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# Community Health Centers and State Health Policy: A Primer for Policymakers

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# Executive Summary

Reaching some of the nation's most vulnerable populations, community health centers connected more than 19.5 million people throughout the U.S. and its territories with primary health care services in 2010, and form much of the fabric of the U.S. health care safety net.[1] Although the federal health center program was initiated and still is largely implemented without significant state involvement, state governments' relationships with these safety net providers have grown over the years as states have worked to increase coverage and access to care. States also have a considerable role in financing and sustaining these core safety net providers. As state Medicaid programs have grown, so too have the number and proportion of Medicaid patients served at Federally Qualified Health Centers (FQHCs) and the dependence of these health centers on these federal-state payments.

States can affect the viability, quality and performance of health centers as part of a state's health care system. States can foster collaboration through primary care offices, primary care associations, Health Center Controlled Networks, and Regional Extension Centers. States also have many levers, including licensing, purchasing and funding, to help integrate health centers into state delivery systems and optimize the role of health centers as partners in achieving state access, cost and quality goals.

This primer provides an overview of community health centers and other types of FQHCs, which are supported or monitored by the Health Resources and Services Administration (HRSA). In light of the passage of the Patient Protection and Affordable Care Act (ACA), this is an opportune time for states to consider how health centers and the safety net will fit within a state's health care system and contribute to a reformed system. The primer is intended to assist state policymakers in developing successful strategies to integrate health centers into state delivery systems. This primer was developed through a National Cooperative Agreement (NCA) with HRSA's Bureau of Primary Health Care (BPHC).

## Background

The first health centers took root more than 40 years ago with the mission of providing primary health care for the poor. Federal grants supported health centers that were established to serve a medically underserved area (MUA) or population (MUP); provide a detailed scope of primary health care as well as enabling services (health, education, translation, transportation, preventive dental, mental health, etc.); provide services to all regardless of ability to pay; and are governed by a community-based board of which the majority of the members (51 percent or more) receive their care at the health center.[2]

When health centers were established, they were viewed as complementary to the newly created Medicaid program, which established federal-state matching payments to pay for the care of the poor.[3] However, until the 1980s there was little interaction between state Medicaid and health centers – health center operations were funded primarily by grants from the federal government. This primary source of support would ultimately change as Medicaid revenues exceeded federal grants to become the health centers' largest single source of income fostered by the Omnibus Budget Reconciliation Act (OBRA) of 1989, which established the FQHC payment designation.[4]

With the recent passage of the American Recovery and Reinvestment Act of 2009 (ARRA) and the passage of the ACA in 2010, health centers have received further support. ARRA funding aimed to further strengthen health centers and allow them to care for the rising numbers of newly uninsured patients by providing nearly $1.5 billion in capital investment funding for construction, renovation and health

information technology adoption, and $500 million to expand services to additional patients in need.[5] The ACA builds on the investments ARRA made in health centers. The ACA contains $11 billion in new funding for health centers, $1.5 billion of which is dedicated to health center capital needs, expanding and improving existing facilities and constructing new sites; and $9.5 billion of which is dedicated to allowing health centers to expand their operational capacity to serve almost 20 million new patients and improve their medical, oral and behavioral health services.[6]

## State Levers for Working with FQHCs to Achieve State and Federal Policy Objectives

### Engaging Health Centers in Delivery System Reform

As states work to improve access to and quality of care in their health care delivery systems, health centers can be important partners, including in implementation of key aspects of the ACA. Many opportunities exist to work with health centers through partnerships on state initiatives and federal funding opportunities to help improve access, cost and quality, such as around the development of medical homes.

### Directing State and Federal Grant Funds

States can direct appropriations and channel federal grant monies to health centers to help them continue to achieve state priorities in improving access and outcomes even in this currently challenging environment. Examples include directing state money to help support health center service expansions and directing federal grant funds to health centers to help achieve state immunization and newborn screening targets.

### Health Care Purchasing

A state purchases a significant share of health care through Medicaid, the Children's Health Insurance Program (CHIP), State Employees Benefit Plans and other programs. There are additional purchasing mechanisms states control which can influence the operation of health centers to help a state achieve health care goals around access, quality and cost. These include using managed care organization contracting to support state integration goals and encouraging the creation of health center affiliated plans.

### Licensing Health Care Facilities and Health Professionals

Licensure laws help protect the public by ensuring that health care facilities meet minimum health, safety and quality standards, and that health care professionals meet standards with regards to education and qualifications. Many states monitor patient safety for all licensed health care facilities by requiring them to report patient safety data directly to the state. State regulators can close doors to unqualified health professionals working in their state through professional licensure requirements, but they also can open doors to bring new kinds of practitioners to the state to address critical workforce shortages. This state role is crucial to safety net providers such as health centers that encounter many barriers to recruiting and retaining the workforce they need.

### Reaching the Uninsured Who Are Eligible for Public Coverage

As states look towards 2014 and enrolling newly eligible populations into Medicaid and subsidized health plans, states may want to look to health centers for assistance. Health centers are poised to serve nearly 20 million additional individuals under the ACA,[7] and states may benefit from improving their partnerships with health centers around enrollment to ensure states meet their coverage goals.

## Future Challenges

### Health Care Reform

Safety net providers, including health centers, can help states meet their health care reform goals. Health centers can provide a source of primary health care for the newly insured through state exchanges, through the Medicaid expansion and for those who will remain uninsured. Already serving more than seven million uninsured and more than seven million individuals on Medicaid, health centers can be a resource for states as they expand coverage under the ACA and connect people with primary care providers.[8] As states work to meet the challenge of providing better care at a lower cost to a significant number of newly insured individuals, health centers will be important partners for the state.

