱ designated FQHC services as a mandatory Medicaid service that all states must cover and reimburse on a cost-related basis, using the Medicaid prospective payment system.¹⁵ The goal of these payment changes was to prevent health centers from having to use the PHS Act grant to subsidize Medicaid underpayments.

Health Reform and Health Centers

The Prelude: The American Recovery and Reinvestment Act (ARRA)

Leading up to health reform, health centers had already experienced a significant investment of federal funding to expand services at existing care delivery sites and to increase the number of access points. The Health Care Safety Net Act of 2008¹⁶ reauthorized the Health Centers Program for four years and provided funding to grow the program by 50 percent over this time frame. The Act also reauthorized and increased funding for the National Health Service Corps.

In 2009, Congress passed the American Reinvestment and Recovery Act,¹⁷ which appropriated \$2 billion for investment in health center expansion. ARRA included funding to increase the number of health center sites as well as funding to assist health care providers with broader adoption of health information technology (HIT). About 99 percent of health center physicians are predicted to be eligible for Medicaid HIT adoption incentive payments, which invest in HIT infrastructure for providers that serve a disproportionate share of Medicaid patients. The rapid investment of ARRA's health center expansion funding has resulted in 126 new access points and three million additional patients served. The funding was disbursed based on unemployment rates, with communities suffering from the highest unemployment rates receiving higher funding levels.¹⁸

The Affordable Care Act

The Affordable Care Act (ACA) fundamentally alters the policy and operational landscape for community health centers, since they serve the uninsured and low-income patients most likely to be positively affected by reform. Direct investments in health center capacity and increased access to affordable insurance enable health centers to play an important role in increasing access to care for underserved communities and populations.

ⁱ The 1990 payment changes also included a parallel reform in Medicare but included an upper limit or “cap” on these payments.

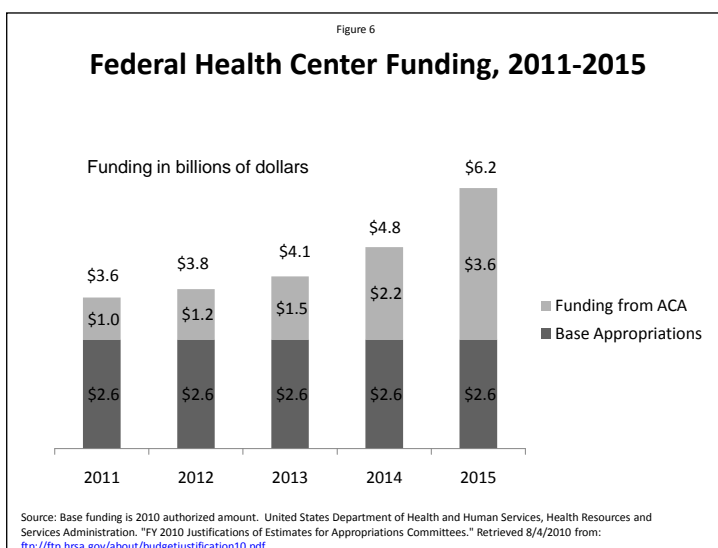
Provisions in the Affordable Care Act Affecting Health Centers

The passage of the Affordable Care Act will bring about significant changes to the health care system. With a focus on expanding health coverage, while improving quality and controlling health care costs, the new law includes a number of provisions and initiatives that will affect health centers.

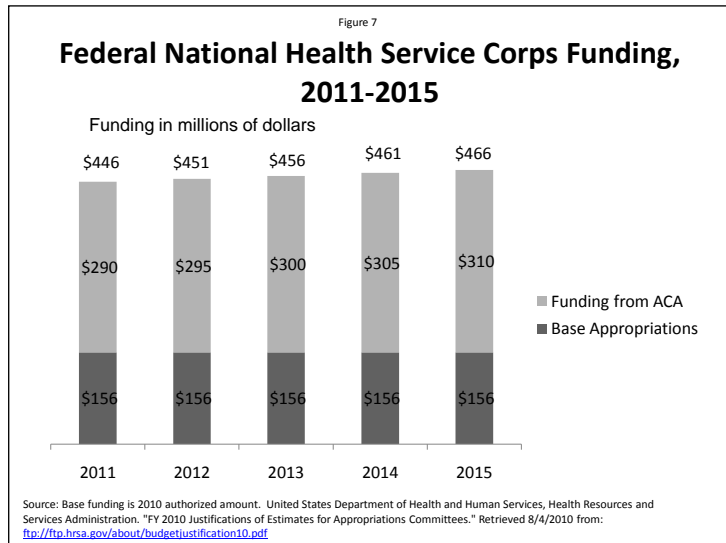
- **Increased funding for health centers:** \$11 billion is allocated for broad health center expansion over five years, which will enable them to serve more patients.
- **Insurance expansions:** Medicaid coverage will be expanded to all individuals below 133% of the federal poverty level and health insurance exchanges will be created, with subsidies for low and moderate income individuals. These expansions will improve access to coverage for many uninsured health center patients.
- **Medicare payment reform:** A Medicare prospective payment system for health centers will be developed and the Medicare payment cap will be eliminated.
- **Workforce and training:** \$1.5 billion is appropriated for the National Health Service Corps, which provides staffing for many health centers. In addition, a number of grant and repayment programs, including the Teaching Health Centers program, will increase funding for recruitment and training to bolster the primary care workforce.
- **Delivery system reform:** Several pilot and demonstration programs will reorganize the health care delivery system. Health centers are positioned to participate in many of these new initiatives, many of which include an emphasis on comprehensive patient care and prevention.

