

medicaid
and the uninsured

**Health Centers Reauthorization
An Overview of Achievements and Challenges**

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March 2006

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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 bipartisan group of national leaders and experts in health care and public policy.

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EXECUTIVE SUMMARY

Since the establishment of the first health center in 1965, health centers have evolved into an essential component of the health care safety net. Today, over 1,000 federally funded and “look-alike” health centers serve 14.3 million people, three-quarters of whom are uninsured or covered by Medicaid. As the nation’s largest primary care system, health centers care for one in five low-income uninsured persons and one in nine Medicaid beneficiaries.

Health centers serve a predominantly poor and minority population. In 2004, over 70 percent of health center patients had incomes below 100 percent of the Federal Poverty Level (FPL), and 91 percent had incomes below 200 percent FPL. A majority of patients were racial or ethnic minorities. Over one-third were Hispanic, and nearly one-quarter were African American in 2004. Health centers are also an essential source of health care for people without insurance and those on Medicaid. In 2004, 40 percent of health center patients lacked insurance and another 36 percent were covered by Medicaid. These patients often face barriers accessing health care services, and might have gone without needed care had health centers not been available to them.

In response to increasing need, health centers have grown significantly in recent years. Overall, the number of health center sites increased 58 percent from 1997 to 2004, and the number of patients increased 90 percent over the same time period. Yet, despite an increase of 141 percent in the number of uninsured patients served from 1990 to 2004, health centers alone were not able to ensure adequate health care access for all the uninsured.

Health centers rely heavily on Medicaid to finance their overall operations. In 2004, health centers’ total operating revenues were \$6.7 billion. Medicaid was the primary payer accounting for over one-third of total operating revenues followed by federal grants at just under a quarter. In contrast, payments from Medicare and private payers represented six percent each of total operating revenues. The growing reliance on Medicaid has occurred over time. In 1985, Medicaid accounted for only 15 percent of total revenues increasing to 37 percent in 2004. Adjusted for inflation, Medicaid revenues per patient grew by 138 percent over the same time period. At the same time, federal grant funds per uninsured patient fell by 31 percent in real-dollar terms.

The importance of Medicaid to the financial strength of health centers is even more evident when comparing the revenues received from each payer to what the health centers charged for providing the services. In 2004, the payment to charge ratio for Medicaid was 87 percent compared to 70 percent for Medicare and only 57 percent for private health insurance.

There are a number of reasons for the low payment rates received from Medicare and private insurance companies, but the causes are primarily the lack of payment protections similar to those offered by Medicaid and high patient cost sharing requirements. Unlike for private insurance, federal rules govern Medicaid payments to health centers. These rules mandate that payments account for the costs of providing services, thus ensuring the adequacy of payments. Although Medicare also pays a preferred payment rate to health centers, these payments have been subject to an overall cap since 1992. The often high

cost sharing requirements imposed on Medicare and privately insured health center patients also contribute to health center losses on these patients. Because health centers refuse to turn away patients due to an inability to pay, they only collect what patients are able to pay, writing off any unpaid amounts.

The effect of the payment shortfalls from Medicare and private insurance is to reduce the number of patients health centers are able to serve. If Medicare and private insurance plans had paid health centers at the Medicaid level in 2004, an additional 200,000 patients could have been served.

Despite the success of health centers, they face a number of future challenges. As the program looks toward reauthorization in 2006, these challenges will likely form the context of the policy debate. These challenges include:

- Medicaid changes in the Deficit Reduction Act of 2005, including increased state flexibility over benefit design and cost sharing requirements, which will likely lead to a rise in the number of uninsured patients and a decrease in Medicaid revenues;
- Implementation of the Medicare Part D drug benefit that may affect how and where low-income health center patients obtain needed prescription drugs, and whether health center pharmacies will continue to be reimbursed for the drugs provided to their dually eligible Medicaid patients;
- Increasing numbers of uninsured and underinsured patients with complex health needs at the same time that revenues to cover the uninsured are declining;
- The need to improve quality through investment in and adoption of health information technology and the development of other strategies aimed at improving continuity of care and care coordination;
- Pressure to respond to the needs of an increasingly diverse patient population; and
- The need to increase by nearly 50 percent the health center workforce over the next few years to meet goals set out by the President and to better align the National Health Service Corps program with the Health Centers program to guarantee a vital health center workforce in the future.

The growth and performance of health centers over the past four decades are a testament to their resilience in the face of remarkable change in the nation's health system. The reauthorization of the health center program offers an opportunity to celebrate its successes but also to address ongoing challenges to ensure the continued vitality of health centers in the future.

INTRODUCTION

On December 11, 1965, the nation's first neighborhood health center opened its doors. Located in the heart of Boston's Columbia Point Housing Project, an impoverished and heavily minority public housing project, the health center's mission was to bring affordable and accessible services to a neighborhood whose residents lived with the daily realities of racial and economic exclusion. Columbia Point was established by a group of pioneering physicians on the faculty of Tufts University Medical Center and was modeled on clinics established to furnish health care to residents of South Africa's racially segregated homelands.

Columbia Point would soon be followed by health centers in Mound Bayou Mississippi, Chicago, Denver, the Watts neighborhood of Los Angeles, and in other locations. These initial health centers struggled with many of the same patient care issues that challenge policy makers today: the need to emphasize quality, encourage patient accountability, and meet the unique needs of their communities through "enabling" services and the provision of care in a culturally competent fashion. Finally, the first health centers sought an approach to health care that ultimately gained enormous prominence and has become a central theme of health care quality and accountability today: the integration of patient care with public health and community-wide interventions. In this way, these health centers focused on improving the overall health of their communities, as well as that of individual patients.¹

While health centers' roots can be found in the civil rights movement and the War on Poverty,² their fundamental mission and community achievements have enabled them to thrive throughout four decades of astounding health system change. By 2004, 914 federally funded health centers, along with 97 additional "look-alike" health centers funded with state, local, and private funds, furnished health care to more than 14.3 million persons in all states and the District of Columbia. Today's health center network is the nation's largest primary care system, serving one in nine Medicaid beneficiaries, one in five low-income uninsured persons, and one in seven low-income, non-elderly U.S. residents (i.e., at or below 200 percent of federal poverty level).³

This policy brief provides a profile of health centers today, using the latest available federal data. Following this profile, the report examines the key challenges health centers face in sustaining and improving health care in their communities and assesses the potential impact of the President's FY 2007 budget proposal. During 2006 Congress is expected to enact legislation to reauthorize the program (as with other programs authorized under the Public Health Service Act, the health centers program is time-limited and must be renewed every several years). The issues and challenges reviewed here are expected to form the policy context for program reauthorization.