### Workforce Shortages and Capacity Issues

Health centers have a chronic shortage of practitioners, which has been exacerbated by the recent push to expand the health center system, and states have a chronic shortage of practitioners willing to serve Medicaid, uninsured and other vulnerable populations. Because states and health centers share the common goal of ensuring access to care for the most vulnerable, working in partnership to address workforce shortages will be important. There are strategies that can be employed to address shortages and capacity limitations, including allowing providers to practice to the full limits of their scope of practice, and building the skill set needed for those within the current health workforce, as well as those in training, to perform in new team-based models of care delivery.[9]

### Technology Investments

Implementing new information technology systems to keep pace with care coordination, quality and patient safety monitoring, as well as to assist with enrollment and retention in coverage, is a challenge for most health centers. Moving health centers further along in health information technology adoption will improve quality and delivery of care and benefit the populations they serve. It will also be important for health centers as they participate in the movement to more integrated systems of care and new payment methodologies; these require more real-time ability to share, collect and analyze data about the quality and cost of care for groups of patients.

## Conclusion

Over the years, the relationship between health centers and states' health systems has grown. The significant challenges facing states in 2011, including tremendous fiscal and capacity constraints and the pressures of health care reform implementation, elevate the importance of a continuing role for health centers in a state's health care system. While the ACA presents challenges for states, it also brings new resources and opportunities to reduce costs and improve access and quality of care. Health centers have a track record in providing coordinated, comprehensive primary care that has been shown to reduce disparities in care and lower costs.[10,11] By making use of policy levers to work with health centers and better integrating health centers into states' health systems, states can be well positioned to achieve both the aims and requirements of the ACA, as well as their own goals for an improved health system.

## Introduction

Reaching some of the nation's most vulnerable populations, community health centers connected over 19.5 million people throughout the U.S. and its territories with primary health care services in 2010, and form much of the fabric of the U.S. health care safety net.[12] The Institute of Medicine recognizes federal, state and locally supported health centers, along with public hospital systems and local health departments, as "core safety net providers." These providers have two distinguishing characteristics:

1. *By legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and*
2. *A substantial share of their patient mix is uninsured, Medicaid and other vulnerable patients.*[13]

Although the federal health center program was initiated and still is largely implemented without significant state involvement, state governments' relationships with these safety net providers have grown over the years as states have worked to increase coverage and access to care. As state Medicaid programs have grown, so too have the number and proportion of Medicaid patients served at Federally Qualified Health Centers (FQHCs) and the dependence of these health centers on these federal-state payments. Medicaid funding accounts for a significant portion of a typical health center's operating revenue (37.7 percent); aid from state and local grants account for an additional 11.3 percent.[14] Thus, states have a considerable role in financing and sustaining these core safety net providers. States can also affect the viability, quality and performance of health centers as part of a state's health care system, and efforts to reform that system through strategies such as funding and purchasing.

This primer provides an overview of community health centers and other types of FQHCs, which are supported or monitored by the Health Resources and Services Administration (HRSA). The box below explains the various types of FQHCs. For ease of reading hereafter, these entities are referred to collectively as health centers. The primer is intended to assist state policymakers in developing

**Community health centers are the most common type of "Federally Qualified Health Center" (FQHC), but there are others. The term FQHC includes:**

- Federally-funded health centers, which are public and private non-profit clinics that meet certain criteria under the Medicare and Medicaid programs and receive federal grant funds under the Health Center Program, established at Section 330 of the Public Health Service Act (PHSA). Some target specially defined populations such as migrant and seasonal farmworkers or homeless persons, while others target a general community and are commonly referred to as "community health centers." These "grantees" comprise more than 90 percent of all FQHCs, and the program is managed by the federal Health Resources and Services Administration (HRSA).
- Look-Alike health centers are public and private non-profit clinics that meet the requirements to receive a grant under Section 330, but do *not* receive federal grant funding. The Look-Alike program is managed by HRSA in conjunction with CMS.
- Some outpatient health programs or facilities operated by tribal or urban Indian organizations. HRSA is not involved with these FQHCs, except for the few that also receive Section 330 grants.

successful strategies to integrate health centers into state delivery systems. In light of the passage of the Patient Protection and Affordable Care Act (ACA), this is an opportune time for states to consider how health centers and the safety net will fit within a state's health care system and contribute to a reformed system. Health centers will play an important role in serving much of the newly insured population, both those covered through the Medicaid expansion and through qualified health plans offered through the health insurance exchanges, as well as serve as a source of continuing care for the remaining uninsured. Additionally, the ACA provides opportunities to develop models to improve and coordinate care. Health centers have been at the forefront of developing many of these new care delivery models, such as medical homes, that are being supported in the ACA and may be good sources for promising practices for the state.

This primer was developed through a National Cooperative Agreement (NCA) with HRSA's Bureau of Primary Health Care (BPHC). This primer and other project activities were intended to help inform state policymaking and promote communication between state policymakers and health centers and thus support achievement of their shared goal of improving access to quality, affordable health care for our nation's most vulnerable populatios.

## History

The first health centers took root more than 40 years ago when two Tufts University physicians secured a federal grant to open health centers in two poor communities: first, in urban Boston, Massachusetts and second, in rural Mound Bayou, Mississippi.[15] Federal grants and local community resources and involvement were the seeds for subsequent growth of health centers and their mission of providing primary health care for the poor. At the time, health centers were viewed as complementary to the newly created Medicaid program, which established federal-state matching payments to pay for the care of the poor.[16] While parallel in mission, there was little intersection between state Medicaid and health centers at the time – health center operations were funded primarily by grants from the federal government. This primary source of support would ultimately change as Medicaid revenues exceeded federal grants to become health centers' largest single source of income.[17]

Within a decade, the number of health centers increased to about 100, boosted by the Economic Opportunity Act of 1964, which provided the means for poor, underserved communities to address their health care issues through health centers. Health centers proved to be a boost to local economies due to the jobs and investments they created; they also helped reduce the costs of hospital-based medical services.

