

medicaid and the uninsured

March 2013

Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth *Executive Summary*

Today, over 1,100 federally funded community health centers play a vital role in ensuring access to health care for a predominantly low-income population in medically underserved communities. Health centers' ability to provide comprehensive primary care and improve access to high-quality care while holding down health care cost growth has been well-documented. As health reform spurs coverage expansion and efforts to improve quality, the nation's reliance on health centers is likely to grow.

In the Affordable Care Act (ACA), Congress invested \$11 billion over five years to expand the health center program, to broaden access to care in lower-income communities as coverage expands. As policymakers and others gear up for ACA implementation, understanding the role of health centers and the characteristics of the people they serve is increasingly important. This brief provides a current snapshot of health centers and discusses recent developments that can be expected to have a significant impact on health center growth in the coming years.

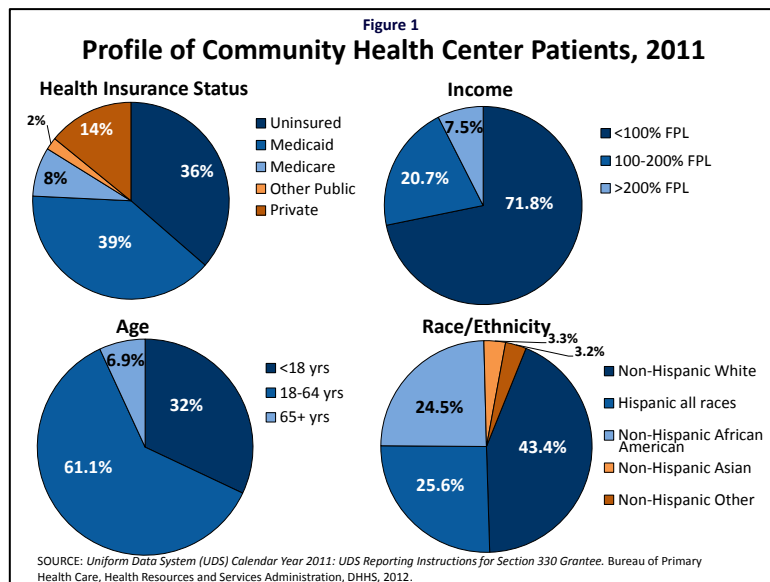
Current profile

- **Health centers' safety-net role.** In 2011, 1,128 health centers operating in about 8,500 sites provided 80 million visits to about 20 million patients, primarily for medical care, but also for dental, behavioral health, and enabling services. More than 70% of health center patients are below the federal poverty level, or FPL (Figure 1). Most are working-age adults (60%) and children (33%), and about 7% are seniors. Over half are members of racial or ethnic minority groups. Health centers serve more than 1 in 6 low-income people nationally.

- **Health center patients.** More than a third of health center patients are uninsured and almost 40% are covered by Medicaid. Under the ACA, the number of health center patients is expected to grow significantly, but their uninsured rate is expected to fall. Still, the share of their patients who lack coverage will remain high, and health centers will probably serve a larger share of those who remain uninsured.

- **Scope of services.** Health centers provide primary care spanning physical, oral, and mental health care, as well as enabling services (e.g., translation, transportation) that help patients access care. Between 2000 and 2011, the availability of both oral and mental health care in health centers grew dramatically, a reflection of both widespread need and increased federal funding.

- **Health center volume and staffing.** Health center visits increased from 38 million in 2000 to 80 million in 2011, and the number of health professionals and other staff increased by almost two-and-a-half times. Medical staff doubled and dental and behavioral health staff nearly tripled.



▪ **Medicaid support.** Medicaid accounts for nearly 40% of health center revenues (Figure 2), reflecting the large share of health center patients covered by Medicaid and Medicaid’s special payment rules for health centers. Medicaid rates are prospectively set and based on reasonable costs, which means that the costs of treating Medicaid patients will not be shifted to grant funding that is meant to finance care for the uninsured and services that private insurance may not cover. Under the ACA, Qualified Health Plans must also use this methodology to pay health centers.

