

medicaid and the uninsured

May 2003

Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role

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Introduction

In 2001, health centers provided health care services to nearly 12 million people at more than 4,000 sites across the United States. As such, the health center program is a crucial part of the health care safety net for low-income individuals and medically underserved communities. This policy brief looks at health centers in detail in order to illuminate the role they play as providers of care and to document the important nexus between health centers and Medicaid.

Part 1 profiles health centers, describing their key characteristics, the populations they serve, the services they provide, and important aspects of their operation. Part 2 focuses on the role of Medicaid as a critical and sustaining source of financing for health centers. Part 3 explores the implications of the relationship between Medicaid and health centers, documenting the impact of Medicaid policy and dynamics on health centers and, in turn, the bearing that health centers' viability has on access to care for Medicaid beneficiaries and other low-income populations. The Bush Administration's goal of doubling the size of the health centers program over five years is considered in the context of the Administration's recent proposals to cap federal financing of Medicaid and extend states dramatically more flexibility.

The health center data and statistics presented in this policy brief are derived from the Uniform Data System, a government-maintained system that collects extensive data on patients, staffing, revenues, and services, on a calendar year basis from federally funded health centers.¹

Part 1. An Overview of Health Centers

History of the Program

The federal health centers program began in 1965 as a demonstration of the Office of Economic Opportunity (OEO). The program was conceived when OEO officials found evidence of serious health problems in poor urban and rural

¹ All federally funded health centers are obligated to regularly report complete UDS data beginning in their third full year of operation, as well as certain UDS information from the time they begin services. The entities whose data are reported in the UDS all receive at least one grant under the Public Health Service Act for the establishment and operation of a community health center, a migrant health center, a health care for the homeless program, or a public housing primary care program.

communities throughout the nation.² Following 10 years of documented success in bringing quality, comprehensive primary health care to medically underserved populations,³ Neighborhood Health Centers, as they were initially known, gained permanent status under the Public Health Service Act in 1975. The legislation, now known as the health centers program, authorizes federal funding for the development and operation of entities that satisfy certain statutory requirements.⁴

The health centers program is administered by the Bureau of Primary Health Care in the Health Resources and Services Administration of the Department of Health and Human Services. Health centers frequently operate in tandem with the National Health Service Corps,⁵ which provides scholarships and loan repayment assistance to health professionals who agree to practice for a period of time in communities with identified shortages of practitioners. Both health centers and the Corps were reauthorized by the 107th Congress as part of the Health Care Safety Net Act of 2002.⁶ In its recent report entitled “Fostering Rapid Advances in Health Care,” the Institute of Medicine noted health centers’ strong track record in both primary care and chronic care management and called for demonstrations in these settings that, building on centers’ existing achievements, would be aimed at developing model primary care practices.⁷

Health Centers Today

In General

Health centers consist of two groups. The first consists of health centers that receive development and operating grants under the federal health centers program. The second consists of health centers that meet all the requirements of the federal health centers program, but, because of the limited availability of federal funds, do not receive federal operating grants. These “look alike” health centers, as they are known, are treated as federally funded health centers for purposes of Medicare and Medicaid, discussed below.

In 2001, 748 federally funded health centers (up from 671 in 1997) operated in all states, the District of Columbia, and the Commonwealth and Trust Territories – slightly over half of them (51 percent) in rural communities. Total federal health center funding for FY 2001 stood at \$1.169 billion, with total allocations to health centers that year of \$990 million. Federally funded health centers furnished care in 4,128 sites, an increase of 42 percent compared to the number in 1997. Over the same four-year period, the number of people who received services in federally funded health centers grew 25 percent, reaching 10.3 million in 2001

² Daniel R. Hawkins and Sara Rosenbaum, Community Health Centers: Issues and Challenges. *The Future of the Health Care Safety Net* (American Association for the Advancement of Science, Chicago, IL, 1997)

³ Bailly BE, et al. *Experts with Experience Community & Migrant Health Centers Highlighting a Decade of Service (1990-2000)* U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. 2000.

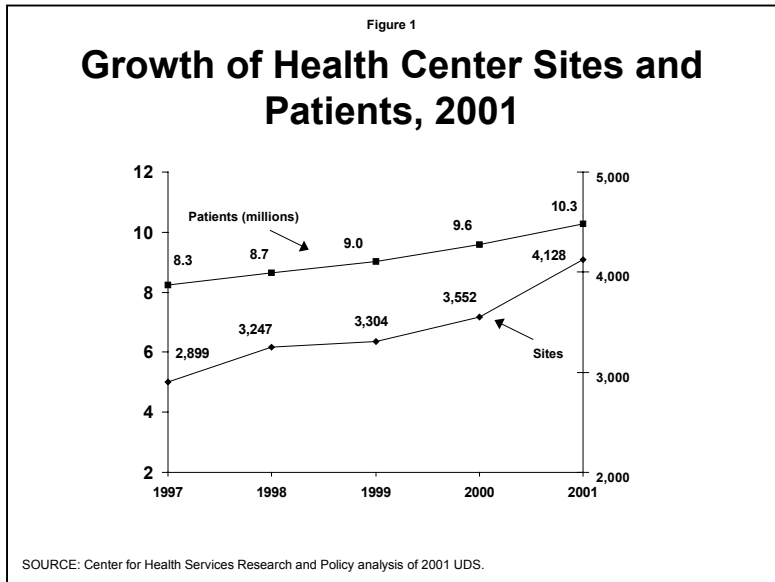
⁴ Sec. 330 of The Public Health Service Act, 42 USC Sec. 254b.

⁵ Sec. 331 of The Public Health Service Act, 42 USC Sec. 254d.

⁶ P.L. 107-257

⁷ Institute of Medicine, “Fostering Advances in Health Care” (National Academy Press, Washington D.C. 2002) p. 6.

(Figure 1). Actually, this figure understates the total patient volume, as health centers' obligation to report UDS information does not commence until an initial operational period has elapsed. Preliminary federal statistics indicate that new grantees in 2001 served an additional 500,000 patients.



Although the Uniform Data System information contained in this report is available only for federally funded health centers, state and local funds supported an additional 97 “look alike” health centers in 2001. In 2001, “look-alike” health centers served more than 900,000 patients. Taken together, then, federally funded health centers and these “look-alikes” served some 11.7 million persons in 2001, making the combined system of health centers the largest unified primary health care program in the United States.

Estimated Number of Patients Served by Health Centers, 2001	
Federally funded health centers	10.3 million
“New start” federally funded health centers	.5 million
“Look-alike” health centers	<u>.9 million</u>
<i>Total</i>	<i>11.7 million</i>

Defining Characteristics of Health Centers

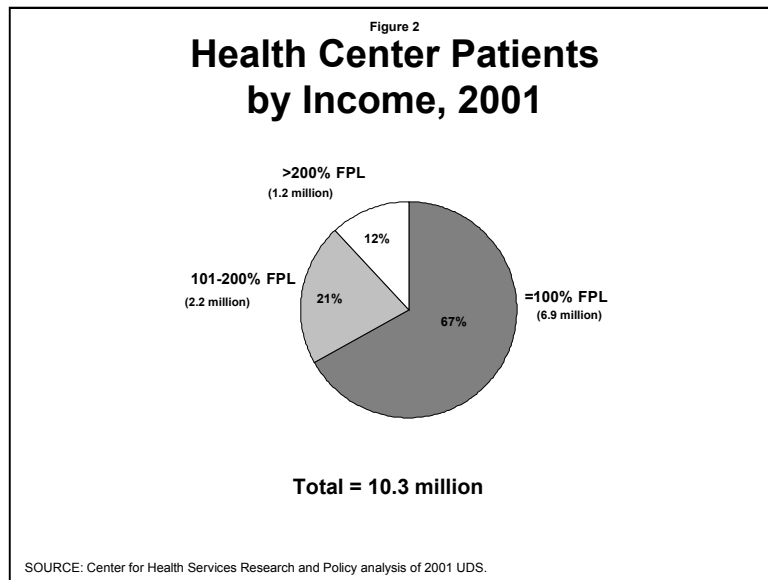
The federal health centers statute establishes certain basic criteria that apply to all entities that qualify for federal funding. All health centers:

- Are located in or serve communities and populations that have been formally designated as “medically underserved,” based on elevated poverty and diminished population health indicators;
- Provide comprehensive primary health care, consisting of primary medical care of the type found in a family medicine practice (frequently including dental care too), and services and patient supports needed to facilitate access to care, such as case management, translation, and transportation assistance;
- Serve the entire community and use a fee schedule adjusted for family income, to ensure that low-income patients face only nominal charges for the care they receive; and
- Are governed by a community board, the majority of whose members are patients of the health center.