In the late 1980s, hard economic times challenged both state governments and health centers. States turned to managed care to help control costs and comply with federal mandates to cover more people. Health centers struggled with financial trouble, closures, and organizational changes partly due to their initial experiences with managed care contracting.[18] But in 1989, health centers received a shot in the arm with the passage of the Omnibus Budget Reconciliation Act (OBRA), which established the FQHC payment designation.

At the time, Congress was concerned that health centers were shifting federal grant funds meant to care for the poor and uninsured to cover the costs of caring for Medicaid and Medicare patients because of inadequate reimbursement rates. In response, Congress established a cost-based reimbursement system for health centers meeting the criteria to be an FQHC.[19] Health clinics that qualified for the FQHC designation (see inset) could now receive Medicaid and Medicare reimbursements based on their actual costs, including overhead expenses such as mortgage and utilities. According to the Institute of Medicine, the cost-based rates were viewed as a "critical silent subsidy" that helped health centers pay for overhead and infrastructure costs in addition to the services rendered, thus freeing up limited grant dollars to pay for the costs of caring for the uninsured.[20]

Over the years, state and federal officials felt this new cost-based reimbursement was inflationary and a disincentive to control costs. With the Omnibus Budget Reconciliation Act of 1990, Congress established an All-Inclusive Payment System under Medicare; under this system, FQHCs were reimbursed their reasonable costs, subject to productivity screens and upper payment limits established by CMS. In 1997, Congress passed the Balanced Budget Act (BBA), which was the beginning of the end of cost-based reimbursement under Medicaid and aimed to phase it out over five years. The BBA was eventually replaced by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.[21] BIPA ended cost-based reimbursement and required states to reimburse FQHCs using a new prospective payment system (PPS) based on a fixed payment per visit using the average cost per visit over the 1999-2000 period as a base and adjusting thereafter using the Medicare Economic Index

for inflation. States are able to make additional adjustments in the payment formula to allow for more generous payments.

During the 1990s, the number of health centers climbed to 700, with centers located in all 50 states, the District of Columbia, U.S. territories and commonwealths. By decade's end, these centers were treating more than nine million patients annually.[22] Under President George W. Bush, health center growth continued. The President's Health Center Initiative, launched in 2002, added more than 500 new access points (new grantee organizations or new sites managed by existing grantees); awarded nearly 400 grants to expand the medical capacity of existing service delivery sites; and awarded 350 grants to existing grantee organizations to add or expand oral health, mental health and substance abuse services.[23] In August 2007, to address continued need and an uneven distribution of health centers, President Bush launched the High Poverty County Presidential Initiative aimed at increasing access to primary health care in some of the poorest counties in the United States.[24]

**The American Recovery and Reinvestment Act**

In 2009, shortly after President Obama came to office, the American Recovery and Reinvestment Act of 2009 (ARRA) was passed. Among a number of investments to stimulate the economy and respond to the effects of the economic downturn, ARRA included $2 billion for health centers. ARRA funding aimed to further strengthen health centers and allow them to care for the rising numbers of newly uninsured patients by providing nearly $1.5 billion in capital investment funding for construction, renovation and health information technology adoption, and $500 million to expand services to additional patients in need.[25] ARRA investments included:

- New Access Points: $155 million in grants was made available to support 126 "New Access Points" across the country. New Access Points are either new health center grantees or new locations that enable existing health centers to increase access. New Access Points were estimated to allow 750,000 additional Americans to be served by health centers. HRSA BPHC awarded 127 grants totaling $156 million.[26]
- Increased Demand for Services: $338 million in grants was made available to expand services currently offered by existing health centers. Expanded services included adding new providers, extending hours of service and expanding services.[27] HRSA BPHC awarded 1,129 grants totaling $342 million.[28]
- Capital Improvement Program: $851 million in grants was made available to address health center facility and equipment needs. The grants supported the construction, repair and renovation of health centers, as well as funding the purchase of new equipment or health information technology systems and expanding the use of electronic health records.[29] HRSA BPHC awarded 2,617 grants totaling $853 million.[30]
- Facilities Investment Program: Over $600 million in awards was made available to support major construction and renovation projects at 85 health centers and to help networks of health centers adopt electronic health records and other health information technology systems.[31] HRSA BPHC awarded 184 grants totaling $640 million, of which $120 million was for health information technology adoption.[32]

Additionally, ARRA increased funding for the primary care workforce by $500 million, including $300 million for the National Health Service Corps,[33] which supports many health centers in recruiting and retaining key medical staff.[34]

While ARRA was meant to provide additional resources to health centers during the economic downturn, the downturn that led to the Recovery Act also significantly affected state budgets and lead to a decline in state funding of health centers. ARRA investments helped offset the impact that this decline in state funding would have had.[35] Analysis of ARRA funding for health centers indicates that they were able to quickly expand to serve new patients and provide relief to communities hardest hit by the recession, not only by increasing the availability of services but through new and retained jobs and the purchase of goods and services.[36,37] The New Access Points and Increased Demand for Services grants alone allowed health centers across the country to serve an additional 4,350,401 patients.[38]

**The Patient Protection and Affordable Care Act**

The Patient Protection and Affordable Care Act (ACA) builds on the investments ARRA made in health centers. The ACA contains $11 billion in new funding for health centers, $1.5 billion of which is dedicated to health center capital needs, expanding and improving existing facilities and constructing new sites; and $9.5 billion of which is dedicated to allowing health centers to expand their operational capacity to serve almost 20 million new patients and improve their medical, oral and behavioral health services.[39]