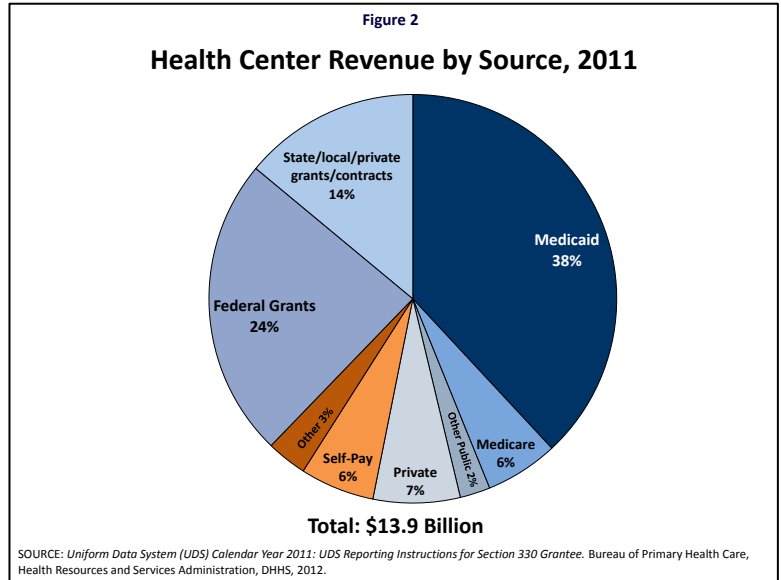
▪ **ACA investments.** The ACA established an \$11 billion Health Center Trust Fund and provided \$1.5 billion in new funding for National Health

Service Corps, on which health centers rely heavily to recruit medical and dental providers. These and other key investments – ongoing regular appropriations, expanded coverage, continuation of Medicaid’s special payment rules and their extension to Exchange plans – were expected to support the expansion of health centers and access in medically underserved communities to prepare for increased demand for care as coverage expands. Health centers’ capacity was projected to virtually double by 2019, to 40 million patients.

Current challenges

- The Supreme Court decision on the ACA, effectively making the Medicaid expansion a state option, creates uncertainty about what the size and location of the remaining uninsured population will be. A state decision not to expand Medicaid would likely depress health center growth because health centers would have to divert growth funds to finance care for uninsured patients who were expected to gain Medicaid coverage.
- Even if all states adopt the Medicaid expansion, millions of people will remain uninsured. Given that health centers will continue to shoulder the cost of treating many of the uninsured and under-insured, adequate payment on behalf of insured patients is necessary to avoid the use of grant funds meant for care for the uninsured to fill gaps for the insured instead.
- Two recent budget actions challenge health centers’ ability to grow on pace. First, regular federal appropriations for health centers were cut in 2011 by \$600 million. As a result, health centers had to divert an equal amount from the Health Center Trust Fund to avoid reducing their capacity by as many as 5 million patients. Second, under sequestration, health centers face a 5.19% cut in their base appropriations in the second half of FY 2013. Although the Health Center Trust Fund is partially protected, homeless program funding from the Fund will fall by 5.79% and total losses from sequestration are projected to be \$120 million in FY 2013, which translates to 900,000 fewer patients served and 3 million fewer visits.

Having prepared for a decade of strong growth, health centers now face significantly diminished funding and the prospect of a slower expansion of Medicaid, both of which exert downward pressure on health center expansion. In light of health centers’ role in our health care system and their unique potential to advance the goal of expanded access to care for the medically underserved, these shifts in the direction of retrenchment pose a challenge going forward.



Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth

Introduction

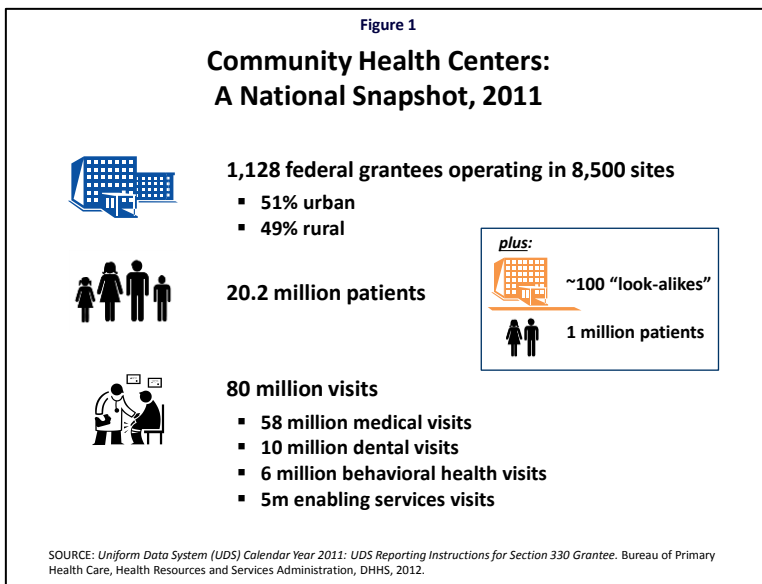
Today, over 1,100 federally funded community health centers operating in more than 8,500 urban and rural locations play a central role in ensuring access to health care in medically underserved communities across the country. Health centers’ ability to provide comprehensive primary care while holding down health care cost growth has been documented in both national estimates and specialized studies evaluating the impact of health centers on access, quality, and cost.¹ As health reform spurs both coverage expansion and efforts to improve the quality of care, the nation’s reliance on health centers is likely to grow. Recognizing the need for an expanded role for health centers as coverage expands, Congress made a five-year \$11 billion investment in health centers as part of the Affordable Care Act (ACA) to broaden access to care in lower-

income communities. As policymakers and providers gear up for ACA implementation, understanding the role of health centers and the characteristics of the populations they serve is increasingly important.