Health Center Patients

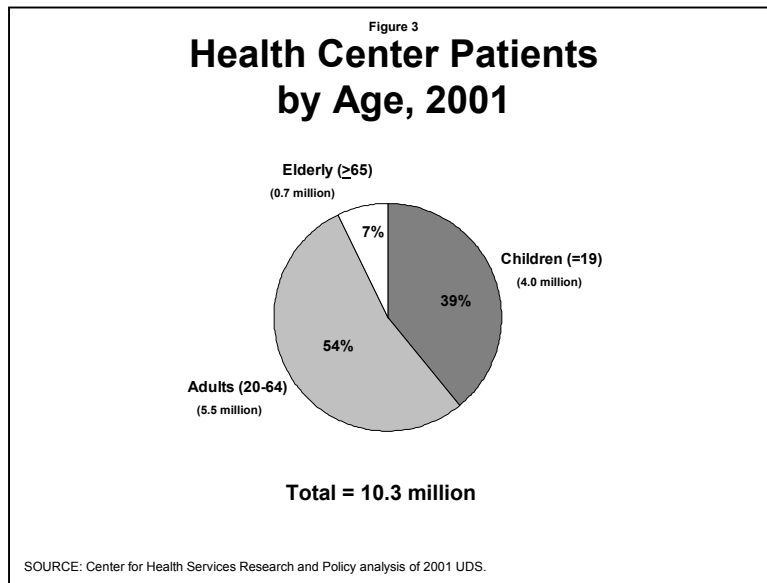
No two health centers serve precisely the same patient populations, but patients of federally funded health centers share certain common characteristics. Virtually all are low-income and they are disproportionately members of racial or ethnic minority groups. Most patients are either covered by Medicaid or are uninsured. The demographic composition, health status and insurance coverage of those served by health centers are described below.

Income. Health center patients are overwhelmingly low-income (Figure 2). In 2001, 88 percent of all health center patients whose family income was known at the time of service were at or below 200 percent of the federal poverty level (\$17,650 for a family of four in 2001). The vast majority (67 percent of all patients) had family income at or below the poverty level.⁸



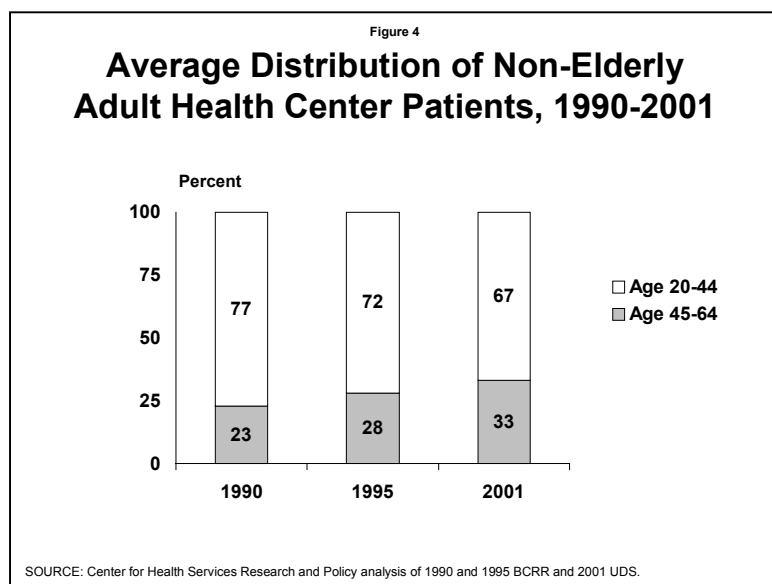
⁸ Proctor BD and Dalaker J. “Poverty in the United States: 2001.” Census Bureau Current Population Report. September 2002.

Age. In 2001, patients of health centers were relatively young on average. Thirty-nine percent of all health center patients were under age 20, 54 percent were working-age adults, and 7 percent were over 65 (Figure 3).



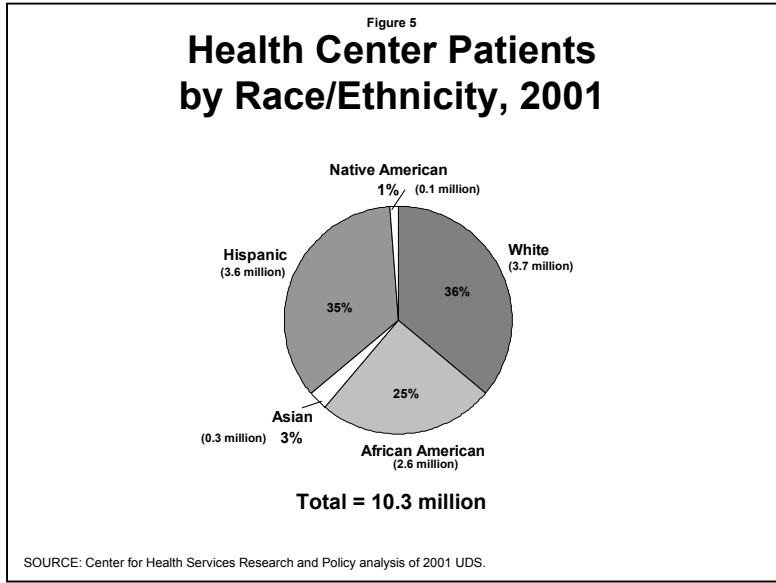
Closer analysis of trends, however, shows important dynamics in the adult health center population. Specifically, the average age of adult health center patients is rising, and the number of elderly patients is growing rapidly. Between 1990 and 2000, the number of elderly patients served by health centers grew by 55 percent (from 440,000 to 683,000), signaling the increasing role that health centers have come to play as a source of health care for the elderly over the last decade. This growth in the number of elderly patients also suggests that health centers may be facing increased service demands associated with the more complex health needs of the elderly.

Figure 4 shows how the age distribution of non-elderly adult patients served by health centers has changed over time. The figure shows a steady decline in the proportion of young working-age adults (age 20-44), from 77 percent of all non-elderly adult patients in 1990 to 67 percent in 2001; the proportion of older working-age adult patients rose



correspondingly, from 23 percent to 33 percent. This shift toward older working age adult patients also could be expected to signal a growing need for health services among adult patients.

Gender, race and ethnicity. In 2001, 59 percent of all health center patients were female. White patients represent the single largest racial/ethnic group receiving care in health centers (36 percent), but not the majority of all health center patients. On the contrary, in 2001, almost two-thirds (64 percent) of all health center patients were members of racial or ethnic minority groups. Hispanics, who comprised 35 percent of health center patients – a figure barely less than whites – constituted the largest minority population served (Figure 5). African Americans made up another 25 percent of health center patients. The remaining patients were of Asian descent (3 percent) or Native Americans (1 percent).