However, funding for health centers in federal FY (FFY) 2011 was decreased from anticipated levels. Legislation early in 2011 resulted in a $600 million loss in discretionary funds to health centers, offsetting some of the gains made in the ACA.[40] This loss in funding for health centers forced HRSA to divert money from planned expansion funds to prevent health centers from having to reduce services, service locations and staff. This diversion of funds to support health centers' operations resulted in HRSA being unable to fund the majority of the new start and "new access point" applications and the "expanded services" applications it received.[41] HRSA was only able to make 67 new start/new access point awards out of more than 800 applications, leaving unfunded more than 733 applications from 50 states, the District of Columbia and Puerto Rico, representing an estimated 4 million patients.[42] Health centers that want to expand to new sites or increase the number of people served without a new access point award have to attest that they are able to do so without additional federal grant funding, making it challenging for health centers to increase capacity when the number of uninsured and underinsured increases.

While annual appropriations funding was reduced for health centers in FFY 2011, decreasing the impact of new funding through the ACA, the ACA includes other provisions beyond those mentioned above that directly or indirectly impact health centers' ability to deliver services and strengthen coverage and delivery of care in a state.

**Insurance Coverage Expansion**: The expansion of insurance coverage under the ACA may have the largest impact on health centers. The expansion of Medicaid eligibility, the primary payer for health center patients, to 133 percent of the federal poverty level (FPL) for all citizens and legal residents under age 65 is estimated to increase the percentage of Medicaid patients served by health centers from 38.5 percent in 2010 to 43.9 percent by 2019.[43] Additionally, coverage through the health insurance exchanges for those above 133 percent of the FPL will provide a new coverage mechanism for many currently uninsured health center patients. By 2019, it is estimated that 9.2 percent of health center patients will be covered by exchange plans.[44]

**Workforce Investments**: The ACA invests in building workforce capacity, including $1.5 billion in funding for the National Health Service Corps. The ACA also provides support for new health center-based residencies and a number of grants and repayment programs, all of which will increase funding for recruitment and training of the primary care workforce.[45,46] A teaching health center grant program was established by the ACA to start or expand accredited primary care residency training programs. A direct total appropria-

tion of $230 million from FY 2011 through FY 2015 was made to reimburse teaching health centers for the training costs and for the additional patient costs associated with clinician training.[47]

**Payment Protections and Improvements**: The Secretary of HHS is required to establish a prospective payment system (PPS) for Medicare payments to health centers to start in 2014, and the ACA expands the scope of services a health center can be reimbursed for under Medicare to include certain preventive benefits.[48,49]

**Care Delivery Models**: Health centers have often been at the forefront of care delivery innovations. The ACA establishes several new programs and demonstration projects to promote integrated care delivery, and these models offer opportunities for health centers to build upon these innovative approaches, becoming further integrated into service delivery reform efforts. For example, the ACA establishes an Accountable Care Organization (ACO) program under Medicare, through which groups of providers who agree to be jointly responsible for the care of a specified group of patients may share in part of any savings achieved. The final regulation regarding this program permits health centers to participate in ACOs as independent members, and to form ACOs among themselves. The ACA also contains a Medicare demonstration program, the Independence at Home Medical Practice Demonstration Program, to test a payment incentive and service delivery model that uses physician and nurse practitioner home-based primary care teams;[50] creates a Medicaid State Plan Option with an enhanced Federal Medical Assistance Percentage (FMAP) for two years to promote health homes and integrated care for chronically-ill Medicaid enrollees;[51] and establishes a new Centers for Medicare and Medicaid Services (CMS) Innovation Center to further test new models of payment and care delivery aimed at reducing health care costs and enhancing quality.[52]

## The "101" on Federal Support for Health Centers

In 1996, the Health Centers Consolidation Act combined all health center types – community, migrant, homeless and public housing health centers – under one umbrella, in Section 330 of the Public Health Service Act (PHSA). This law authorized competitive federal grants – which now provide 23.2 percent of operating revenue on average[53] – to health centers that meet a set of statutory requirements, including:[54]

- Serve a medically underserved area (MUA) or population (MUP);
- Provide a detailed scope of primary health care as well as enabling services (health, education, translation, transportation, preventive dental, mental health, etc.) described in 42 U.S.C. 254b(b)(1);
- Provide services to all regardless of ability to pay; and
- Are governed by a community-based board of which the majority of the members (51 percent or more) receive their care at the health center.[55]

Health centers that receive federal grant funds under Section 330 were also given access to other federal programs that support their mission, including the Health Center Federal Tort Claims Act (FTCA) Program and federally backed loan guarantees for capital improvement projects. The FTCA insures federally-funded health centers and their providers so they do not need to purchase private medical malpractice insurance, thus saving health centers an estimated $88 million a year on malpractice insurance costs.[56] Federally-funded health centers also are able to recruit physicians through the National Health Service Corps and J-1 Visa Waiver Program (foreign medical graduates). The 340B Drug Pricing program allows health centers and other federally qualified covered entities to purchase pharmaceuticals at prices lower than the Medicaid rebate price for about a 19 percent cost savings.[57]

The more than 100 Look-Alike health centers in the United States also play an important role in providing primary health care to the underserved. Authorized by Congress as a means of supporting and expanding the safety net, Look-Alikes qualify as FQHCs and therefore may be reimbursed by Medicaid and Medicare using the same payment method as for grantee health centers. Also like grantees, Look-Alikes must meet the same statutory requirements under Section 330 of the PHSA as stated above. However, they do not receive federal grant funds, usually because of limited available funding. Look-Alikes do have access to a number of other important federal programs, as noted in Table 1.