This brief provides an overview of health centers, using data from the Uniform Data System (UDS), which is maintained by the Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care (BPHC) in the U.S. Department of Health and Human Services. The brief then discusses recent developments that can be expected to have a significant impact on the scope and rate of health center growth in the coming years.

An Overview of Health Centers

Health centers’ safety-net role. In 2011, 1,128 federally funded health centers operating in 8,504 sites (an average of 7.5 sites per grantee) served 20.2 million patients (Figure 1). Approximately 100 “look-alike” health centers meeting all federal requirements but not receiving a federal grant under §330 of the Public Health Service Act served another 1 million patients. Health centers were distributed about evenly between urban (51%) and rural (49%) communities. Total patient visits reached 80 million in 2011, including 58 million medical, 10 million dental, 6 million behavioral health, and 5 million enabling services visits. To be certified as a health center, grantees and look-alike clinics must satisfy five basic requirements: location in or service to medically underserved communities and populations (such as farmworkers and homeless populations); provision of comprehensive primary health care; service to the entire community; prospective adjustment of charges in accordance with ability to pay; and governance by a community board more than half of whose members are patients of the health center.



Reflecting the mission of the health center program, more than 70% health center patients have family income below the federal poverty level, or FPL (Figure 2). About 60% are female. Working-age adults make up about 60% of health center patients, children account for roughly a third, and about 7% are seniors. Over half of health center patients (57%) are members of racial or ethnic minority groups.

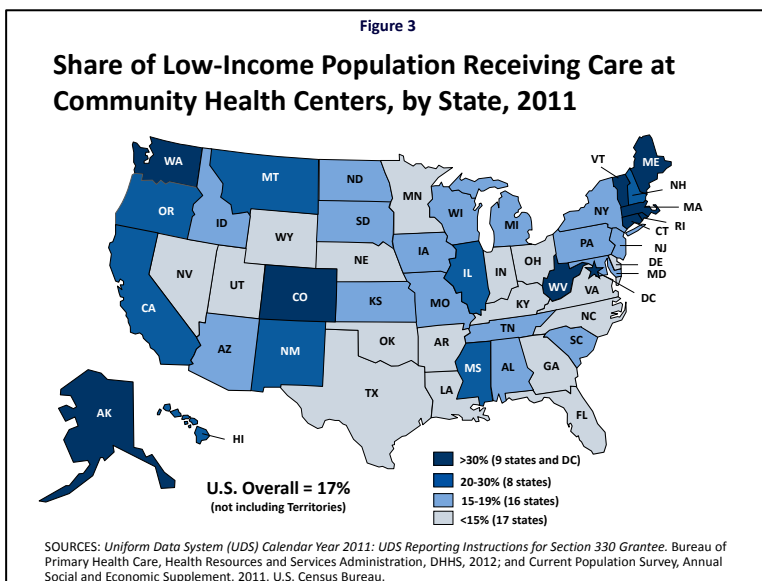
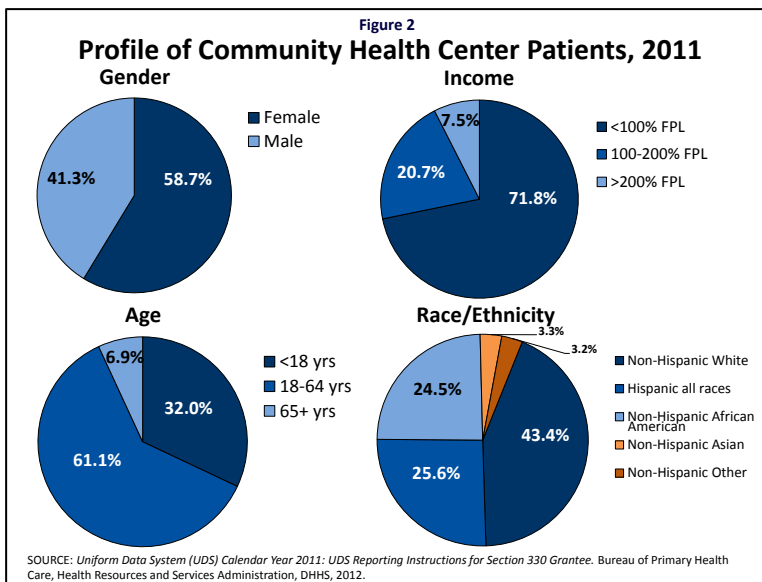
Health centers play a major national role in providing health care for low-income populations and an even larger role in many states (Figure 3). In 18 states, including the District of Columbia, health centers serve at least 1 in 5 low-income people, defined as individuals and families with incomes below 200% FPL (\$39,060 for a family of three in 2013); in nine of these states and DC, health centers provide care to more than 30% of the low-income population.