¹ H. Jack Geiger, 2005. "The First Community Health Centers" *Jour. Amb. Care Management* 28:4 pp. 313-319.

² B. Lefkowitz, 2005. "The Health Centers Story: Forty Years of Commitment," *Jour. Amb. Care Management* 28:4 (Oct.-Dec.) pp. 295-303

³ Calculation by GWU, Center for Health Services Research and Policy, using Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

A PROFILE OF HEALTH CENTERS

Background

The legislative authority establishing the health centers program is found at Section 330 of the Public Health Service Act,⁴ which provides grants to develop and operate primary health care clinics that furnish care to residents of geographic areas considered medically underserved or to special, medically underserved populations such as migrant farmworkers, or homeless persons.⁵ Unlike other federal grant programs that provide funding to states in the form of block grants to serve designated populations (such as persons with serious mental illness⁶ or mothers and children⁷), health centers receive direct federal funding. In this sense, the health centers program represents a distinct federal investment in community health.

By law, health centers must meet four basic standards in order to receive funds to support overall operations and help defray the costs of serving uninsured patients:

- Be located in or serve a medically underserved community, defined as one with a high proportion of low income persons and demonstrably elevated levels of death and disability from preventable causes;
- Offer a comprehensive range of primary health services, as well as supportive services such as translation and transportation services that promote access to health care;
- Prospectively adjust the fees charged for services based on patients' ability to pay, using a published sliding fee schedule; and
- Be governed by a board, a majority of whose members are health center patients.⁸

In a federal policy context, there actually are two classes of health centers: the large number that receive federal grants under §330; and a much smaller but important group of entities that meet all §330 location, service, affordability, and governance requirements but whose operating grants come from state, local and private revenue sources. This latter group of entities is known as “look-alike” health centers. These entities, like their federally funded counterparts, qualify for special coverage and payment treatment through Medicaid and Medicare.

⁴ 42 U.S.C. §254b

⁵ 42 U.S.C. §254b(a)(1)

⁶ Mental Health Services Block Grant, 42 U.S.C. § 300x et. seq.

⁷ The Maternal and Child Health Services Block Grant 42 U.S.C. §701 et. seq.

⁸ 42 U.S.C. §254b(a) and (e)

Health centers operate in collaboration with other safety net providers in their communities, including public hospitals, community hospitals with mission-driven commitments to care for underserved residents, and an estimated 800-1,000 “free clinics” located throughout the country.⁹ Through these collaborations, health centers are able to promote access to the full continuum of care, from primary to specialty to inpatient hospital care.

As a result of the extensive data collected from federally funded health centers by the federal government and available through the Uniform Data System (UDS),¹⁰ a great deal is known about health centers. UDS data allow a relatively close examination of the patients served, services furnished, the health center workforce, and revenues received. No federal data are collected on look-alike health centers; however, the National Association of Community Health Centers collects and makes available a limited amount of patient data from these clinics. When available, this information is presented along with the UDS data to give as full a picture as possible.

How Many Patients Are Served by Health Centers?

In 2004, 914 federally funded health centers provided primary health care to more than 13 million patients at more than 5,500 urban and rural sites, which include over 650 newly established delivery sites.¹¹ Additionally, an estimated 97 look-alike FQHCs served approximately 1.2 million patients. In total, all FQHCs served 14.3 million persons¹² (Figure 1).

Figure 1
Estimated Number of Patients Served by Federally Funded and Look-Alike Health Centers, 2004

<u>Type of Health Center</u>	<u>Number of Centers</u>	<u>Number of Patients Served</u>
Federally Funded Health Centers	914	13.1 million
“Look-alike” Health Centers	97	1.2 million
Total	1,011	14.3 million

Source: 2002 UDS data on federally funded health centers, supplemented by data on look-alike centers from the National Association of Community Health Centers.

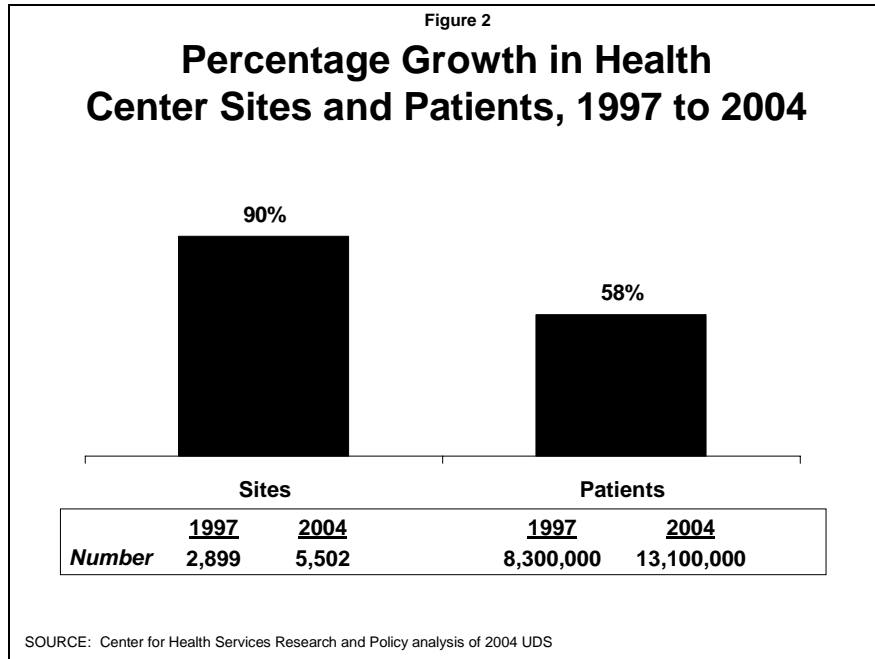
⁹ Catherine Hoffman and Susan Starr Sered, *Threadbare: Holes in America’s Health Care Safety Net* (Kaiser Family Foundation, Washington D.C., 2005). Available at <http://www.kff.org/uninsured/upload/Threadbare-Holes-in-America-s-Health-Care-Safety-Net-report.pdf> (Accessed December 20, 2005).