Health insurance status. Data on the insurance status of health centers’ patients underscore the mission of the program, and illuminate health centers’ role in serving the uninsured and individuals covered by Medicaid. Figure 6 shows the distribution of health center patients by insurance status.

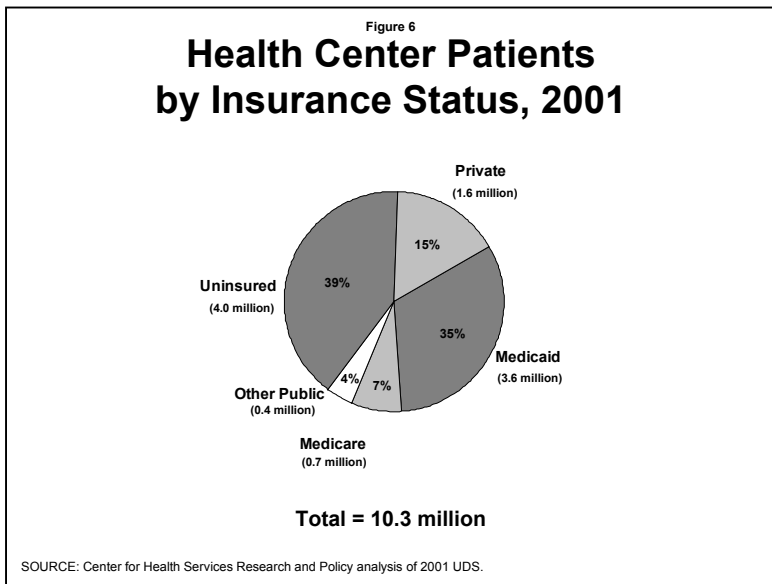
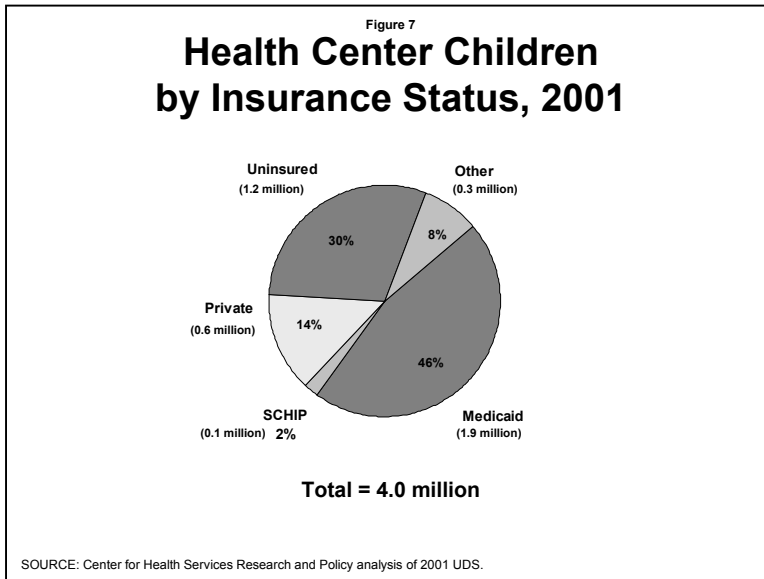


Figure 6 shows the distribution of health center patients by insurance status. In 2001, 39 percent of all health center patients were uninsured. Another 35 percent were enrolled in Medicaid, 7 percent received Medicare, 5 percent were privately insured, and 4 percent had other public insurance. Assuming the distribution was similar in new health centers and “look-alike” FQHCs,

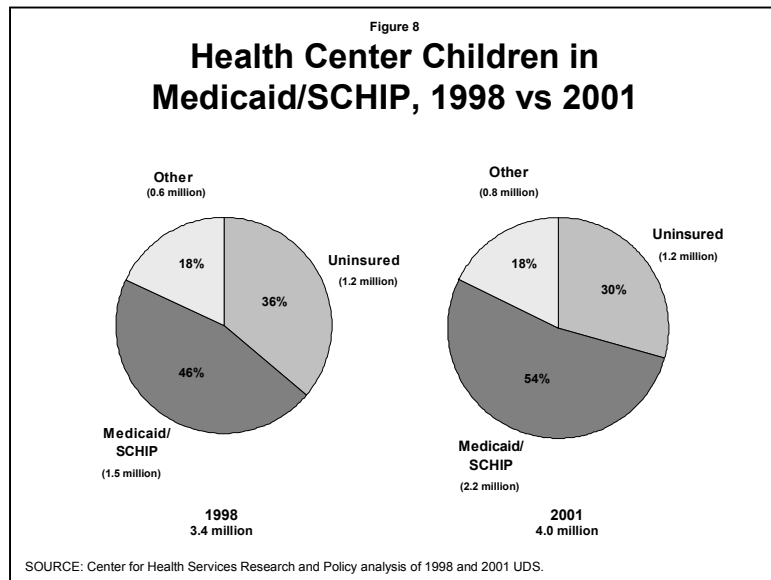
some 4.1 million of the total 11.7 million health center patients in 2001 were Medicaid beneficiaries.

While more than one-third of all health center patients are Medicaid beneficiaries, Medicaid is an even bigger factor among children: of the 4 million children who were patients in 2001, nearly half were enrolled in Medicaid (Figure 7). SCHIP's



role in health centers was very small; only 2 percent of all pediatric health center patients were enrolled in SCHIP. The minimal involvement of SCHIP reflects the depth of poverty among the children health centers serve – recall that, in 2001, two-thirds of all health center patients were at or below the federal poverty level – and the greater likelihood of Medicaid eligibility for that reason.

Although the proportion of health center children covered by Medicaid and SCHIP is smaller than might be expected given the prevalence of low income, the combined impact of recent Medicaid and SCHIP expansions has been significant. In 1998, of the 3.4 million children who were health center patients, 36 percent were uninsured and 46 percent were insured through Medicaid or SCHIP⁹ (Figure 8). By 2001, the number of children receiving services in health centers had grown by more than 15 percent. At the same time, the proportion who were uninsured had dropped to 30 percent, and the proportion with Medicaid or SCHIP coverage had risen to 54 percent. These figures suggest that some 200,000 children seen by health

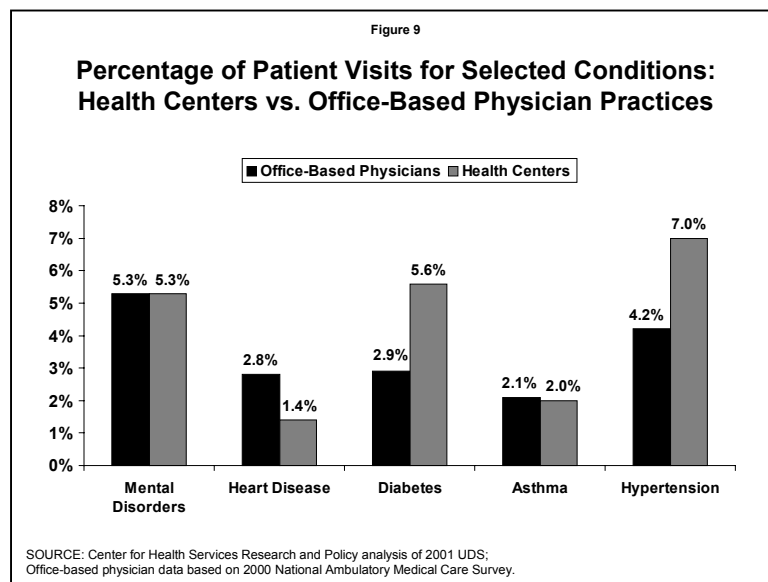


⁹ Since 1998, the UDS included insurance data by children (under 20 years) and adult (20 and over) age groups.

centers in 2001 who would otherwise have been uninsured had health insurance, due in large part to Medicaid and SCHIP expansions.