Expanded Health Center Capacity

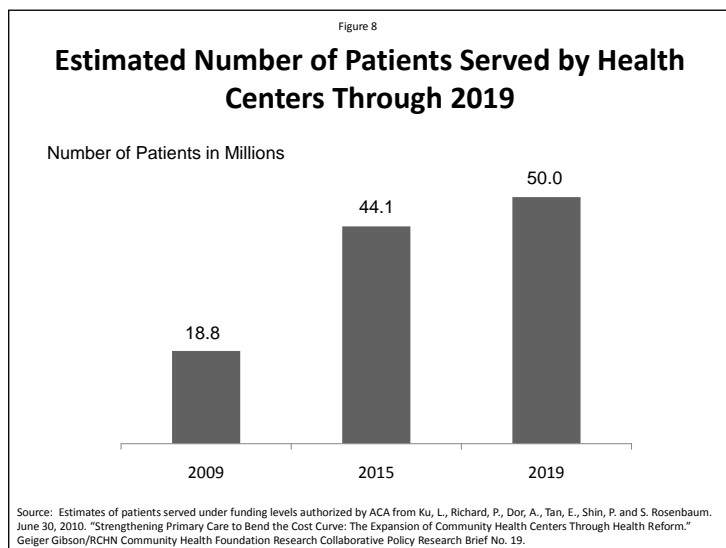
The reform law authorizes a major and mandatory investment in community health centers and the National Health Service Corps from 2011 through 2015. It provides \$11 billion for health center expansion over the five-year period and permanently reauthorizes the Health Centers Program, which was previously subject to periodic reauthorization (Figure 6).¹⁹ The law also permanently reauthorizes the NHSC and increases funding for the Corps by \$1.5 billion over five years, nearly doubling federal support for NHSC (Figure 7).



It is expected that the new funding will be used to add new health center grantees and service sites as well as enhance the service capacity of both new and existing sites by expanding the hours of service and offering a broader range of services, such as mental health, dental, and pharmacy services. Of the \$11 billion given to health centers, \$9.5 billion is allocated to the expansion of operational capacity while the remaining funding is allocated to capital needs, such as renovating existing sites and upgrading IT systems.



The funding increases for health centers will enable health centers to add sufficient service capacity to reach up to 44 million patients by 2015 and up to 50 million patients in 2019 (Figure 8). While the number of uninsured patients is projected to drop significantly nationwide, the share of uninsured patients cared for by health centers is expected to remain relatively high compared to other primary health care providers. Twenty-two percent of health center patients are expected to lack insurance in 2019, down from 38 percent in 2009.²⁰