¹⁰ Federally funded health centers are required to submit tabulated financial, utilization, and patient demographic data to the Health Resources and Services Administration.

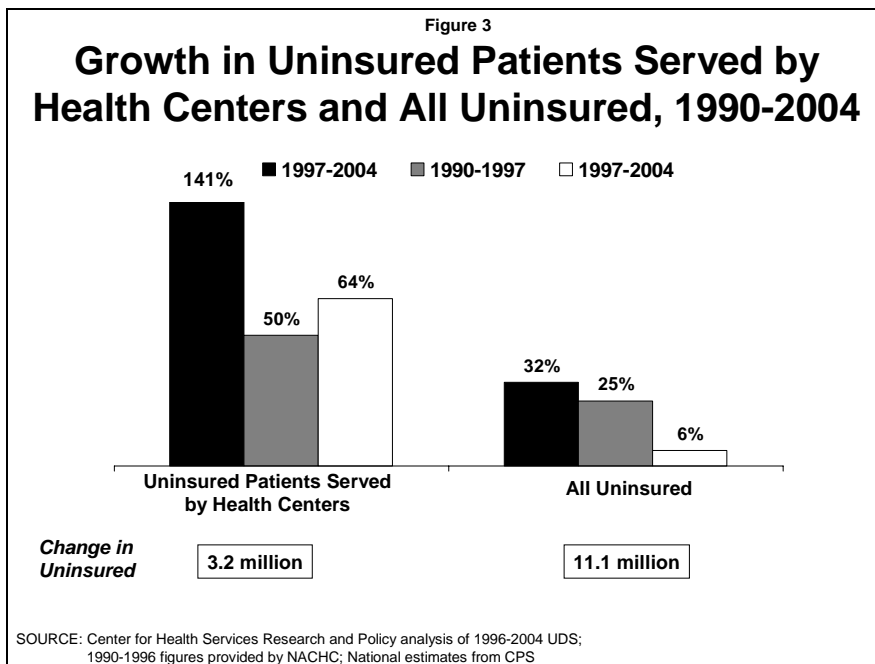
¹¹ General Accountability Office, “Health Centers: Competition for Grants and Efforts to Measure Performance Have Increased.” July 2005 (GAO-05-645).

¹² Because of the lack of reporting requirements, data on look-alikes are limited to Figure 1.

Over the past few years, health centers have grown significantly in terms of both the number of sites and the number of patients served. Between 1997 and 2004, the number of federally funded health center sites grew by 90 percent, while the number of patients served grew by nearly 60 percent (Figure 2).



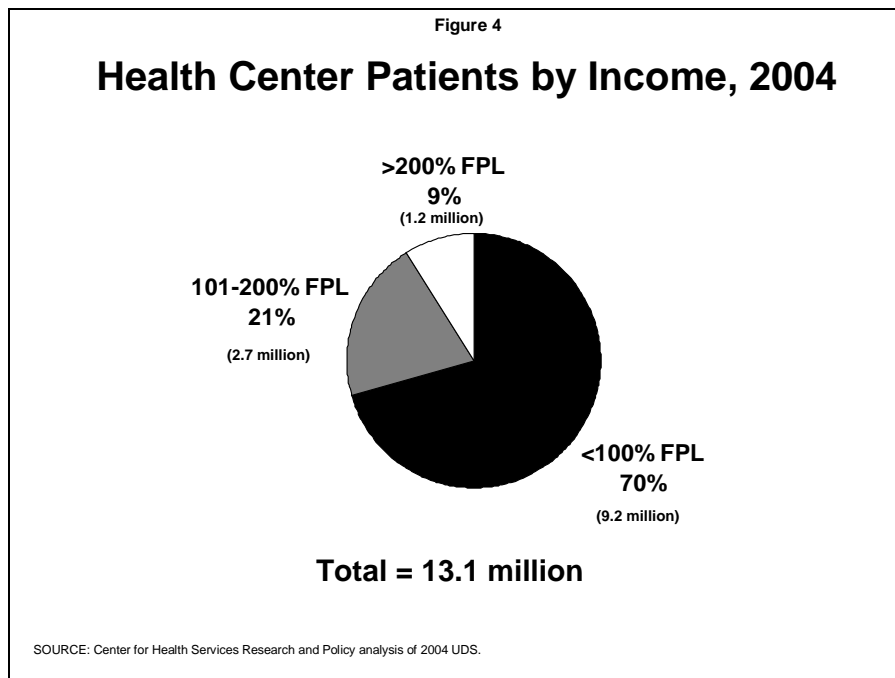
The increase in the number of uninsured served by health centers was also substantial. Between 1990 and 2004, the number of uninsured users grew by 141 percent, far surpassing the national increase in uninsured persons over this time period (Figure 3).



However, even as health centers have expanded to respond to the problem of medical underservice, their availability remains inadequate to meet national estimates of need. The 14.3 million persons reached by federally funded and look-alike health centers in 2004 represented only one-quarter of the estimated 50 million low-income people without a regular source of health care that year.¹³ In response to President Bush's 2005 recommendation for the establishment by 2008 of a health center in every poor county (defined by the Administration as counties with over 35.3 percent of their residents living below 200 percent FPL), one study concluded that new health centers would be needed in more than 900 poor counties. Over 20 million people live in these counties; 42 percent are poor and more than 3 million are uninsured (representing 8 percent of all uninsured persons nationally).¹⁴

Who Are the Patients Served by Health Centers?