It is worth noting that, of the 1.2 million uninsured children served by health centers in 2001, a high proportion could be expected to be eligible for Medicaid or SCHIP. Research suggests that a key reason for non-enrollment of Medicaid-eligible individuals is the absence of active outstationed enrollment at health center sites – despite a provision of federal Medicaid law that requires such outstations in all federally qualified health centers (FQHCs) and disproportionate share hospitals.¹⁰

Health status. When UDS data are compared to health status data for the general population, there is evidence of worse health status among health center patients, particularly on selected key measures. A special analysis conducted by the government, that compared health status data from UDS and the National Ambulatory Medical Care Survey, shows that health center patients are more likely to experience hypertension and diabetes (Figure 9). These results suggest greater health care needs among health center patients, and associated higher health care costs.



Services Furnished by Health Centers

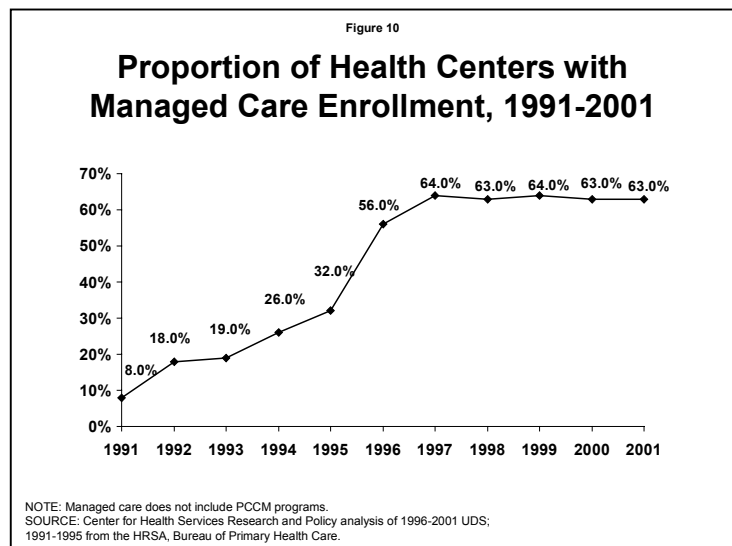
Health centers are best known for the comprehensive primary care services they furnish, but have also gained widespread recognition, as outlined by the recent IOM report, for their ability to manage chronic disease. The following details help to illustrate the scope, volume, and reach of the care health centers provide.

¹⁰ Nolan L, Harvey J, Jones K, Vaquerano L, and Zuvekas A. "The Impact of the State Children's Health Insurance Program (SCHIP) on Community Health Centers." The George Washington University Center for Health Services Research and Policy. June, 2002.

- Health centers reported a total of 31.1 million medical encounters (3.4 per patient served) and 3.2 million dental encounters in 2001 (2.3 per patient served), making them a principal source of primary medical care for low-income, medically underserved families, and frequently the *only* source of dental care.
- Health centers provide extensive women's health services. In 2001, health centers served over 324,000 pregnant women, accounting for approximately one in every 10 pregnancies among low-income women that year.¹¹ In addition, in the same year, health centers furnished 169,000 mammograms and over 1.1 million pap smears, making them one of the most important sources of preventive health care for breast and cervical cancer among low-income women.
- Since 1998, over 240 health centers have participated in disease management collaboratives in the areas of diabetes, asthma and depression in order to improve the management of these chronic diseases.
- In 2001, health centers provided transportation to health center sites to 1.1 million persons, and furnished translation services for approximately 2.9 million patients (comprising one-third of total health center patients) whose primary language was not English.
- In many areas, health centers may be the sole providers of mental health and substance abuse services. Health centers reported over 2 million encounters with 630,000 patients who had substance abuse problems or other mental disorders. Mental health and addictive disorders are now among the most common health problems reported by health centers.

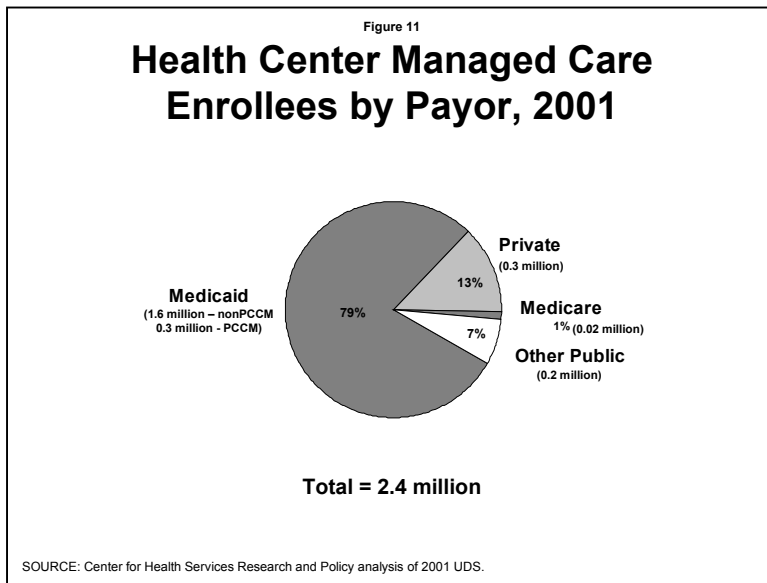
Health Centers and Medicaid Managed Care

Health centers participate actively in Medicaid managed care, and Medicaid managed care is a dominant component of health centers' overall managed care activity. In 2001, 63 percent of health centers reported providing services to patients enrolled in publicly or privately sponsored managed care plans (Figure 10), and 79 percent of all health center



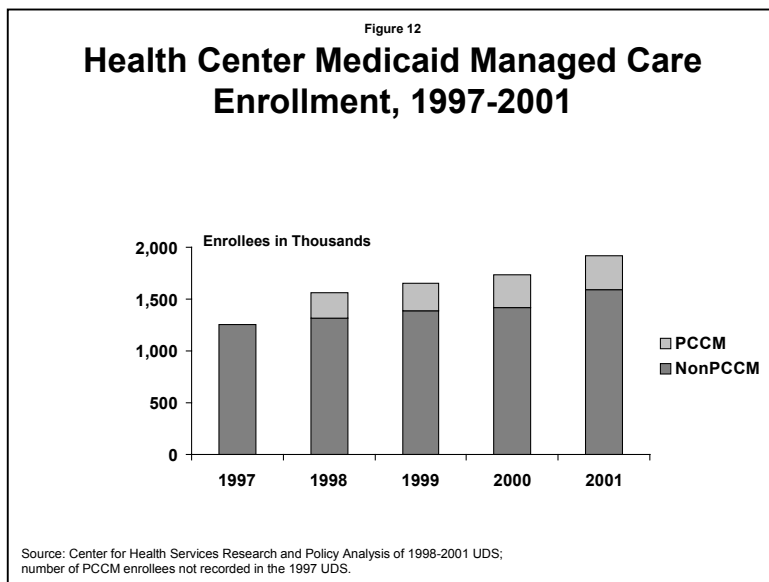
¹¹ Based on 2000 UDS estimates. As of 2001, the UDS does not collect data on the number of women known to be pregnant.

patients in managed care were insured by Medicaid (Figure 11). Over half the 3.6 million Medicaid patients seen by health centers were enrolled in some form of managed care.