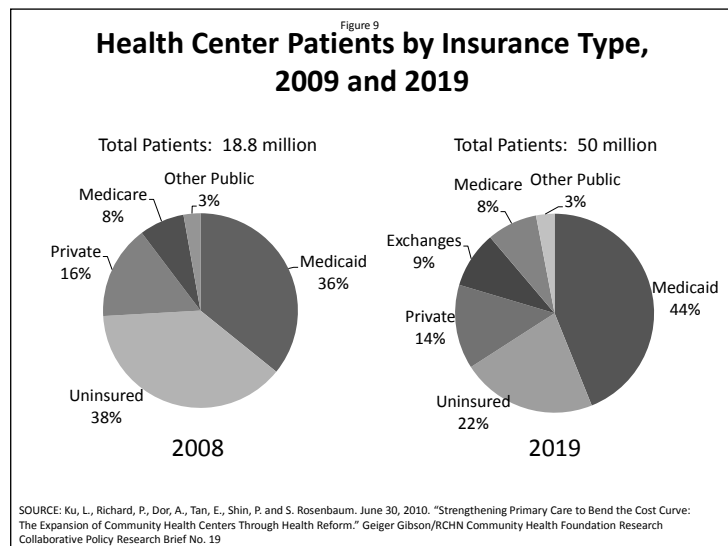
Insurance Expansions

Medicaid

For health centers, the extension of Medicaid to all children and adults with family incomes below 133 percent of the federal poverty level is the most significant of the ACA's insurance reforms. When fully phased in, the Medicaid expansion is estimated to reach some 16 million persons, and can be expected to have a major impact on the insurance status of health center patients. The proportion of Medicaid patients served by health centers will rise from 36 percent in 2009 to 44 percent by 2019 (Figure 9).²¹

Individuals who become newly eligible for Medicaid will receive a benchmark benefit package defined by the states. The benchmark benefits must be at least equivalent to the essential health benefits specified in the law but may be less than the full Medicaid benefit package. As a consequence, for newly eligible beneficiaries, health center (or FQHC) services may no longer be required. At the same time, the Medicaid rules governing health center payments will still apply to services provided by health centers to both traditionally eligible and newly eligible beneficiaries.²²

Beyond the low-income eligibility expansions, health centers can be expected to benefit from other Medicaid reforms as well. For example, the Act provides coverage for tobacco cessation services for pregnant women²³ and gives states incentives to provide coverage for certain preventive services with no cost sharing.²⁴ Coverage of these services will ensure that health centers receive reimbursement for their efforts to focus on prevention and keep their patients healthy.



Private Health Insurance through State Health Insurance Exchanges

Other key components of health reform are the creation of Health Insurance Exchanges that connect patients with insurance and the premium subsidies for lower and moderate income individuals to make insurance more affordable. Many uninsured health center patients with incomes above the new Medicaid eligibility threshold will likely qualify for subsidies in the Exchanges, and recent legal immigrants who are in the five-year waiting period and are not yet eligible for Medicaid may also obtain coverage through the Exchanges. The availability of this new coverage and the associated drop in uninsured health center patients will have a major impact on health centers' operations; by 2019, 9.2 percent of health center patients are projected to be covered by exchange plans.²⁵ Approximately 30 percent of all health center patients have family incomes that exceed the federal poverty level, and as health centers grow, the number of patients with incomes high enough to qualify for Exchange coverage is also expected to rise.

Qualified health plans sold through the Exchanges must offer a standard set of "essential health benefits" that will cover a broad range of services and ensure that coverage is adequate. While FQHC services are not specifically designated as part of the essential benefit package, many of the services provided by health centers will be considered essential health benefits, including ambulatory patient care, maternity care, mental health and substance use disorder services, prescription drugs, laboratory services, prevention and wellness care, and pediatric care including oral and vision care. In addition, the legislation provides cost-sharing assistance to individuals with incomes below 250 percent of the federal poverty level to limit what these individuals will have to pay out-of-pocket in order to access needed services. Together, these

provisions should bolster revenues from private insurance by ensuring that most services provided by health centers are reimbursed and by reducing the level of unreimbursed care health centers must absorb when low-income patients are unable to pay required deductibles, co-insurance, and copayments.

Furthermore, in recognition of the fact that the new coverage available as a result of health reform will target lower-income individuals who are more likely to live in medically underserved communities, health insurance plans operating in the Exchanges will be required to contract with “essential community providers,” including health centers.²⁶ Plans also will be required to pay health centers in accordance with the Medicaid prospective payment system (PPS).²⁷

Finding and Enrolling Eligible Individuals

The ACA emphasizes the simplification of online enrollment and the use of administrative mechanisms that maximize applicants’ ability to complete application forms. Although the law does not require the use of alternative enrollment sites and enrollment assistance through community programs, previous experiences with Medicaid enrollment and Massachusetts’ health reform program indicate that health centers will provide critical enrollment assistance services to help patients gain coverage and maintain continuous coverage.²⁸

Medicare Payment Reform

The ACA revises Medicare FQHC coverage and payment policies in several ways that reflect the growing importance of health centers to Medicare beneficiaries. Since 2000, the proportion of Medicare patients at health centers has held steady at just over seven percent.²⁹ This proportion can only be expected to increase due to several factors, including an increasing life expectancy among the poor, the aging in place of low-income community residents, changes in the range of health care services offered by health centers, and a declining willingness among private physicians in some communities to treat Medicare beneficiaries, particularly those dually eligible for Medicare and Medicaid.