**Table 1 - Differences between Federally-Funded FQHCs and FQHC Look-Alikes**

| | Federally-Funded (330) Health Centers | FQHC Look-Alikes |
|---|---|---|
| Competitive application process | Yes | No |
| Receive funding directly from federal government | Yes | No |
| Serve a medically underserved area or population | Yes | Yes |
| Provide services regardless of ability to pay | Yes | Yes |
| At least 51 percent of governing board members must be active users of the health center | Yes | Yes |
| Provide a detailed scope of primary health care and enabling services | Yes | Yes |
| Medicaid/Medicare reimbursement under FQHC payment system | Yes | Yes |
| Access to National Health Service Corps/J-1 Visa Waiver programs | Yes | Yes |
| FTCA coverage | Yes | No |
| 340B drug pricing program | Yes | Yes |
| Federal loan guarantee program | Yes | No |
| Comply with BPHC Uniform Data System (UDS) | Yes | Yes – starting with CY 2011 data |

### Health Center Snapshot

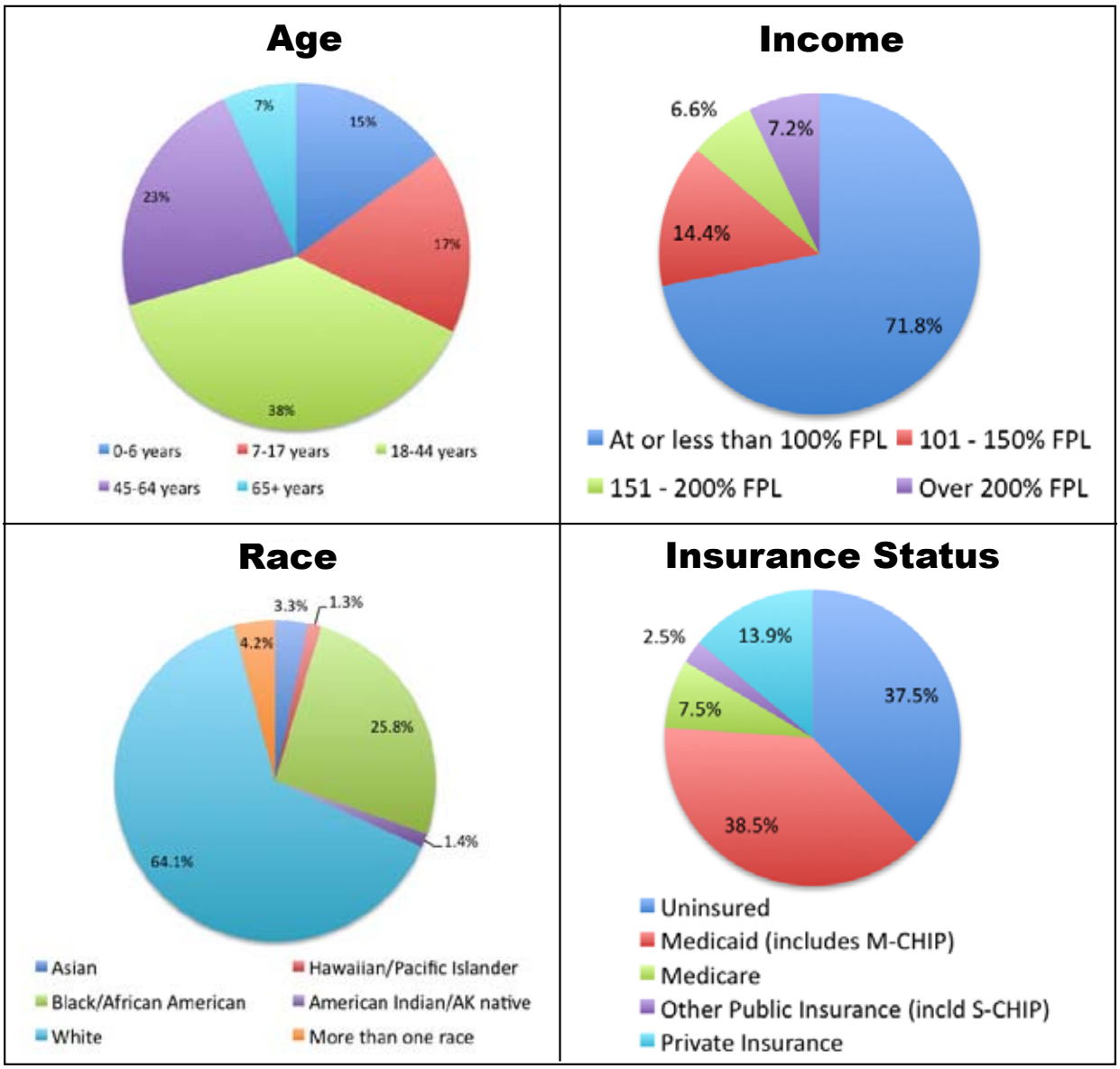
In 2010, nearly 19.5 million people received care at more than 1,100 health center grantees across more than 8,000 service sites.[58] These patients are predominantly minorities, poor, uninsured or covered by Medicaid. Although patients treated at health centers are relatively young (70 percent are below age 45),[59] they tend to be in poorer health with more chronic conditions than the general population.[60] For a profile of health center patients, see Figure 1.