Between 1997 and 2001, the number Medicaid enrollees who were members of risk based Medicaid managed care plans grew by 26 percent. That year, approximately one of every 12 Medicaid managed care enrollees received services from a health center, a fact that reveals the importance of health center services to managed care operations in most states.¹²

In 2001, the vast majority of health centers' Medicaid managed care patients were enrolled in capitated managed care organizations (83 percent), rather than PCCM arrangements (17 percent). However, states' increasing use of PCCM in recent years has led to an increase in the proportion of health center managed care patients who are enrolled in a PCCM arrangement (Figure 12).



¹² <http://cms.hhs.gov/medicaid/managedcare/mmcpr01.pdf>.

Patient Trends: Growing Medicaid and Uninsured Populations

Between 1997 and 2001, as the number of health centers grew, the volume of Medicaid and uninsured patients served by health centers also grew dramatically.

Health centers and the uninsured. Between 1990 and 2001, the number of uninsured Americans grew by 19 percent, from 34.7 million to 41.2 million. Over the same period, the number of uninsured persons served by health centers grew by 82 percent, from 2.2 million to 4 million (Figure 13). In 1990 health centers served 1 out of every 16 uninsured persons in the U.S.; by 2001 that

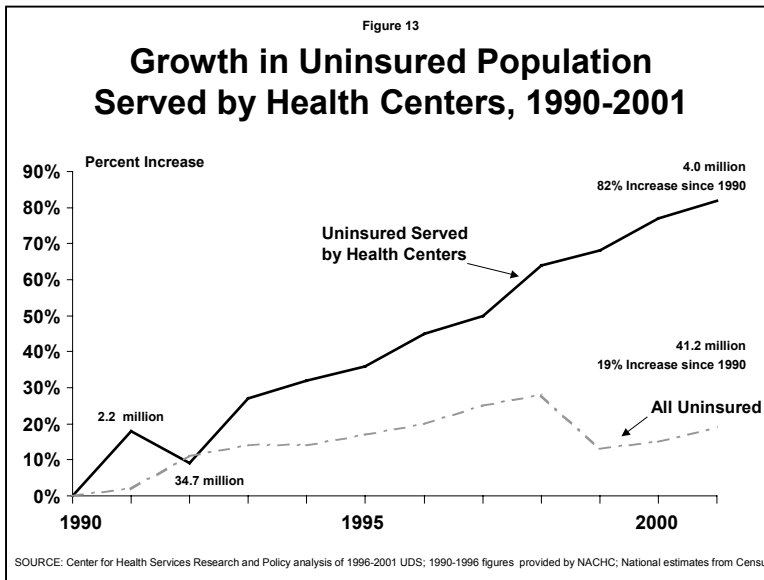
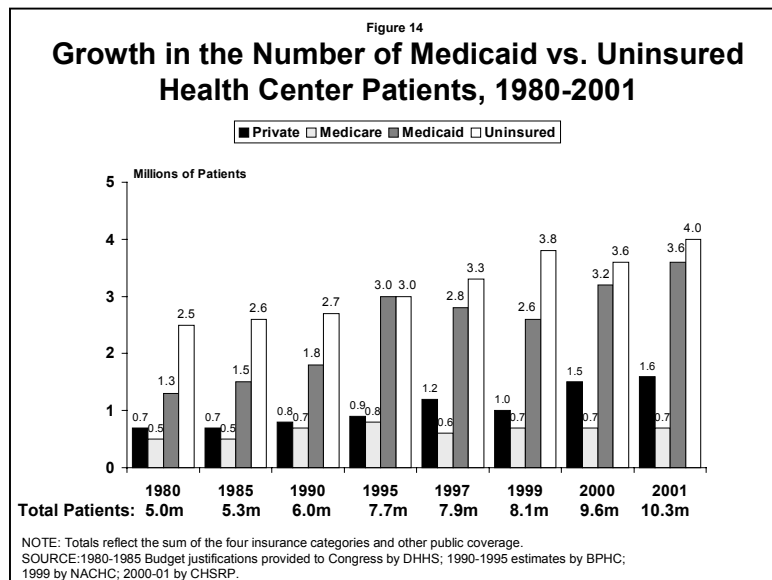


figure had grown to 1 in 10. This growth suggests increasing concentration of the uninsured in health centers – perhaps reflecting both the measurable decline in access to private physician services among uninsured patients¹³ as well as patients' perception of health centers as responsive and accessible providers.

Health centers and the Medicaid population. Between 1980 and 2001, the number of Medicaid patients served by health centers nearly tripled, from 1.3 million to 3.6 million persons (Figure 14), compared to 50 percent growth in total Medicaid enrollment in this period. Although growth in the number of Medicaid patients served by health centers tracks the growth of Medicaid

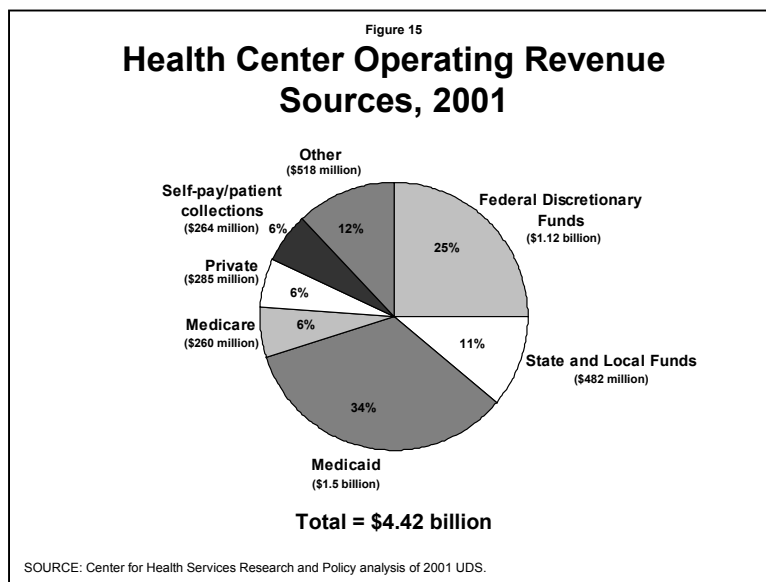


¹³ Cunningham PJ. "Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001." Center for Studying Health System Change, Washington D.C. 2002

generally, over the past decade, growth in Medicaid patients served by health centers has been greater than the growth in the overall Medicaid population. Additionally, between 1997 and 2001, as Medicaid enrollment rebounded after a significant drop following welfare reform, the number of health center Medicaid patients also grew after an initial decline, surging by 800,000.

Part 2: Health Center Financing: Medicaid’s Role in the Support and Expansion of Health Centers

Federally funded health centers are financed through a combination of federal grants from the Bureau of Primary Health Care, funds from state and local governments, public and private insurance payments, and patient fees. They receive start-up and operating funds through federal discretionary appropriations as well. Figure 15 shows that, in 2001, federally funded health centers’ total operating revenues stood at \$4.42 billion. Although, in the past, federal grants were the largest source of support for health centers, in 2001, they comprised just 25 percent of the total. The largest single source of health center financing was the Medicaid program, which contributed over one-third (34%) of total operating revenues. State and local funding accounted for another 11%, and payments from Medicare, private insurance and self-pay patients each amounted to 6% of centers’ total revenues. The remaining 12% came from other sources such as gifts, grants, and other types of payments.