The demographic profile of health center patients reflects centers' statutory mission. In 2004, 91 percent of the 13.1 million health center patients had family incomes at or below 200 percent FPL (Figure 4). Over 70 percent of all health center patients that year had incomes of less than 100 percent FPL, compared to 17 percent of the U.S. population generally.¹⁵

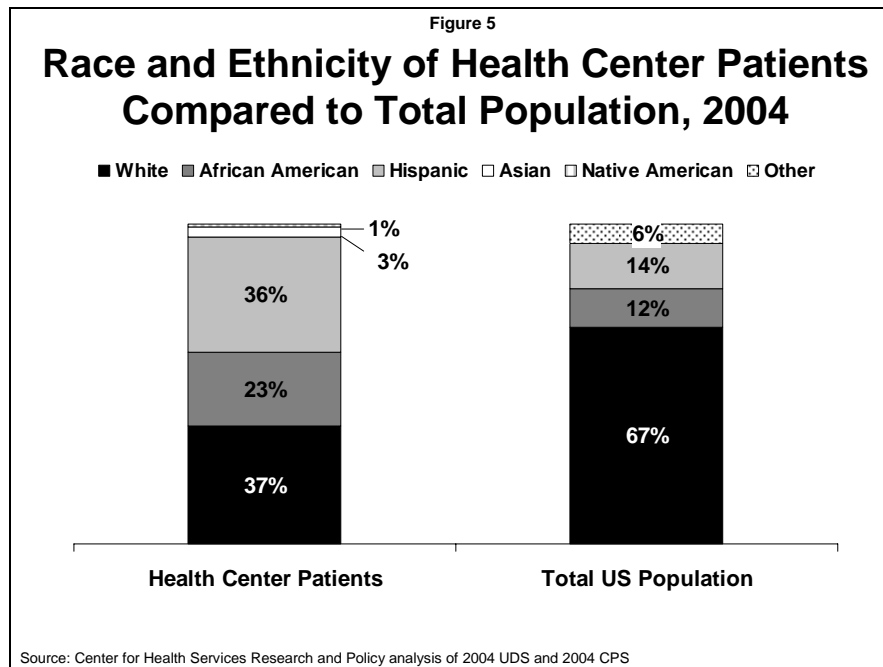


¹³ D. Hawkins and M. Proser, "A Nation's Health at Risk," *Special Topics Issue Brief #4* (Washington, D.C.: National Association of Community Health Centers, March 2004).

¹⁴ Michelle Proser, Peter Shin and Dan Hawkins, *A Nation's Health At Risk III: Growing Uninsured, Budget Cutbacks Challenge President's Initiative to Put a Health Center in Every Poor County*. (NACHC, Washington D.C., 2005). Available at www.nachc.com

¹⁵ Urban Institute and Kaiser Commission on Medicaid and the Uninsured national estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

Health centers are an important source of health care for minority populations. In 2004, 63 percent of health center patients were racial or ethnic minorities. Over one-third were Hispanic, and nearly one-quarter were African American (Figure 5).



Health centers also represent a critical source of health care for low income women and children. In 2004, an estimated 29 percent of health center patients were women of childbearing age (15 - 44 years of age), and 37 percent were children under 20 years of age. In addition, seven percent of patients were persons ages 65 and older. These patients were typically covered by Medicare, but, like most other health center patients, were poor.

Reflecting the effects of poverty and more limited access to health care, health center patients are in poorer health than the general population.¹⁶ Between 1996 and 2004, the proportion of health center visits for chronic conditions increased from 8 to 18 percent.¹⁷ As of 2004, more than a quarter of all medical visits at health centers were tied to the treatment of a chronic condition.¹⁸

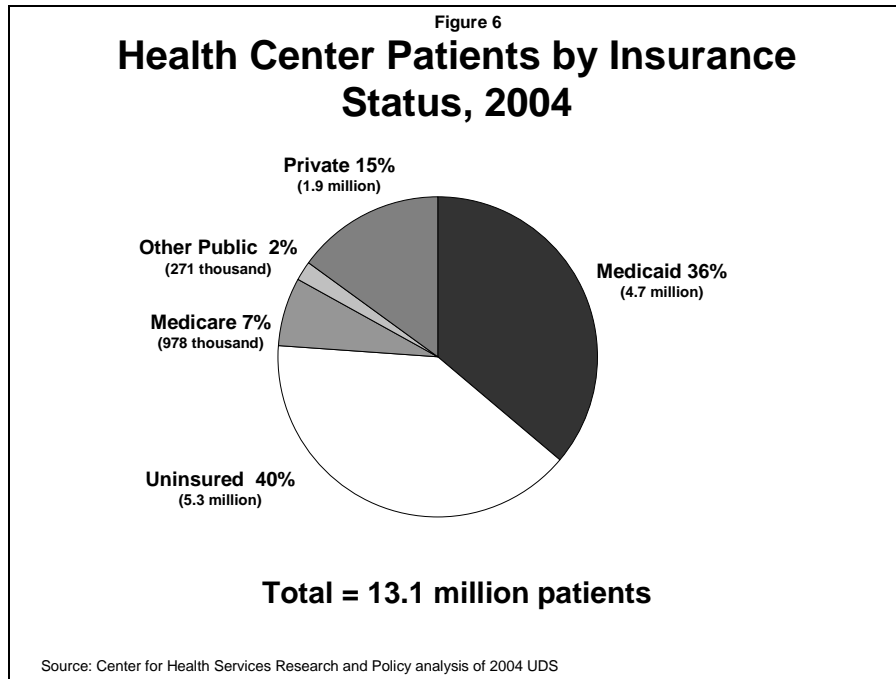
Health centers play an important role in providing access to uninsured patients and those covered by Medicaid. In 2004, 40 percent of patients were uninsured, while another 36 percent were covered by Medicaid. The 4.6 million Medicaid patients served by health

¹⁶ A. Zuvekas, K. McNamara, and C. Bernstein, "Measuring the primary care experiences of low-income and minority patients," *Jour. of Ambulatory Care Management* 22:4 63-78; R. Politzer et. al., "Inequality in America: the contribution of health centers in reducing and eliminating disparities in access to care," *Medical Care research and Review* 58(2) 234-248.