In states with particularly large low-income populations, such as Texas and Florida, health center penetration tends to be lower, in part because, compared with other states, a much larger share of the total state population is low-income.

Health center patients. Consistent with their low income, health center patients are disproportionately likely to be uninsured; they are also disproportionately likely to be covered by Medicaid. In 2011, when the uninsured rate for the non-elderly population overall stood at 18%, 36% of all health center patients lacked health insurance; 39% of health center patients were covered by Medicaid, compared to 17% of the U.S. population overall.²

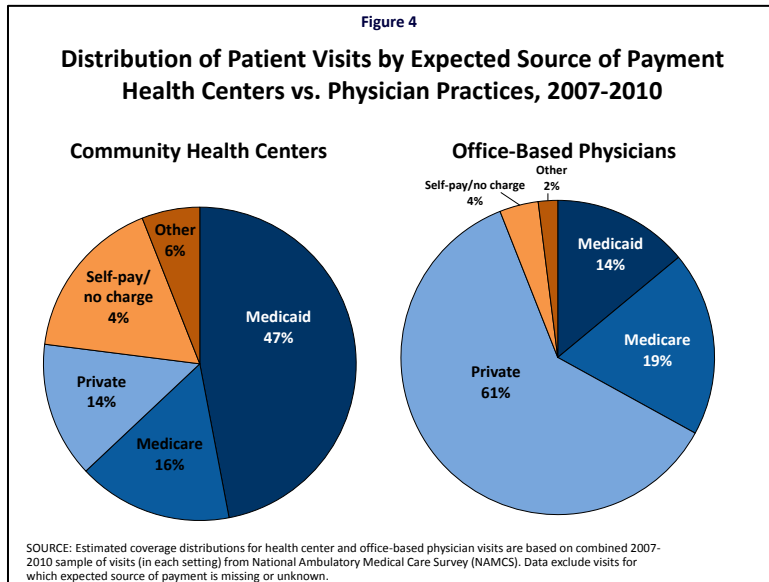
Like privately insured individuals, Medicaid beneficiaries obtain a large share of their outpatient care from private physicians. In 2010, nearly half of all Medicaid visits (48%) and about two-thirds of visits by those with private insurance (67%) were in office-based physician practices.³ However, Medicaid patients account for a

much larger share of health center visits than physician office visits. Data from the National Ambulatory Care Survey in 2007-2010 show that nearly half (47%) of all health center visits are provided to patients covered by Medicaid (Figure 4). By contrast, just 14% of visits provided by office-based physicians are

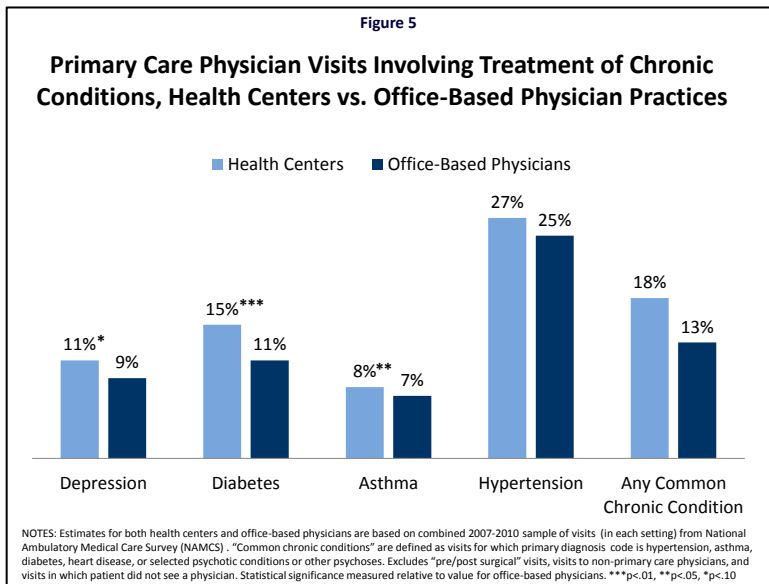


attributable to Medicaid patients; most (61%) are attributable to privately insured patients. In short, although physician offices are more often the setting of Medicaid visits, the care of Medicaid patients is much more central to what health centers do. Further, the share of health center visits that involve the treatment of major chronic conditions is greater in health centers than in office-based physician practices (Figure 5).