The primary change to Medicare payment policy is a requirement that the Secretary of HHS “develop a prospective system for payment” for services furnished by health centers.³⁰ The legislation also eliminates the health center Medicare payment cap. Further, the law clarifies that new Medicare coverage for certain preventive benefits³¹ are to be treated as part of the Medicare core FQHC service definition (along with marriage and family therapy counseling), thus assuring that health centers will be paid through the newly designed prospective payment system for these preventive services.

Workforce and Training

Anticipating significant increases in the number of people with health coverage beginning in 2014, the ACA includes a number of provisions aimed at expanding the health care workforce, especially the number of primary care providers, to ensure that people have access to care as well as coverage. Some of these strategies include increased funding for the National Health Service Corps and funding for community-based training programs. As stated earlier, the ACA

appropriates \$1.5 billion between FY 2011 and 2015 for the NHSC,³² which is projected to result in support for an additional 15,000 medical, nursing, dental and allied health professionals, many of whom will choose to practice at health centers.³³ In addition, the ACA authorizes a teaching health center grant program to provide funding to establish newly accredited or expand existing accredited primary care residency training programs. Teaching health centers are defined as “community based ambulatory patient care centers” that operate primary care residency training programs.³⁴ Interested health centers will be eligible to establish these programs. Accompanying the authorization are appropriations of up to \$230 million from FY 2011 through FY 2015 to reimburse teaching health centers for both training costs and the higher patient costs associated with clinician training.

Delivery System Reform

The ACA emphasizes high quality and efficient health care through a series of initiatives aimed at promoting clinical integration, payment reforms, health information access, use and reporting, and pilot programs to advance quality, particularly for Medicare and Medicaid beneficiaries.³⁵ Some of these quality initiatives include pilots and demonstrations in the creation of health homes for high-need Medicaid and Medicare beneficiaries and funding for behavior modification programs designed to improve the health of Medicaid and Medicare beneficiaries. In this regard, health centers in many communities may be well-positioned to be part of these pilots and demonstrations because of the proportionately large role they play in health care delivery, their “medical home” attributes, and their emphasis on preventive health.

Future Opportunities and Challenges

The success of the investment in health centers hinges on the ability of uninsured health center patients to obtain health coverage. The Affordable Care Act makes a multi-faceted investment in health centers. Reflecting health centers’ now central role in the U.S. health system, the law permanently authorizes the health centers program. In addition, the legislation makes a major near-term investment to increase health center funding dramatically, laying the groundwork for major health center growth between 2010 and 2015.

At the same time, the law anticipates and underscores that the real engine driving long term health center growth is the expansion of insurance coverage for low-income populations. With the aid of enhanced funding, health centers have an opportunity to solidify their position as a critical access point for people newly gaining health coverage. Ultimately, the success of the health centers expansion will be tied to two factors: the ability of their patients to gain access to health insurance and the ability of health centers to attract and retain newly insured patients.

Health centers will continue to play a critical role in caring for the uninsured. Direct operating funding will support this care and other community services. Health centers are a core part of the safety net and providing coverage to the uninsured will remain an essential function. For this reason, assuring coverage and payment policies that preserve grant funding at levels sufficient for health centers to carry out their uninsured care mission is central to ensuring that everyone, regardless of their insurance status, has access to needed medical care.

In addition to supporting care for the uninsured, direct operating support will continue to play a central role in health centers' success by enabling health centers to furnish patient and community services and supports that are not financed by health insurance. These patient and community supports include translation and case management services, assistance in securing benefits for which patients are eligible, home visiting and nutritional services, and other services essential to patient health. In addition, direct financing can help offset the cost of medically necessary but uncovered treatments as well as out-of-pocket costs that must be borne by health center patients, whose low incomes preclude more than a nominal contribution toward the cost of health care.

Recruiting and retaining qualified health professionals will be challenging. Beyond the financial issues, health centers face a number of challenges. Perhaps above all looms the challenge of recruiting and retaining a full complement of medical, nursing, dental, and allied health professionals able and willing to engage in high quality practice in medically underserved communities. Health centers increasingly care for an aging population with chronic illness. Improving knowledge, skills, and capacity in the field of adult medicine represents a major goal for today's health centers, one that can be more comprehensively advanced as health center capacity grows.