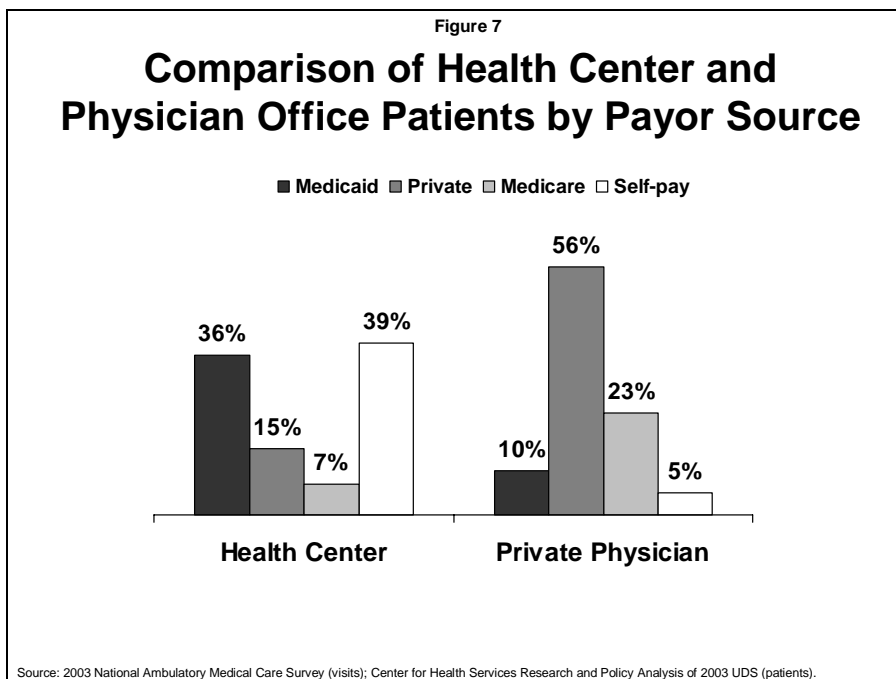
¹⁷ Based on health center visits for HIV, asthma, chronic bronchitis and emphysema, diabetes, heart disease, and hypertension.

¹⁸ National Association of Community Health Centers, *The Safety Net on the Edge* (NACHC, Washington D.C., 2005). Available at www.nachc.com/research/Files/SNreport2005.pdf.

centers represented roughly 11 percent of all persons enrolled in Medicaid that year. While over three-quarters of health center patients were either uninsured or enrolled in Medicaid only 15 percent had private health insurance (Figure 6).



The patient mix at health centers differs significantly from that found in private primary care physician practices. While Medicaid and self-pay (or uninsured) patients made up three-quarters of the total health center patient population in 2003, only 15 percent of patients seen in private practices were self-pay or Medicaid (Figure 7).



What Services Do Health Centers Provide?

By law, health centers must provide certain primary care services as a condition of receiving operational grants. These primary health services encompass a broad range of services and patient supports, as shown below.

Primary Services at Health Centers

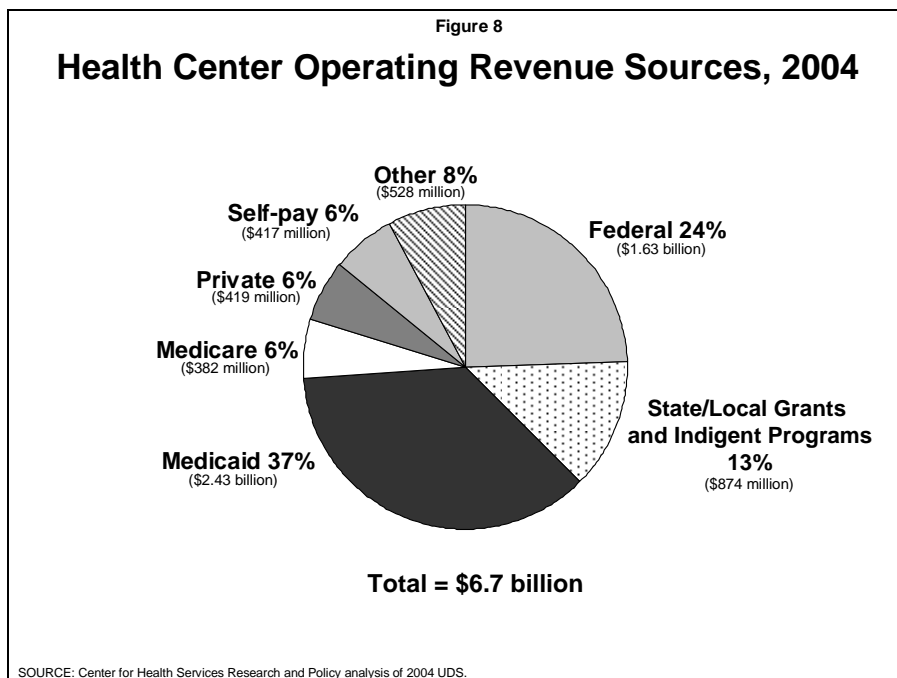
1. Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;
2. Diagnostic services;
3. Preventive health services, including prenatal services, well-child care, immunizations, cancer and other preventive health screenings, family planning services, and preventive dental services;
4. Emergency medical services;
5. Pharmaceutical services;
6. Referrals to other medical and health-related providers, including substance abuse and mental health providers;
7. Case management services;
8. Enabling services, such as transportation and translation services; and
9. Patient education.

Source: 42 U.S.C. §254b(b)(1)

HEALTH CENTER FINANCING

In 2004, federally funded health centers' total operating revenues stood at \$6.7 billion. Medicaid was the largest revenue source (37 percent) followed by federal grants (24 percent) and state and local grants (13 percent). Payments received from uninsured patients nearly equaled payments from private insurance companies and Medicare; each represented six percent of total operating revenues (Figure 8).

The shift in health center revenue mix over time has been dramatic. When health centers were created in 1965, they were almost wholly supported by federal grants. By 2004, federal grants had declined to 24 percent of health centers' total operating funds, while Medicaid had increased to more than one-third of total operating revenues. The decline in federal grants for the uninsured has been somewhat offset by an increase in state and local grants and funding from indigent care programs. Combined, these sources comprise 37 percent of operating revenues, equaling Medicaid's contribution. Nevertheless, Medicaid's role in financing health center operations is significant.