Seventy-two percent of health center patients are at or below the poverty level, and 93 percent are below 200 percent of the poverty level. Seventy-seven percent of health center patients are either uninsured or covered by Medicaid.[61] Health centers can provide important continuity of care for these individuals who

often "cycle" on and off Medicaid coverage due to factors such as changing income, age, family status and disability eligibility.[62] These individuals are often without insurance coverage for long periods of time. Health centers can bridge these gaps by providing uninterrupted coverage in spite of health insurance status. Health centers can continue to play this role after health care reform coverage expansions occur in 2014, as individuals will continue to move among the differing health insurance programs as their income fluctuates.

Private health insurance covers just 13.9 percent of health center patients. In 2010, health centers charged private insurers over $1.5 billion, but received only slightly over $864 million in collections – 57.2 percent of what they charged.[63]

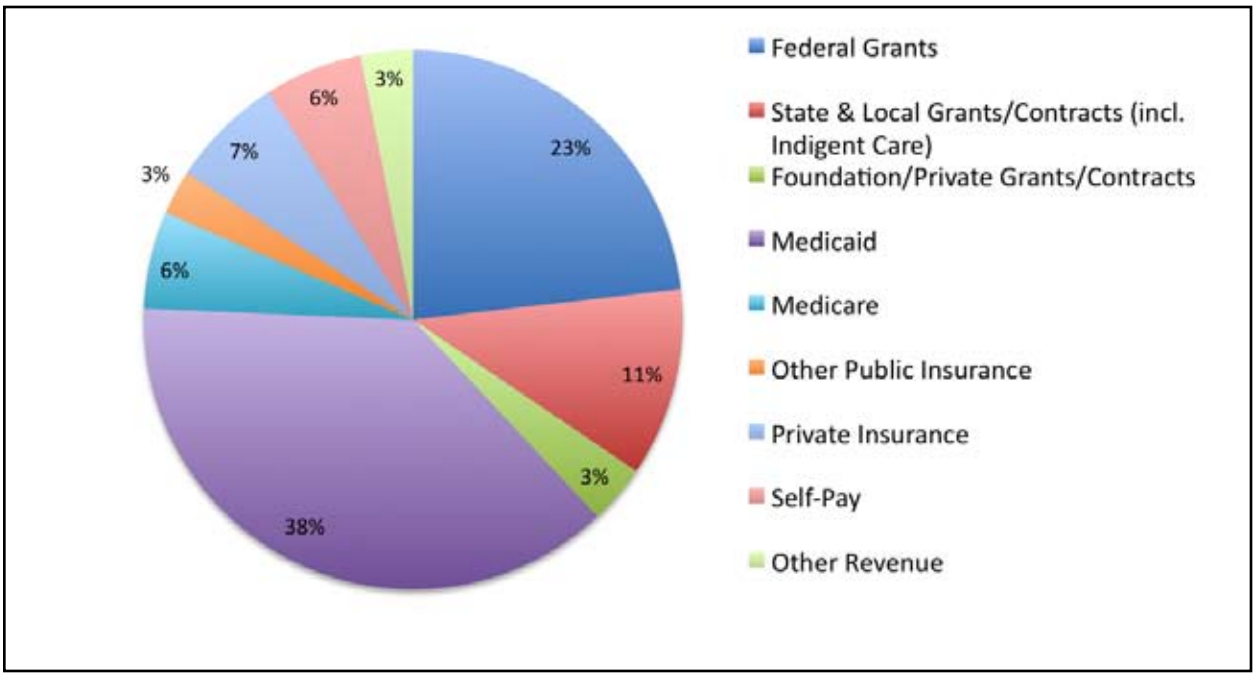
**Figure 1 – Federally-Funded Health Center Patients by Selected Characteristics, 2010**[64]



## Medicaid Matters

Medicaid matters a great deal to a health center. It is the largest source of health center operating revenue (37.7 percent), providing far more funding than Medicare and other public insurance (8.5 percent), private insurance and self-pay (12.7 percent) and federal grants (23.2 percent).[65] (Figure 2)

**Figure 2 – Federally-Funded Health Center Operating Revenue, 2010**[66]




Health centers matter a great deal to Medicaid agencies as they are playing an increasingly large role in providing access to primary care for Medicaid enrollees. Medicaid eligibility expansions over the past two decades have resulted in an increase in both the number and percentage of Medicaid patients seen at FQHCs. During the last decade, the number of Medicaid patients seen at health centers increased more than twice as fast as the number of Medicaid enrollees overall (116 percent vs. 49 percent between 2000 and 2009), and in 2009, federally-funded health centers provided primary health care to one in every seven Medicaid beneficiaries.[67]

This trend is expected to continue under the ACA as illustrated by the insurance expansion in Massachusetts under state health reform. In Massachusetts, insurance expansions led to an increase in the demand for primary care, especially in medically underserved low-income communities. Health centers in Massachusetts played a significant role in meeting this demand by expanding caseloads during the early years of the reform by four percent in 2006 and an additional eight percent in 2007, increasing from 431,005 enrollees in 2005 to 482,503 in 2007. These increases were primarily due to providing access to approximately 24,000 more Medicaid and CHIP enrollees.[68]

Heavy Medicaid caseloads means heavy reliance on Medicaid to cover operating costs. This reliance may place some health center operations on unsure ground during state Medicaid budget shortfalls. (See appendix for state-by-state data on number of centers, patients served, Medicaid dollars spent and percent of total revenue that is Medicaid.)

**FQHC Reimbursement Policies**

**Prospective Payment System**: During the 1990s, health centers were reimbursed using a cost-based reimbursement system. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 replaced this system with a Prospective Payment System (PPS) under Medicaid that set a standardized per-visit payment rate for each health center. For 2001, this rate was set at 100 percent of a health center's average reasonable costs for a visit in 1999 and 2000. The determination of reasonable costs included a proportionate share of the FQHC's operational costs as well as providers' time and resources.