In the U.S. overall, Medicare beneficiaries make up 8% of health center patients. However, in 11 states (Arkansas, Kentucky, Maine, New Hampshire, North Carolina, North Dakota, South Carolina, Vermont, Virginia, West Virginia, and Wyoming), Medicare patients make up more than 10% of all health centers patients – in Maine, the Medicare share is 20%.⁴ Finally, the role of health centers for certain sub-populations also warrants special note. Health center patients account for 1 in 6 births to low-income women.⁵ Health centers also serve 1 in 4 farmworkers and 1 in 3 people who are homeless.⁶



Based on Congressional Budget Office estimates of the impact of the ACA on coverage rates in 2019, assuming that all states adopt the Medicaid expansion, the total number of health center patients can be expected to increase significantly, but the share of health center patients without health insurance can be expected to decrease significantly (Figure 6); still, the proportion of health center patients who are uninsured would remain high (22%). Further, the CBO projections underlying these estimates may overstate the increases in coverage because they were issued before the Supreme Court decision in *NFIB v. Sebelius*, which, in effect, permits states to opt out of the ACA's Medicaid expansion for low-income adults.⁷



In any case, if the experience in Massachusetts following implementation of that state's health reform plan is a guide, health centers are likely to provide care for a substantially larger share of the remaining uninsured population under the ACA.⁸ To illustrate, in 2005, health centers served 153,085 of all 545,000 uninsured residents of Massachusetts – about 28%. By 2011, the total number of uninsured in Massachusetts had dropped to 219,000; health centers cared for nearly 60% of these remaining uninsured individuals.⁹

Scope of health center services.

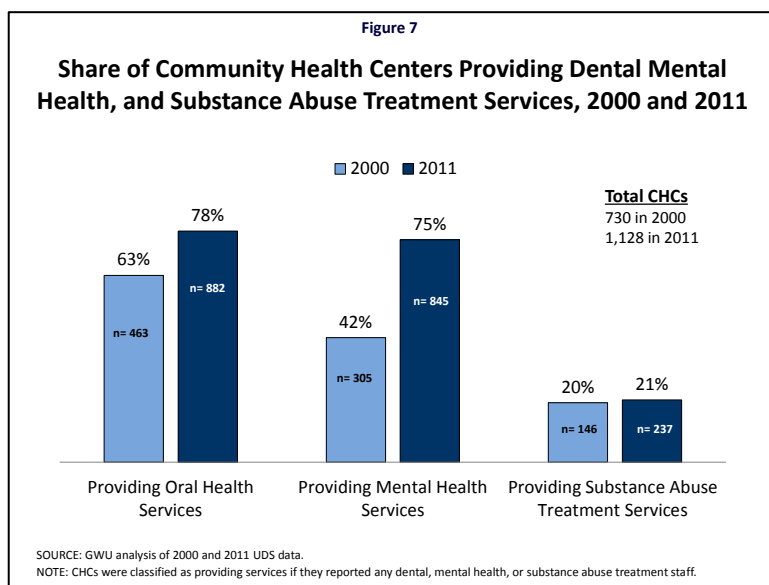
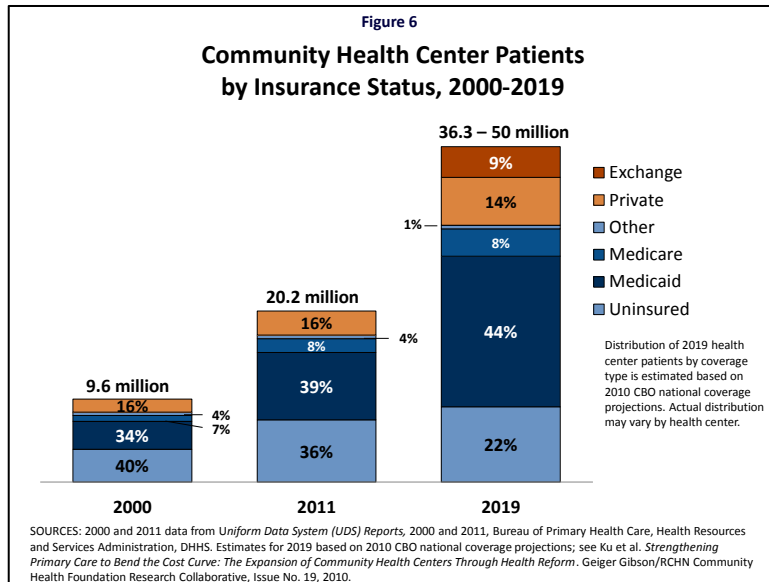
Health centers offer primary care services that span physical, oral, and mental health care. They also provide “enabling services” such as translation, transportation, and case management that help ensure that health center patients can access care.