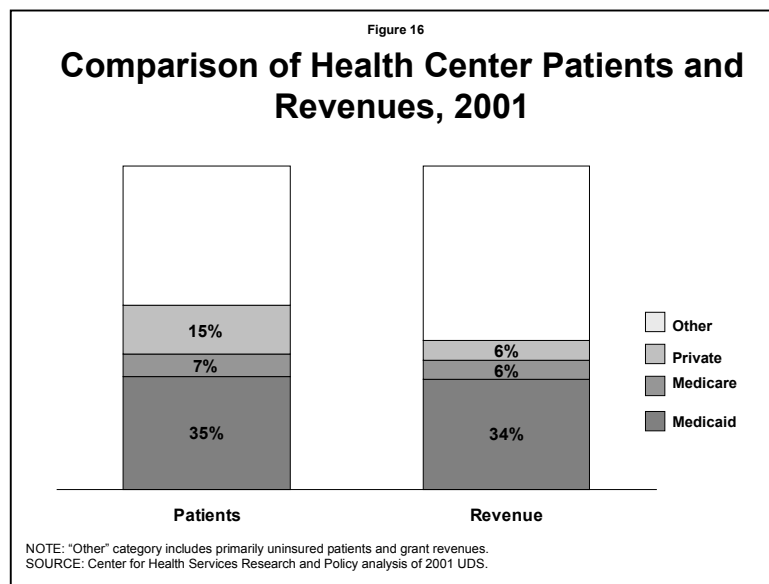
Federal discretionary funds. In 2001, total federal discretionary funding for health centers was enough to yield just \$279 for each uninsured patient served by a health center that year. Assuming that the 4 million uninsured patients served by health centers obtained all their care in these sites, this per capita amount might have been sufficient to cover the costs of the most basic care, but not to meet the needs for specialty and inpatient care. To understand how modest health center’s per capita grant payments for the uninsured are in relation to need,

compare this \$279 figure with the \$4,370 average per capita expenditure on personal health care in 2001.¹⁴ Thus, on a per capita basis, grants to health centers for uninsured patients covered only 6 percent of per capita health care expenditures that year.

Furthermore, not all federal appropriations for health centers are available to defray the costs related to providing services to current patients at current levels. A substantial share of the discretionary funds appropriated annually by Congress is needed to establish new health centers and/or to expand existing grantees' service areas. These funds are also needed to expand critical services such as dental care, mental health services, and prescription drugs, and to invest in activities such as participation in disease collaboratives, designed to improve the quality of health center care. Clearly, these competing needs for operating support and funds to expand into new communities or broaden available services place immense pressures on annual federal health center appropriations, which comprise only one-quarter of total health center operating funds.

In light of the large proportion of health center patients who are uninsured (39% in 2001), revenue shortfalls associated with caring for uninsured and under-insured low income patients present increasing challenges to health centers' ability to sustain their current operating levels. The significant decline in the number of private physicians who report that they treat uninsured patients¹⁵ further intensifies the pressure on health centers to act as a safety net.

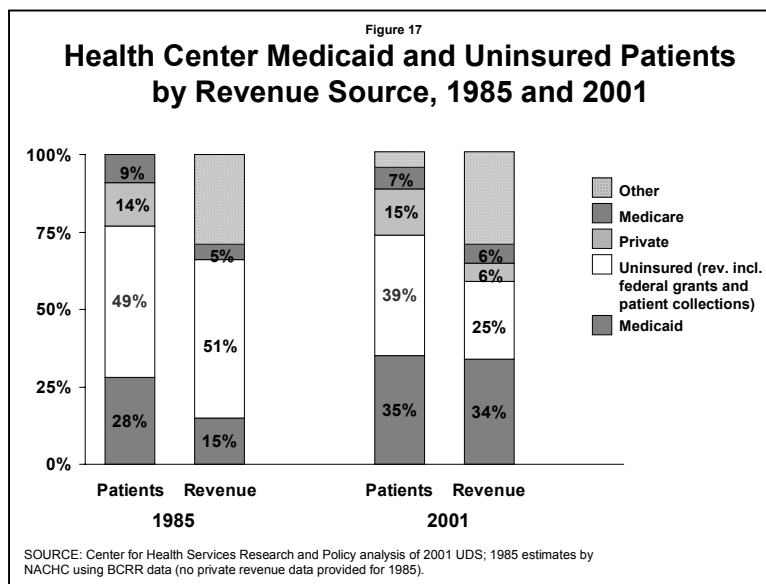
Health insurance. As Figure 16 displays, health insurance is a critical source of financing for health centers. Together, payments from Medicaid, Medicare, and private insurance made up 46% of centers' total operating revenues in 2001. Of these three payers, Medicaid played the largest role by far, accounting for nearly three-quarters of all health center revenues generated by insurance payments.



¹⁴ 2001 per-capita personal health care expenditures calculated from Levit et al., "Trends in U.S. Health Care Spending, 2001", *Health Affairs*, 22(1), Exhibit 1, p. 155, January/February 2003.

¹⁵ Cunningham P.J. "Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001." Center for Studying Health System Change, Washington D.C. 2002.

Figure 17 shows the distribution, by payer source, of health center patients and revenues in 1985 and 2001. Important shifts in the profile of health center patients and financing emerge from comparisons between the two years. The share of health center patients who were covered by Medicaid increased by one-quarter, to reach 35% in 2001; the proportion of health centers' operating revenues attributable to Medicaid more than doubled between the two years, from 15% to 34%. At the same time, the share of health center patients who were uninsured dropped by one-fifth (from 49% to 39%), and the portion of health centers' revenues attributable to federal grants – the principal source of payment on behalf of uninsured patients – fell by one-half, from 51% to 25%. This gap between the proportion of patients who are uninsured and the proportion of revenues that come from grants to support their care underscores the importance of adequate financing through public and private health insurance, which would ensure that grant funds for care of the uninsured are not used instead to defray the cost of serving insured patients.



In this regard, the private health insurance data presented in Figure 17 are notable. Figure 17 shows that in 2001, privately insured patients accounted for 15% of all patients but only 6% of their total operating revenues. This gap between patients and revenues might be attributable, in part, to the better health status and lower utilization of privately insured patients as well as less frequent use of health centers by this population. But key structural differences between Medicaid and private health insurance suggest a more compelling explanation. Whereas Medicaid offers comprehensive benefits, nominal or no cost-sharing and payment rates tied to health centers' operating costs, private health insurance—especially in the case of policies that are available and affordable for low-income persons—frequently offers more limited benefits, significant deductibles and coinsurance and steeply discounted provider payment rates. To the extent that the structure of private health insurance itself results in

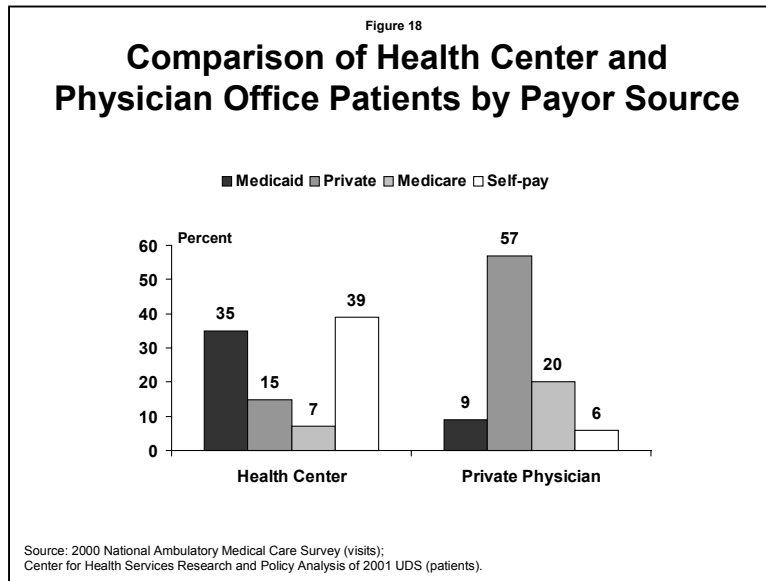
underpayment, further strain is placed on federal health center grant payments for support of the uninsured.

Medicaid's financing role. In 2001, Medicaid was the single largest beneficiary of health center services, as well as health centers' single largest source of financing. This fact crystallizes the fundamental interrelationship between Medicaid and health centers and suggests, by extension, that dynamics in one domain are bound to have important impacts in the other.