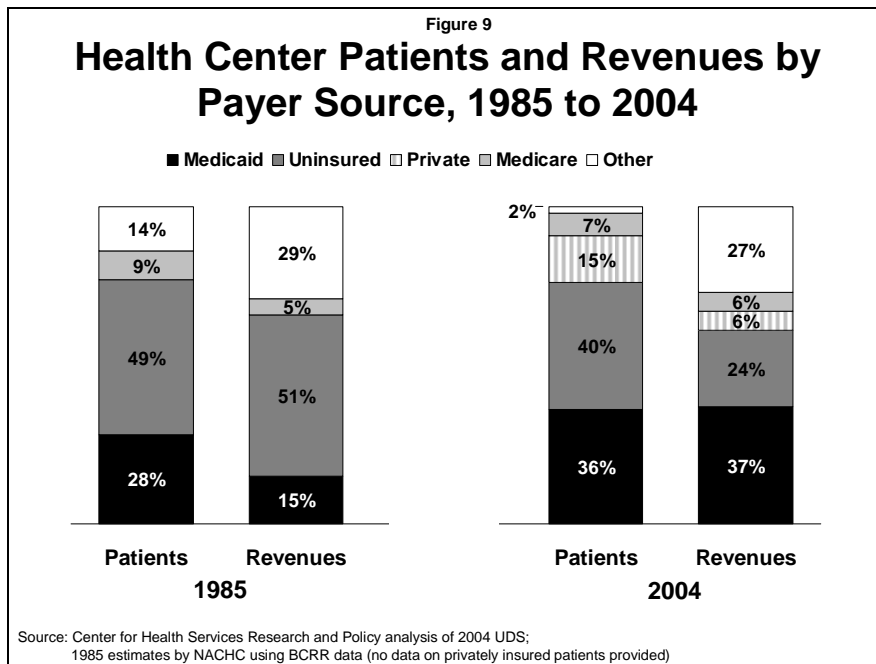


Medicaid's Role in Fueling and Sustaining Health Center Growth

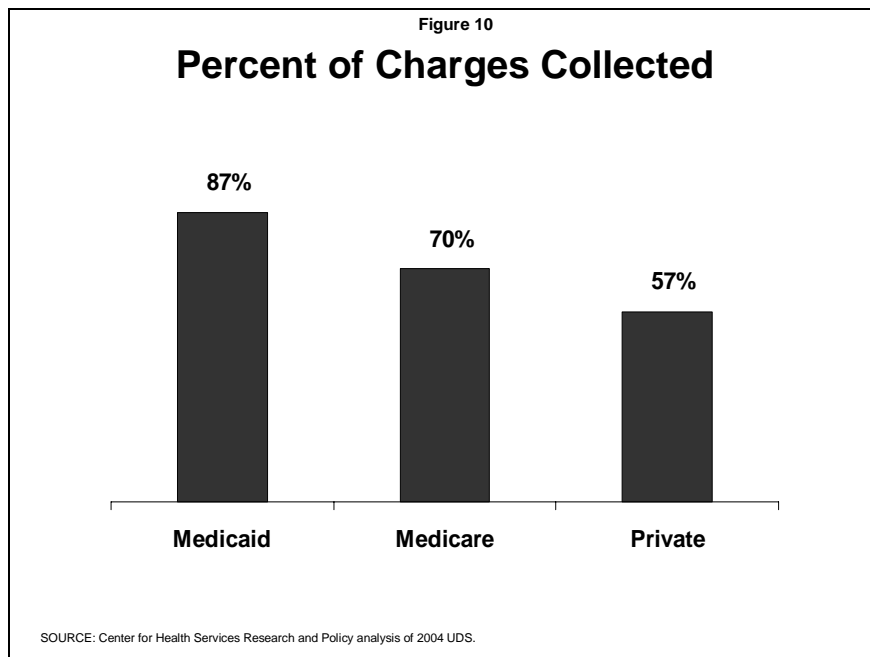
Medicaid's increasingly important role as the health care safety net for low-income people has also been instrumental in supporting health center expansion over the past 20 years. Medicaid coverage expansions have meant that individuals who would have been uninsured 20 years ago, particularly low-income children and pregnant women, are now covered by Medicaid. Many of these Medicaid beneficiaries receive their care at health centers. In addition, Medicaid payment policy changes have resulted in fair reimbursement for health centers for the costs of caring for Medicaid patients.

The growing influence of Medicaid on health center operations can be seen in changes over time in the proportion of patients served and in the distribution of revenues. In 1985, approximately 600 health centers served 5.3 million patients. Nearly half of these patients were uninsured while only just over a quarter (28 percent) were enrolled in Medicaid. By 2004, the total number of patients served by health centers had increased to 13.1 million, and the number of uninsured and Medicaid patients served increased 147 percent. While uninsured patients still exceeded Medicaid patients, the gap had closed, with the uninsured representing 40 percent and Medicaid patients representing 36 percent of total patients served (Figure 9).

Over the same time period, Medicaid revenues also grew both in terms of real dollars and as a proportion of total revenues (Figure 9). Health centers experienced nearly a 19-fold increase in overall Medicaid revenues and a 551 percent increase in Medicaid revenues per patient. Adjusted for inflation, Medicaid revenues per patient grew by 138 percent over nearly two decades. By contrast, over this same twenty-year time period, federal grant funds per uninsured patient grew by only 88 percent in nominal funds, but fell by 31 percent in real-dollar terms.



Another way to highlight Medicaid's unique support for health centers is to examine the payment-to-charge ratio for Medicaid and other payers. The payment to charge ratio compares revenues received from each payer against what a health care provider charges for the services provided. When revenues are compared to charges, Medicaid is by far the strongest payer. In 2004, Medicaid paid 87 cents for every dollar charged. In contrast Medicare paid 70 cents per dollar charged and payments from private health insurance yielded only 57 cents in revenue for every dollar charged (Figure 10).



The relative strength of Medicaid reimbursement can be explained largely by federal payment rules that mandate payments to health centers account for the costs of providing services to Medicaid patients. Payment rules implemented in 1989 established a cost-based reimbursement methodology that set minimum payments at 100 percent of reasonable costs. Statutory changes in 2001 shifted Medicaid health center reimbursement from one reflecting all reasonable costs to one in which costs are recognized prospectively in order to permit more cost controls while still accounting for increases in the costs of providing services. While somewhat more limited, this system still ensures continued adequate Medicaid payments to health centers.

Other factors also contribute to the relative adequacy of Medicaid payments, including comprehensive coverage and the limited cost sharing responsibilities borne by Medicaid-insured patients. Health center services are a mandatory Medicaid benefit, meaning they must be covered by all state programs. Additionally, the comprehensiveness of Medicaid coverage amounts to relatively good coverage for chronic and high cost health conditions such as mental illness and HIV/AIDS. Nominal cost sharing requirements in Medicaid also mean that health centers are not at risk for large unpaid cost sharing in the form of copayments, deductibles, and coinsurance.