Since 2002, the FQHC per-visit rates have increased annually using the Medicare Economic Index (MEI), an estimate of changes in physicians' operating costs. Rates also are required to be adjusted to take into account any increase (or decrease) in the scope of Medicaid covered services furnished by the health center.[69] A 2005 Government Accountability Office (GAO) study shed some light on how the PPS was working in practice. This report found that the MEI underestimates inflation in health center costs; that some states did not include all Medicaid-covered FQHC services in determining the PPS rates; and that more than half the states using the PPS had not determined how they would address the requirement to adjust their PPS rates for a change in scope of services.[70]

GAO also found that the move to PPS created financial incentives for health centers to operate more efficiently. "[Health Center] providers that keep their costs below their payment amount profit; conversely, providers lose money if their service costs exceed the payment amount."[71] Given that the rate does not vary regardless of the intensity of the services, Medicaid FQHC payments may not adequately cover costs if a patient is complex and requires more intensive services.

While the PPS rate evolved from cost-based reimbursement and no longer can be equated with costs, the higher Medicaid payment for a routine office visit at an FQHC compared to the same visit for a private practice often generates tensions within states. It is important to note that PPS rates are intended to help health centers meet at least two important federal mandates:

- **Health centers are required to include a broader range of services in a typical "visit" than private practices.** Federal Medicaid law requires that FQHC Medicaid payments cover the comprehensive package of primary and preventive care services that the centers are required by law to provide to Medicaid enrollees. This package of services is generally broader than what other Medicaid outpatient providers provide. Health centers are required to provide, either directly or through referral, preventive dental care, mental health services, laboratory tests, X-ray, pharmacy services as appropriate, outreach and health education, transportation and translation services.

  Alternative approaches are possible. Iowa Medicaid is paying fee-for-service plus a monthly care management fee to health centers to offer a limited benefit package to adults who would not ordinarily be covered by Medicaid. A waiver is necessary in order for an FQHC to be able to offer less than the full Section 330-required list of services (more information follows later in this primer).
- **Health centers must provide care to all, and their patients tend to be sicker.** Although a majority of health center patients are young (less than 65 years old), patients tend to be sicker and have more co-occurring chronic conditions than patients seen in private practices or outpatient departments.[72,73] Therefore, the PPS rate helps account for service intensity required

> by health center patients. Despite being generally sicker, health center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care.[74]

It also should be noted that the PPS rate is a "bundled" payment, meaning that health centers cannot bill separately for specific services provided during an office visit. For example, if a patient receives an EKG during an office visit, a private physician can bill for the EKG separately, in addition to billing for the office visit. In contrast, the health center may not bill separately for the EKG; it receives only the standard per visit rate, regardless of the volume or types of services provided.

**Alternative Payment Mechanism**: States have the option of using an alternative payment mechanism (APM) in place of the PPS, provided the payment rate is not lower than what would be paid under PPS and the health center agrees to it. For example, states may opt to establish an alternative PPS or retain the original cost-based reimbursement system provided the APM plan receives prior approval from both CMS and the health center(s) to which it will be applied.

**Wrap-Around Payments**: Managed care payments account for a significant portion of health center revenue – 45 percent of their revenue is generated by serving Medicaid managed care enrollees.[75] States are required to make supplemental or "wrap-around" payments to health centers for care of Medicaid and CHIP managed care patients. These wrap-around payments cover the difference between the rates paid by managed care plans and the FQHC prospective payment rate (or APM). The intent of this wrap-around, or supplemental payment, is to insure that health centers receive no less payment when they contract with a Managed Care Organization (MCO) than if they were contracting directly with the state and being paid full PPS (or APM) from the state Medicaid and CHIP programs.

**No Cost Sharing**: Historically, under Medicaid, there was little or no cost sharing through co-payments, which places health centers under less financial risk. However, the Deficit Reduction Act of 2005 changed this, giving states greater flexibility in allowing cost sharing through approaches such as co-payments. In addition, health centers must often absorb costs for privately insured patients who are required, but often are unable, to pay some portion of care. Health centers also must absorb any Medicare co-payments for dual-eligible patients for whom Medicare payment rates exceed Medicaid payment rates.

### Medicare Matters

In 2010, approximately 7.5 percent of health center patients were eligible for Medicare, with a large percentage of these individuals being dually-eligible for both Medicare and Medicaid. Similar to Medicaid, Medicare reimburses health centers using a standardized per-visit payment rate. To determine this rate, a health center submits a cost report to Medicare each year. The Medicare contractor determines the center's average reasonable cost per visit, and then applies two caps to this amount. The first cap is a productivity screen, which reduces the per-visit amount if a provider is determined not to have provided a minimum number of visits during the year. The second is an Upper Payment Limit (UPL) that is set by regulation. In 2010, a GAO analysis of FQHC Medicare cost reports found that in 2007, approximately 72 percent of FQHCs had approved costs per visit that exceeded the Upper Payment Limits, and an additional seven percent had their reimbursement reduced due to the productivity guidelines. Combined, these two caps reduced Medicare payments to health centers by $58.2 million, or 14 percent, below their approved costs for the year.[76]

The ACA requires that a new PPS-based payment methodology be implemented for health centers starting in 2014. It also requires that total payments under this new system must equal 100 percent of health centers' costs without the application of UPLs or productivity screens.[77]

CMS is currently implementing a new Medicare demonstration, the Federally Qualified Health Center Advanced Primary Care Practice demonstration project. Operated in partnership with HRSA, this demonstration will pay an estimated $42 million over three years to up to 500 FQHCs to coordinate care for up to 195,000 Medicare patients. Participating FQHCs will receive a monthly care management fee of $6.00 for each eligible Medicare beneficiary attributed to their practice. This fee is intended to help defray the cost of transformation into an advanced primary care practice. Paid quarterly, this fee will be in addition to the usual all-inclusive FQHC payment received for providing Medicare covered services.[78]