Numerous factors may underlie the observed growth in the Medicaid proportion of health center patients and revenues, including:

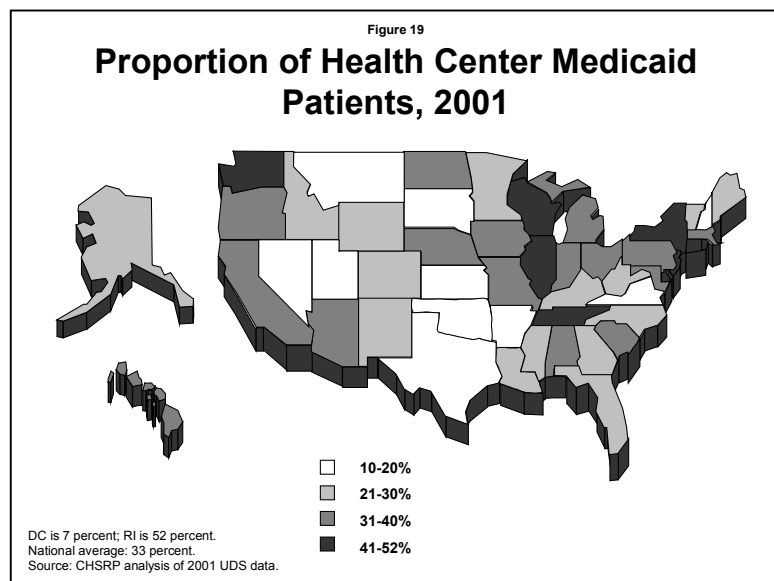
- *Medicaid eligibility expansions.* Between 1985 and 2001, legislation mandated important expansions in Medicaid eligibility, and many states undertook additional expansions using optional and demonstration authorities. The effect of these expansions, together with demographic shifts and changes in the economy, was a more than doubling of Medicaid enrollment, from roughly 22 million in 1985 to about 45 million in 2001.
- *Broad Medicaid benefit package.* Also in this period, the Congress passed "Federally Qualified Health Center" legislation that mandated Medicaid coverage of health center services (as well as payment on a cost-related basis). Coverage became particularly comprehensive for children following the broadening of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits in Medicaid. EPSDT encompasses comprehensive health assessments, CDC-recommended immunizations, vision, dental, and hearing care, and case management services for those with chronic conditions – all services that a health center might furnish. Furthermore, Medicaid routinely pays for health center services provided "off-site" (e.g., in schools, mobile vans, public housing satellite clinics, homeless shelters). In contrast, even generous levels of private health insurance tend to be more limited in their coverage of services for children with chronic developmental conditions and typically pay only for services provided at a health center's main site, and may exclude from coverage services provided by non-physicians, such as nutritionists and translators.
- *Medicaid payment rates and arrangements.* As mentioned above, Medicaid payments to health centers are governed by reasonable cost principles. Private insurance, on the other hand, may pay deeply discounted rates and involve more complex and time-consuming claims payment procedures. Also, unlike Medicaid, private insurance requires increasingly high deductibles and co-payments, which could have the dual effect of suppressing utilization among low-income privately insured patients, and reducing health center revenues from private insurance, if unpaid cost-sharing amounts are borne as bad debt by the institutions.

Taken together, these changes in Medicaid had a significant impact on health centers, which in turn have become a mainstay of the delivery system on which Medicaid beneficiaries depend. Just how significant Medicaid is to health centers in comparison to private primary care physicians can be seen in Figure 18, which compares the insurance coverage status of patients seen in these two settings. Whereas Medicaid covers only 9% of all physician office visits, it covers 35% of all health center patients.

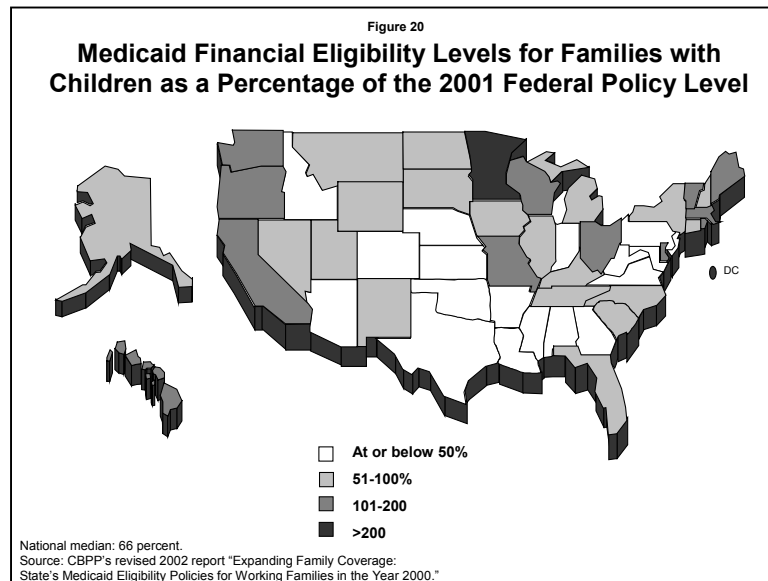


To shed more light on the broader context in which Medicaid provides key financing to health centers, we identify below aspects of states' Medicaid programs and other factors that affect the amount of Medicaid revenue that health centers receive. The state-to-state variation in the Medicaid proportion of patients served by health centers (Figure 19) likewise reflects the contribution of the factors we highlight here.

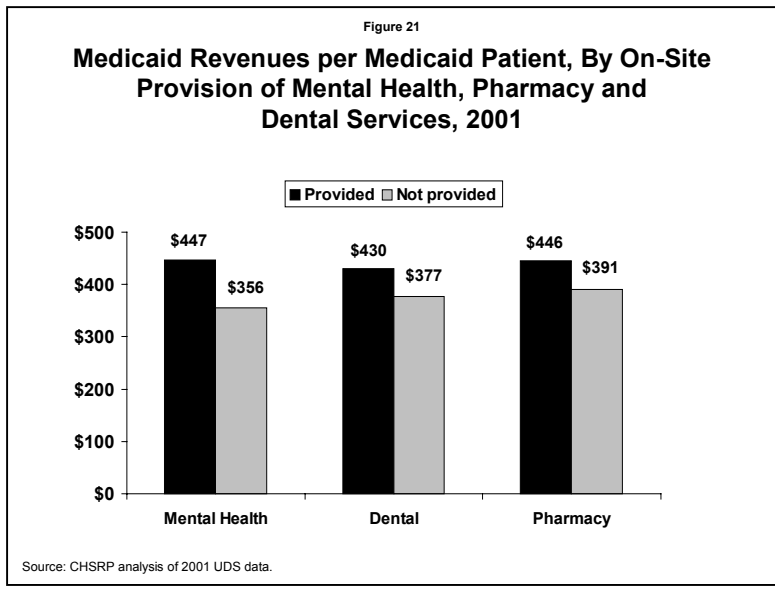
- Medicaid income eligibility standards.* Working-age adults and their children are the predominant users of health centers. Thus, states' Medicaid income eligibility criteria for children and families, which determine the size of the population eligible for the program, have an important



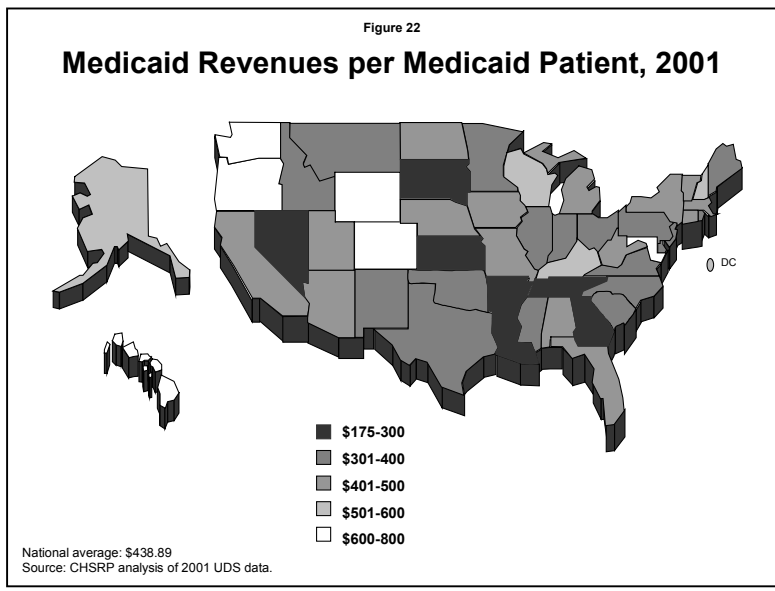
impact on the role Medicaid plays as a source of financing for health centers. Figure 20 shows state Medicaid eligibility standards for families with children.