In recent years, the proportion of health centers offering oral and mental health care has grown in response to widespread need and new federal funds provided by the ACA to expand the health center program, (Figure 7). In 2000, 63% of the nation’s 730 health centers that year furnished oral health care; by 2011, 78% of the more than 1,128 health centers operating by then were providing oral health services, resulting in almost a doubling of the number of health centers providing this care. Even more dramatic gains have occurred in the availability of mental health services. In 2000, just over 40% of health centers that year, a total of 305, offered mental health care; this figure rose to 75% in 2011, a total of 845 health centers that year. While the number of health centers providing substance abuse treatment rose by about 90 between these two years, the share of health centers offering these services remained essentially unchanged, at about 20%.

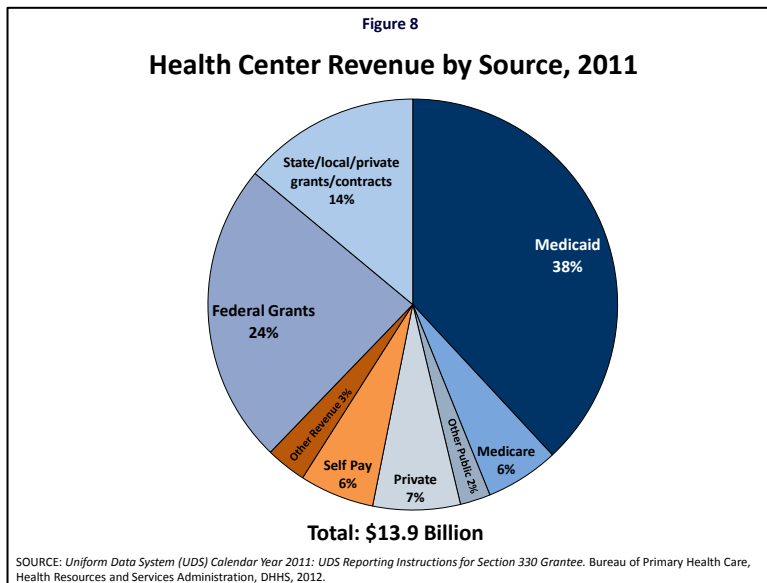
Health center volume and staffing.

As the number of health centers and health center sites has risen, so has the number of health center visits. In 2000, health centers reported a total of 38 million visits; by 2011 that figure had grown to 80 million visits. To meet the increased demand for care, the number of health professionals and other staff working in health centers has also grown. In 2000, about 56,000 full-time-equivalent (FTE) staff worked at health centers. By 2011, the number of FTEs had increased by almost two-and-a-half times, reaching over 138,000 nationally.

This increase includes a doubling of medical staff and a near tripling of dental and behavioral health FTEs. Just in the last three years, health centers have added more than 25,300 jobs, evidence of their importance as a source of local employment and economic growth in many underserved and low-income communities.¹⁰



Medicaid's role in supporting health centers. Medicaid is the single largest source of health center revenues, accounting for 38.1% of the total in 2011 (Figure 8). Medicaid's large financing role reflects both the large share of health center patients who are covered by Medicaid and the special payment rules for federally qualified health centers (FQHC) that apply in both Medicaid and the Children's Health Insurance Program (CHIP). These rules require state Medicaid programs and CHIP to pay health centers for "FQHC services" (a mandatory Medicaid benefit) and other covered ambulatory care services in accordance with a prospectively established rate, determined for each individual health center, that reflects the reasonable cost of treating



enrollees. Whereas private health insurance pays deeply discounted rates to health centers, the cost-related payment methodology required in Medicaid and CHIP means that the cost of treating patients covered by these programs will not be shifted to grant funding that is intended to finance care for the uninsured and services such as translation and other patient supports that private insurance may not cover. Beginning in 2014, the ACA requires that Qualified Health Plans (QHPs) also use the FQHC payment methodology to pay for care furnished by health centers.

ACA investments in health centers. The ACA made a major investment in health center growth through the establishment of a five-year (2011-2015) \$11 billion Health Center Trust Fund, paired with \$1.5 billion in new funding for the National Health Service Corps, on which health centers rely heavily to recruit medical and dental providers. These new investments were to be accompanied by other key investments: ongoing discretionary appropriations that support basic health center operations; the ACA's Medicaid expansion to low-income adults; the establishment of subsidized health insurance coverage through the new Exchanges; continuation of the special payment rules for health centers under Medicaid and CHIP; and extension of these payment rules to QHPs sold through the Exchanges. This multi-faceted set of reforms was expected to provide a strong enough financial environment to support the expansion of health centers and access to care that were estimated to be needed in medically underserved communities. Projections indicated that health centers' patient care capacity would virtually double by 2019 to 40 million patients.¹¹

Current Issues and Discussion

The health center program was among the first components of our health care system to experience the impact of the ACA, as funding from the Health Center Trust Fund, created to spur health center growth in preparation for expanded coverage and demand for care, began to flow in 2011. The impact of the ACA will be felt more fully and system-wide beginning January 1, 2014, when millions of uninsured Americans gain coverage through the expansion of Medicaid and subsidized private coverage through the new Exchanges. This broad expansion of coverage will lower financial and other barriers to access to care for many low- and middle-income people. By the same token, the coverage expansion will translate

into new revenues for health centers and other safety-net providers that furnish the lion's share of uncompensated care.