Health Centers Lose Money on Medicare and Privately Insured Patients

Unlike reimbursement for Medicaid patients, health centers lose money on Medicare and privately insured patients. While the reasons vary by payer, the low payment rates result from the lack of payment protections, more limited coverage, and higher patient cost sharing requirements.

Although Medicare, like Medicaid, covers FQHC services¹⁹ in accordance with a preferred payment rate, in fact, Medicare FQHC payment levels have been subject to a cap since 1992.²⁰ Despite steadily rising costs over the intervening decade, Medicare payments increasingly have fallen in relation to health center costs, even as patients have become more complex to manage.

Private health insurance, on the other hand, offers no payment protections. Moreover, private health insurance coverage for low income workers (those typically served by health centers) is often limited and requires relatively high cost sharing on the part of the employee. As a result, insurance policies do not cover some of the services health centers provide, and patients typically cannot pay the required coinsurance or deductible amounts. An unwillingness to turn people away because of inability to pay means that health centers only collect what patients are able to pay, writing-off any unpaid amounts.

Low payment-to-charge ratios in the case of Medicare and private health insurance carry significant implications for the strength of health centers. If health centers are unable to recapture the cost of caring for insured patients from insurers, the shortfall directly affects the availability of grant funds meant for care of the uninsured. Because uninsured health center patients are virtually all low income and unable to absorb insurance payment shortfalls, this means that ultimately, fewer uninsured patients can be served.

¹⁹ 42 U.S.C. §§ 1395-1395g

²⁰ 42 CFR 447

The net effect of insurance payment shortfalls translates into real health care loss. In 2004, Medicare and private insurance represented \$800 million in revenues; had these insurers paid health centers at the Medicaid level that year, health centers would have realized an additional \$96 million in revenues, which would have translated into over 200,000 more patients served.

KEY CHALLENGES FACING HEALTH CENTERS

As health centers look toward reauthorization of their program, they face many challenges. The biggest of these challenges stems from federal policy changes to the Medicaid program and, to a lesser degree, the implementation of the Medicare Part D drug benefit. These changes will likely have a direct, financial impact on health center operations. Health centers must also contend with a rising, and increasingly complex, uninsured population. And, in an era of potentially tightened funding and reimbursement, health centers must continue to provide the high quality, culturally competent care on which their patients rely.

For FY 2007, the President has proposed a \$181 million increase in the federal health center appropriation, a recommendation that is particularly notable given the broad range of recommended program funding reductions that also are contained in the Administration's budget request. At the same time, this request represents only a 10 percent increase over FY 2006 appropriations levels to fund the remaining 300 of 1,200 new health center sites.²¹ However, the request represents only a 7 percent increase in real dollar terms, and the amount of funding may be insufficient to cover all 300 new starts. Furthermore, recent changes in federal Medicaid policy may more than offset this modest gain with large losses, if federal Medicaid policy shifts translate into state reforms that reduce eligibility, coverage, and health center payments.

Implications of Federal Medicaid Changes on Health Centers

The Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006, makes changes to the Medicaid benefit package and cost sharing requirements that could in turn have a significant impact on health centers, depending on how states implement the reforms.

Following are key aspects of the legislation.

- The legislation imposes new citizenship verification requirements on all applicants, and at least one study has estimated that these requirements will result in an enrollment drop of between 3 and 5 million persons nationwide.²² Because Medicaid beneficiaries disproportionately rely on health centers for primary care, health centers may face significant Medicaid enrollment declines among their patients.

²¹ Department of Health and Human Services, "Budget in Brief," page 20.
<http://www.dhhs.gov/budget/07budget/2007BudgetInBrief.pdf> (Accessed February 21, 2006)

²² L. Ku, D.C. Ross, and M. Boraddus, "Survey indicates the Deficit Reduction Act jeopardizes Medicaid coverage for 3 to 5 million US citizens," Center on Budget and Policy Priorities (February 17, 2006 revised).

- The law permits states to substitute “benchmark coverage” for the existing Medicaid benefits package for most children and adults. Exceptions to this benefit flexibility include children who must continue to receive all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits to which they are entitled, mandatory pregnant women, parents whose coverage is mandatory, individuals with disabilities or special medical needs, and people with long-term care needs. Modeled on private insurance and the type of coverage offered under separately administered State Children’s Health Insurance Plan (SCHIP) programs,²³ this new benchmark coverage is expected to be less comprehensive than the traditional Medicaid benefit package. For example, in a state that substituted benchmark coverage for near poor families, certain key benefits commonly used by health center patients such as family planning services and supplies, would no longer be required. Although the law provides for continued coverage of FQHC benefits, with payment at the special FQHC rate,²⁴ it is unclear at this point how this special FQHC coverage rule will be implemented in a benchmark state. Thus, the impact of the loss of coverage could translate into a substantial revenue loss.
- Additionally, the new law permits states to impose premiums on certain low income individuals and families and to increase cost sharing obligations, both of which could translate into a significant revenue loss to health centers, as their sliding fee scales offset patients’ higher out-of-pocket payment exposure. (Unlike private providers, health centers could not turn away any patient unable to pay cost sharing, even though they are now permitted to do so by the DRA).

This trend toward more limited benefits and higher premiums and cost sharing will likely affect health centers in several significant ways. First, the imposition of premiums may lead to a rise in uninsured patients as people lose Medicaid coverage because they cannot afford the premiums. Second, as states shift groups of Medicaid enrollees away from traditional Medicaid and toward benchmark plans with limited coverage and high cost sharing, patients with chronic conditions can be expected to begin experiencing significant coverage limits, especially for physical and mental conditions requiring long-term treatment involving specialty care, prescription drugs, and other community services. How this shift affects the ability of health centers to manage patients with higher health needs will bear close watching.

These major shifts in the range of permissible Medicaid design options -- which ultimately can be expected to affect health centers’ most important revenue source at a time of growing need -- form an important backdrop to reauthorization.

Implementation of the Medicare Part D Drug Benefit

Health center Medicare patients, who are not also eligible for Medicaid (dual eligibles), can be expected to benefit significantly from the implementation of Medicare Part D as they gain prescription drug coverage they previously did not have (although to date, many low-income Medicare beneficiaries who are not dually eligible have yet to sign up for the drug benefit).