Establishing networks and referral arrangements will be necessary to ensure health center patients have access to the full spectrum of care. The 2006 reauthorization of the health centers program envisioned network membership as a core attribute of health centers. This early movement on the program's part toward the use of networks and greater service integration is consistent with the Affordable Care Act's emphasis on greater clinical integration to improve the quality of care. By extending insurance coverage to far greater numbers of health center patients, the Act positions health centers to establish the types of referral arrangements and affiliations essential to clinical integration. Also central to health centers' transformation into stronger clinical network members are the health information technology adoption incentives first established in ARRA and strengthened in health reform, along with the pilots, demonstrations, and other investments in clinical integration created by the Affordable Care Act.

With their focus on public health and prevention, health centers will continue to strive to improve both the health of their patients and the health of their communities. Building on the tradition of the original health center demonstrations, health centers embody a mission and community orientation that is essential to bridging the gap between clinical care and public health practice. To a significant degree, health reform, with its unprecedented investment in public health, underscores policymakers' awareness of the extent to which health care costs are driven by the relatively high burden of illness within the U.S. population. By promoting community involvement and community health engagement, health centers historically have sought to make a broader impact on the communities they serve, and their successes are measured not merely in the quality of their clinical care but also in their impact on such measures as childhood immunization rates and infant mortality.³⁶

By simultaneously investing in dramatic health center growth in the most disadvantaged communities while increasing the financial commitment to public health, Congress has in effect

positioned health centers to return to their roots, but in a modern and updated fashion. Health centers have been charged with not only mitigating the primary health care shortage but also with advancing comprehensive primary care while educating a new generation of primary health care professionals trained to think and practice across the full spectrum of patient, community, and population health.

This issue paper was prepared by Sara Rosenbaum, Emily Jones, and Peter Shin at the School of Public Health and Health Services, George Washington University and Jennifer Tolbert with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. Additional support for this issue paper was provided by the RCHN Community Health Foundation.

Endnotes

¹ Patient Protection and Affordable Care Act (Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152). In this paper, these laws are referred to collectively as the Affordable Care Act or ACA.

² This paper uses the term health centers to apply to all federally qualified health centers (FQHCs) which include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs. When discussing specific coverage and payment policies, we use the term Federally Qualified Health Center or FQHC.

³ Personal correspondence with Michael Lardiere, National Association of Community Health Centers, August 2, 2010.

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⁶ Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made it Happen*. (Rutgers University Press, New Brunswick) 2007; Karen Davis and Cathy Schoen, *Health and the War on Poverty* (Brookings Press, Washington D.C.) 1978.

⁷ Most health center information comes from data provided by health centers to the federal government as part of the Uniform Data System, a national reporting system in which all federally funded health centers are required to participate. The latest available public data are for 2008.

⁸ 42 U.S.C. §254b

⁹ HRSA Data warehouse. Available at: <http://datawarehouse.hrsa.gov/nhscdetail.aspx#anchor> (Accessed May 5, 2010)

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- ¹⁵ Shin, P.; Ku, L.; Jones, E.; Finnegan, B. and S. Rosenbaum. May 27, 2009. Financing Community Health Centers as Patient- and Community-Centered Medical Homes: A Primer. The Commonwealth Fund and the Geiger Gibson Program in Community Health Policy, George Washington University.
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- ¹⁷ Public Law 111-5.
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- ¹⁹ PPAC §10503 and PPAC §5601
- ²⁰ Ku, L., Richard, P., Dor, A., Tan, E., Shin, P. and S. Rosenbaum. June 30, 2010. “Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform.” Geiger Gibson/RCHN Community Health Foundation Research Collaborative Policy Research Brief No. 19.
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- ²² PPAC §2001. Section 1937 (b)(4) specifically provides for the provision of FQHC services and PPS reimbursement to FQHCs as provided under §1902(bb) even in the benchmark or benchmark equivalent packages provided for in Section 1937(b); thus, it would appear that FQHC payment rules apply to newly eligible beneficiaries.
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- ²⁴ PPAC §4106
- ²⁵ Ku, L., Richard, P., Dor, A., Tan, E., Shin, P. and S. Rosenbaum. June 30, 2010. “Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform.” Geiger Gibson/RCHN Community Health Foundation Research Collaborative Policy Research Brief No. 19.
- ²⁶ PPAC §1302
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- ²⁹ GW analysis of UDS data, 2000 and 2008.
- ³⁰ PPAC §10501
- ³¹ PPAC §§4103-4105
- ³² PPAC §10503
- ³³ National Association of Community Health Centers. Fact Sheet: Health Centers and Health Care Reform: National Health Service Corps.
- ³⁴ PPAC §5508(a)
- ³⁵ PPAC §§2703-2707 and 3021-3026.
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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.