Still, while the ACA will extend coverage to millions of the uninsured, millions of others will remain uninsured. The Supreme Court's decision on the Medicaid expansion creates uncertainty about what the size and location of the remaining uninsured population will be. But it is likely that, in any state that elected not to take up the Medicaid expansion, the impact on health centers and health center growth will be pronounced. This is because so large a share of health center patients are low-income uninsured people who were expected to gain Medicaid under the ACA, but whose costs health centers would instead have to meet by using funds that were intended for growth. In states that do not expand Medicaid, health center expansion can be expected to be limited, although the magnitude of the impact remains to be seen.

Even if all states adopt the Medicaid expansion under the ACA, millions of people will remain uninsured. Therefore, because health centers are obligated both by mission and by law to offer care to all persons in their service area, health centers' ability to reserve their grant funding for care of the uninsured will continue to be important. Ensuring that both public and private insurance payments reflect the cost of care furnished by health centers will help prevent erosion of this critical funding.

The rates paid by insurers matter because, even while expanded coverage is expected to have an important positive impact on health center revenues, potential limitations of that coverage could still leave health centers with costs that they can only absorb by tapping their grants. For example, people with private coverage purchased through the new Exchanges may face high cost-sharing obligations relative to their means, in the form of deductibles, coinsurance, and copayments. Because health centers adjust patient financial obligations based on ability to pay, to make up shortfalls that result from these sliding-scale adjustments, they may have to draw down grant funds. Also, under their service obligations, health centers cannot deny care even if they are outside an insured patient's provider network and therefore not covered by the insurance – a scenario that can occur if a privately insured patient is unable to secure care from a network provider. Similarly, health centers may incur costs for services (e.g., enabling services, dental care) that private insurance typically does not cover. Given that health centers will continue to shoulder the cost of treating many of the uninsured and under-insured, adequate payment on behalf of insured patients is necessary to avoid the use of grant funds meant to support care for the uninsured to fill gaps for the insured instead. As mentioned earlier, the ACA extends the Medicaid payment rules for health centers to QHPs.

Two recent major recent developments present unanticipated challenges to health centers' ability to grow on pace to meet expected increases in the demand for access to care. First, the Budget Control Act of 2011 cut health centers' discretionary funding base by \$600 million, or more than one-quarter. This reduction in basic funding resulted in the diversion of an equal amount from the Health Center Trust Fund to fill the gap left by the cut. Had the \$600 million in Trust Fund monies not been diverted for basic operations, health centers' reach would have been reduced by an estimated 4.5 to 5 million patients, and staffing reductions would have diminished health centers' capacity to treat and bill for care furnished to insured patients, further reducing health center revenues.

Second, sequestration – automatic across-the-board reductions in federal spending – took effect March 1, 2013. While the Health Center Trust Fund was partially protected from sequestration, base discretionary funding for health centers was not. As a result, health centers are facing a 5.19% reduction in these appropriated funds in the second half of FY 2013. Further, although the Health Center Trust Fund is partially protected, dollars flowing from the Fund to health centers' homeless programs are not,

under a ruling from the Office of Management and Budget (OMB) that limits the extent of the Fund's protection from sequestration. Consequently, homeless program grantees will see a 5.79% cut in their funding from the Health Center Trust Fund. Collectively, the losses to health centers ensuing from sequestration have been projected to total \$120 million in FY 2013, a figure that translates into 900,000 fewer patients served and 3 million fewer visits.¹²

The loss of base discretionary funding as a result of federal budget decisions and sequestration could be reversed. Also, if all states ultimately embrace the Medicaid expansion for adults, health centers will realize the full benefit this coverage expansion was intended and expected to have for their financing. In the meantime, however, having prepared for a decade of strong growth, health centers are struggling to maintain current service capacity in the face of significantly diminished resources. Furthermore, the drag on health center growth that results from these reductions could affect the extent to which the coverage gained by the newly insured – who are disproportionately concentrated in medically underserved communities – can be converted into actual access to care, the ultimate purpose of health reform.¹³

Conclusion

Over the past decade, health centers have grown steadily and expanded the scope of their services to meet patient needs more fully, building on their role as a key source of primary health care for urban and rural medically underserved communities and populations. By 2011, health centers reached 22 million people and, with major investments in the health center program made by the ACA, were on a growth trajectory to double their patient capacity by 2019. The ACA investments reflect the Congress' assessment that expansion of the health center program is an integral component of the framework for expanded coverage and access to care outlined in the health reform law.