- **Medicaid eligibility and participation.** The prevalence of certain sub-populations among whom Medicaid eligibility and enrollment have historically been limited (e.g., homeless people, persons who are not citizens or permanent residents, and migrant and seasonal workers) is likely to depress Medicaid revenues relative to other revenue sources.
- **Provider supply issues.** The impact of physician supply and office-based physician participation in Medicaid may affect the extent to which Medicaid beneficiaries obtain care from health centers.
- **Medicaid reasonable cost payment.** Although federal law requires that Medicaid payments to health centers be related to their costs, states have important discretion regarding the methods they use to determine costs. For example, a state may set upper limits on the costs it will allow for certain items, such as professional clinical and administrative services and staffing, rent, or overhead. States also have discretion to determine whether they will recognize costs related to capital expenditures (e.g., space and equipment) for expansion or initial establishment of new service locations.
- **Outreach and enrollment efforts.** The presence in health centers of outstationed eligibility workers who actively help enroll patients in Medicaid can increase the role that Medicaid financing plays.
- **Health centers' scope of services.** Health centers that offer a broader scope of Medicaid-covered services on-site – in particular, dental care, pharmacy, and mental health benefits – can be expected to bring in more Medicaid revenue. The data shown in Figure 21 support this association.



State by state differences in the factors described above lead to considerable state variation in average Medicaid revenue per Medicaid patient received by health centers (Figure 22). In 2001, Medicaid revenues per capita ranged from \$175-\$300 in Arkansas and Louisiana, to \$600-\$800 in the states of Washington, Oregon, and Maryland.



Part 3: Health Centers, Medicaid, and the Implications of Current Trends and Reform Proposals

This paper on health centers illuminates issues vital to the debate concerning the organization and financing of health care for low-income and uninsured populations in the U.S. These issues stem from the fact that we ask health centers to respond to a set of critical challenges, ranging from furnishing basic

care to meet the diverse needs of the uninsured, to providing a medical home and managing primary and specialized services for millions of low-income publicly insured patients. Meeting these challenges requires that health centers have operating revenues sufficient to maintain their capacity; expansion of existing sites, investment in new health centers, and sustainable funding for the additional capacity created are likewise essential.

Yet, it seems clear that, despite the growing numbers of people without health insurance and the rising costs of health care, federal discretionary funds to finance care for the uninsured will continue to play only a modest role overall in the support of the health centers program. To ensure that the limited federal discretionary funds are available for expansions, new starts, and maintenance of established service sites, health centers therefore must seek maximum resources from other payers to preserve access to care for their overwhelmingly low-income and uninsured patients. As documented here, it is Medicaid that has become the single most important source of financial support for health centers.

Corresponding to the significance of Medicaid financing for health centers is the significance of health centers as a source of access to care for those covered by Medicaid. In 2001, 4.1 million health center patients¹⁶ – over one-third of the 11.7 million persons who received care in these sites – were insured by Medicaid. Health centers furnished care to approximately 1 of every 12 non-institutionalized Medicaid enrollees that year¹⁷ and they are the regular source of care for many Medicaid beneficiaries. The high quality, comprehensive primary care health centers provide – regardless of patients' insurance status – has been well documented.

Recognizing the key role of health centers in the fabric of the health care safety net, the Bush Administration has made expansion of the program a major component of its health policy platform. In the radio address he delivered in conjunction with the 2002 reauthorization of the health centers program, the President emphasized health centers' importance and announced a goal of 1,200 new and expanded health centers by 2006.¹⁸ More recently, in his budget for fiscal year 2004, the President proposed dramatic changes in the Medicaid program. Under the proposal, states could elect to replace the current eligibility entitlement and the shared, open-ended federal-state financing with capped federal funding and unprecedented flexibility to change current eligibility, benefits, and cost-sharing.

In light of the close relationship between health centers and Medicaid, the President's goal of doubling health center capacity must be considered in conjunction with his Medicaid reform proposal. While new state flexibility to expand coverage under the proposal has been hailed, the severe fiscal crises

¹⁶ Includes Medicaid patients from federally funded health centers and look-alikes.

¹⁷ The Congressional Budget Office estimates 44.6 million Medicaid beneficiaries in 2001. "Medicaid and the State Children's Health Insurance Program." March 2002 Baseline.

¹⁸ Radio address by President George W. Bush, October 26, 2002.

across the states dim any real prospects for eligibility expansion. On the contrary, even with open-ended federal matching dollars available, state revenue shortfalls have led many states to propose or take actions to reduce their Medicaid outlays, including eligibility retrenchment, increased cost-sharing, and benefit cut-backs. Given a weak economy and rising numbers of uninsured, the aging of the population, and the steeply rising costs of acute and long-term care – particularly for the more than 6 million elderly and people with disabilities whom Medicaid covers, the additional pressure of a cap on federal Medicaid funding seems certain to lead to further contraction, not expansion, in the Medicaid program.

In addition to the coverage and/or benefit losses that would result directly from reductions in Medicaid, access to care would also be jeopardized because of the acute vulnerability of health centers to Medicaid policy. To illustrate, if states used their new flexibility to reduce Medicaid benefits, then the comprehensive array of services for which health centers now receive Medicaid payment could shrink substantially. Likewise, if not required to pay health centers based on their costs, states might decide to lower their payment rates, leaving health centers with new funding gaps in place of the sustaining payments they get now for the one-third of their patients who are covered by Medicaid. The President's proposed \$784 million for new and expanded health centers over a five-year time period would not be sufficient to offset the mounting operating revenue shortfalls faced by health centers as the population ages, the uninsured numbers grow, and the costs of care increasingly outstrip the relatively low payments that appear to be made on behalf of privately insured patients. Rather, the outcome seems likely to be reduced health center capacity and given the limited participation of private practitioners in Medicaid, reduced access to care for Medicaid beneficiaries, the uninsured, and other low-income populations.

The health care safety net is a complicated weave in which the threads of financing and access are tightly intertwined. The relationship between the health center program and Medicaid, documented in detail in this paper, indicates how stresses on either one cannot help but weaken the other – risking this highly successful component of the nation's system for providing primary and preventive care for vulnerable populations. As the national debate on health care proceeds, proposals that affect Medicaid and health centers should be considered carefully and with special attention to their net impact on financing of these essential providers and on access to care for the low-income and vulnerable populations they serve.

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The Kaiser Commission on Medicaid and the Uninsured was established by The Henry J. Kaiser Family Foundation to function as a policy institute and forum for analyzing health care coverage, financing and access for the low-income population and assessing options for reform. The Henry J. Kaiser Family Foundation is an independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.