²³ S. Rosenbaum, A. Markus, and C. Sonosky, “Public health insurance design for children: The evolution from Medicaid to SCHIP,” *Suffolk Journal of Health and Biomedical Law*, 2004; 1(1):1-47.

²⁴ S. 1932 §3044

At the same time, dual eligibles who received prescription drug coverage through Medicaid prior to Part D implementation, may find themselves enrolled in prescription drug plans that do not cover the drugs they need or place limits on the quantities of drugs that are covered. Assisting patients in understanding their new coverage will be important to avoid unnecessary health complications and may require additional services on the part of health center clinical and case management staff. Equally significantly, 680 health centers offer pharmacy services as an onsite service. These pharmacies rely heavily on reimbursement from Medicaid to fund their operations. If these pharmacies are unable to participate in the plans to which their dually enrolled Medicare patients are assigned, they may experience a significant decrease in revenues

At the same time, the new benefit may offer some health center pharmacies the potential of limited revenue gains. Those health centers able to contract with plans chosen by their Medicare patients who are not duals will be reimbursed for drugs they currently provide to their Medicare patients at low or no cost. Although small, these revenues could then be used to expand the availability of drugs to the uninsured. How the Medicare Part D benefit will affect health centers depends in large part on their ability to participate in the drug plans being offered to their Medicare patients.

A Rising Number of Uninsured and Underinsured Patients with Complex Health Needs

Health centers confront a steep growth trajectory with respect to uninsured patients. Although the proportion of uninsured patients health centers serve has declined over the past twenty years, this group still represents an enormous challenge for health centers in terms of sheer numbers and intensity of need. These clinics are located in the very communities most likely to feel the effects of declining employer coverage and a Medicaid program that will be increasingly less able to meet the health care needs of low income residents.

As the data on health center patient status indicate, the patients health centers serve are increasingly burdened by complex conditions that make management a challenge in primary care settings alone. Health centers already encounter serious difficulties finding specialists to treat their low income patients.²⁵ As the benefit cuts in Medicaid take effect and further erosion of private coverage occurs, health centers will likely face greater obstacles to securing referrals for more intensive care needed by their patients.

Improving Quality and Reducing Health Disparities

A wealth of studies has examined the quality of care furnished by health centers, with notable results. Health centers have been widely recognized for the quality of their care,²⁶ and have had a documented impact on reducing racial and ethnic health disparities, as measured by infant mortality rates, tuberculosis case rates, death rates, and lack of access

²⁵ M.K. Gusmano, G. Fairbrother, and H. Park, "Exploring the limits of the safety net: community health centers and care for the uninsured," *Health Affairs*, 21, no. 6 (2002):188-194.

²⁶ B.E. Baily et al, *Experts with Experience Community and Migrant Health Centers Highlighting a Decade of Service (1990-2000)* (Washington, D.C.:U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, 2002).

to prenatal care.²⁷ Health centers also ensure quality care at lower costs by providing a regular source of primary and preventive health care services and, thus, reducing costly emergency room use and avoidable hospitalizations.²⁸ However, health centers face important new challenges in the area of quality improvement, particularly with respect to the adoption of health information technology, a step President Bush considers essential to the ability of the health care safety net to meet its core missions of health quality improvement and reductions in health disparities.²⁹ Health centers will need to invest in significant capital improvements covering a range of needs over the next decades, from new service sites to new equipment and the hardware and software system investments that have become essential in a health information technology age.

Maintaining Accountability in Increasingly Diverse Communities

One of the more remarkable aspects of health centers is their ability to adapt to the communities they serve, even as their communities undergo significant demographic shifts. As the characteristics of patients change, so do the types of interventions needed to ensure that health care is both clinically and culturally appropriate. Because health centers are governed by patient-majority boards, an orientation to the community is embedded in their operations and policies. Still, health centers will be challenged to respond to the needs of increasingly diverse communities during a time of economic uncertainty.

A Strong Health Care Workforce

Today's health center workforce consists of nearly 40,000 clinical professionals, 33,000 administrative staff, and 11,000 support personnel. An estimated 44,000 additional clinicians, managers, and support professionals will be needed for health centers to meet the goals set out by the President. A recent study examining shortages of medical personnel at community health centers showed widespread understaffing and sufficient difficulty in recruitment to impede the rate at which the Administration's initiative can be achieved. Researchers found that the average health center has a 13.3 percent vacancy rate in its full-time-equivalent family physician positions, and that rural health centers face particularly difficult recruitment challenges, including a lengthy recruitment process.³⁰ In this regard, the National Health Service Corps,³¹ which provides scholarship and loan repayment support to health professions students in exchange for service, represents a critical companion to the health centers program. Its reauthorization schedule parallels that of health centers. Whether Congress moves to more closely align Corps placement policy with the needs of medically underserved communities and the health centers that serve them will be an important issue to watch.

²⁷ P. Shin, K.C. Jones, and S. Rosenbaum, *Reducing Racial and Ethnic Health Disparities: Estimating the Impact of Community Health Centers on Low-Income Communities* (Washington, D.C.:National Association of Community Health Centers, 2003).

²⁸ Hadley J and Cunningham P. "Availability of Safety Net Providers and Access to Care of Uninsured Persons." October 2004 Health Services Research 39(5):1527-1546; Starfield B and Shi L. "The Medical Home, Access to Care, and Insurance: A Review of Evidence." May 2004 Pediatrics 113(5):1493-8.

²⁹ Executive Order 13335 (April 27, 2004)

³⁰ Rosenblatt, R.A., Andrilla, C.H.A., Curtin, T. and Hart, L.G. 2006. Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion," *JAMA* 295:9 1042-1049 (March 1)

³¹ 42 U.S.C. §254d

CONCLUSION

Few programs have generated more respect than the health center program. The growth and performance of health centers over four decades are a testament to their resilience in the face of remarkable change in communities and the health system that serves all Americans. The reauthorization of the health center program offers an opportunity to celebrate its successes and to address ongoing challenges. As even primary health care grows in complexity and technology dependence, as the number of uninsured and underinsured persons continues to grow, and as the major sources of health insurance in the U.S. continue to evolve, so must health centers. The issues identified here are central to their performance over the coming decade as an essential component of the nation's health care safety net.

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