The spending reductions ensuing from the Budget Control Act of 2011 and sequestration, and the prospect of a slower expansion of Medicaid, all exert downward pressure on the extent and rate of health center expansion. Further research and analysis will be needed to assess the magnitude of the impact these developments have on growth. In light of health centers' role in our health care system and their unique potential to expand access to care for medically underserved communities and populations, these policy shifts toward retrenchment pose a challenge going forward.

This issue brief was prepared by Peter Shin, Jessica Sharac, Carmen Alvarez, and Sara Rosenbaum of George Washington University School of Public Health and Health Services, Department of Health Policy, and Julia Paradise of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. Additional support for this paper was provided by the RCHN Community Health Foundation.

Endnotes

- ¹ Richard P et al. Cost Savings Associated with the Use of Community Health Centers. *Journal of Ambulatory Care Management*. 2012 35(1); Goldman L et al. Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures. *American Journal of Preventive Medicine*. 2012 43(2); Shi L et al. U.S. Primary Care Delivery after the Health Center Growth Initiative. *Journal of Ambulatory Care Management*. 2012 35(1); Rothkopf J et al. Medicaid Patients Seen at Federally Qualified Health Centers Use Hospital Services Less Than Those Seen by Private Providers. *Health Affairs*. 2011 30(7); George R et al. Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties. *Journal of Rural Health*. Winter 2009 25(1).
- ² *The Uninsured: A Primer, Supplemental Data Tables*, Table 17, Kaiser Commission on Medicaid and the Uninsured. October 2012. <http://www.kff.org/uninsured/7451.cfm>
- ³ Kaiser Commission on Medicaid and the Uninsured analysis of 2010 Medical Expenditure Panel Survey (MEPS). Data include office visits only; visits to outpatient departments are excluded.
- ⁴ *Key Health Center Data by State, 2010*. National Association of Community Health Centers. <http://www.nachc.org/client/CHCDataByState10.pdf>
- ⁵ *Snapshot: Health Center Patients Have Fewer Low Birth Weight Babies*. National Association of Community Health Centers. October 2010. <http://www.nachc.org/client/documents/Snapshot%20Low%20Birth%20Weight%2010%2010.pdf>
- ⁶ Estimates are based on data showing a total of 3.5 million homeless and 3 million farmworkers and their dependents nationwide. Data on homeless from *How Many People Experience Homelessness?* National Coalition for the Homeless. July 2009 http://www.nationalhomeless.org/factsheets/How_Many.html and Data on farmworkers from *Facts about Farmworkers*. National Center for Farmworker Health. 2012 <http://www.ncfh.org/docs/fs-Facts%20about%20Farmworkers.pdf>
- ⁷ 132 S. Ct. 2566. June 28, 2012. Also, see Rosenbaum S and D Frankford. Update: NFIB v Sebelius. *Law and the American Health Care System* (2nd Edition). Ed. Sylvia Law and Rand E. Rosenblatt. NY: Foundation Press. 2012.
- ⁸ Ku L et al. *How is the Primary Care Safety Net Faring in Massachusetts: Community Health Centers in the Midst of Health Reform*. Kaiser Commission on Medicaid and the Uninsured. March 2009. <http://www.kff.org/healthreform/7878.cfm>
- ⁹ Based on UDS and Census data for 2005 and 2011. Also, see Ku et al. *op. cit.*
- ¹⁰ *The Affordable Care Act and Health Centers*. Bureau of Primary Health Care, Health Resources and Services Administration, USDHHS. <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>
- ¹¹ Shin P and S Rosenbaum. *Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities*. Kaiser Commission on Medicaid and the Uninsured. March 2012. <http://www.kff.org/uninsured/upload/8098-02.pdf>
- ¹² Shin P et al. *Assessing the Potential Impact of Sequestration on Community Health Centers, Patients, and Medically Underserved Communities*. Geiger Gibson/RCHN Community Health Foundation Research Collaborative. The George Washington University School of Public Health and Health Services. 2013. <http://sphhs.gwu.edu/departments/healthpolicy/publications/GGRCHN.pdf>
- ¹³ *Community Health Centers: Opportunities and Challenges of Health Reform*. Kaiser Commission on Medicaid and the Uninsured. August 2010. <http://www.kff.org/uninsured/8098.cfm>

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

This publication (#8098-03) is available on the Kaiser Family Foundation's website at www.kff.org.



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.