Historically, the federal government has worked directly with health centers, with limited involvement from state governments, to build a safety net of health centers to serve vulnerable populations. Over the years, however, there has been increased recognition of the important roles that states play and the need for communication and collaboration between federal and state agencies and health centers in efforts to improve access to primary care. To further the common interest of improving access to care and reducing health disparities, HRSA entered into cooperative agreements with state level Primary Care Offices (PCOs), Primary Care Associations (PCAs) and other state-focused organizations to help improve primary care access and reduce health disparities for low-income and vulnerable populations. In addition, ARRA funding built on existing and established new partnerships in states to assist in the development of health information technology to improve primary care delivery and quality in states.

### Primary Care Offices

HRSA entered into cooperative agreements with each state and territory to establish and support PCOs – state-based offices generally within the state public health agency. PCOs work collaboratively with PCAs (described below), relevant HRSA programs and offices and other organizations to increase access to primary and preventive health care and improve primary care service delivery and workforce availability to meet the needs of underserved and vulnerable populations.[79,80] PCOs are responsible for collecting data to secure federal designation of Health Professional Shortage Areas (HPSAs), as well as Medically Underserved Areas, Medically Underserved Populations and Mental Health and Dental Professional Shortage Areas; they also assist communities that are seeking to obtain or update these designations, which allow them to apply for federal funds to start or expand health centers and services or to address workforce shortages by accessing the National Health Service Corps.

The data PCOs collect that secure these federal designations bring significant resources into a state to improve access to care within specific geographic areas or for underserved populations. For instance, the Oregon Health Policy and Research (OHPR) Primary Care Office, through its PCO agreement, applies for the three types of federal designations from the Bureau of Health Professions, Shortage Designation Branch. These designations allow Oregon to access millions of dollars of federal resources to improve health care in underserved areas of the state. OHPR estimates these designations bring in more than $20 million per year in unmatched federal resources.[81] These resources go a long way in helping the state meet the needs of its residents.

In the context of health care reform, PCOs have important contributions to make to achieve their states' reform goals. PCOs can play an important role in:

- Using workforce data on numbers and locations of health care providers to inform network development for qualified health plans participating in the exchanges;
- Promoting eligible sites and positions and program participation at key training locations for the National Health Service Corps; and
- Facilitating participation of the safety net in preventive and primary care demonstrations and in community transformation grants to help support public health promotion under the ACA.[82]

Additionally, the ACA includes new shortage area and population designations, including Frontier Health Professional Shortage Areas, Health Disparities Populations (HDPs), and Medically Underserved Children and Adolescents (MUCAs). PCOs will play an important role in conducting preliminary statewide analysis for these new designations, as well as assisting in developing approaches for designating HDPs.[83]

### Primary Care Associations

Primary Care Associations, also funded in part by HRSA cooperative agreements, are private, non-profit organizations that represent safety net providers and provide expert support and technical assistance. PCAs vary across states in the mix of providers they represent. PCAs play a key role in communication with health centers, education and training, quality improvement, technical assistance and data analysis. They have played an important role in the development of a system that supports continuous quality improvement, sharing of successful practices and effective chronic disease management. Through their cooperative agreement with HRSA, PCAs are charged with supporting health centers in meeting the requirements of the health center program, and have played a key role in expansion of health centers to serve more underserved people and communities. PCAs and PCOs often work together to identify and coordinate scarce resources to protect and expand the safety net. For example, close collaboration between the Wyoming PCA and PCO has resulted in increased Health Professional Shortage Areas designations within the state.[84] PCAs can also be a resource to state policymakers (see Text Box: Collaboration in Montana: The Montana PA and Medicaid Agency).

**Collaboration in Montana: The Montana PCA and Medicaid Agency**

In Montana, the state Medicaid agency collaborated with the PCA to assist in the creation of an FQHC-based care management program in 2008. The PCA coordinated the process of engaging FQHCs in the project for the state, facilitating an in-person forum that brought health centers together to discuss the concept and designate geographic catchment areas. Further conference calls between the state, the FQHCs and the PCA kept the process moving forward.[85] In 2009, Montana Medicaid selected 14 FQHCs across the state to coordinate both preventive and chronic care services for all Medicaid beneficiaries, paying $3.75 per-member/per-month to each of the selected FQHCs for all Medicaid recipients in each center's catchment areas. The care coordination fee covers chronic care management for patients that are complex and high cost, and prevention efforts for patients at risk of developing chronic health conditions. The ability to work with the Montana PCA to establish and coordinate the state's relationship with FQHCs allowed the state to successfully implement the vision for this program and to capitalize on the ability of FQHCs to provide a comprehensive range of supportive and enabling services within their communities.[86,87]

### Health Center Controlled Networks and Regional Extension Centers

Through ARRA, significant investments were made through existing and new vehicles in assisting providers, including health centers, to effectively adopt health information technology. HRSA-funded Health Center Controlled Networks (HCCNs) are groups of three or more health centers that join together to share resources (e.g. clinical, administrative, technological) and to promote integration and coordination of primary care. HCCNs have been in existence since the mid-1990s, and HRSA has been funding HCCNs to assist health centers in better serving vulnerable populations. HCCNs generally combine resources to assist member health centers in health information technology adoption, including electronic health

records, and funding for these networks was increased through ARRA to support these efforts.[88, 89] To further support the adoption of electronic health record technology, the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act within ARRA established Regional Extension Centers (RECs) to help primary care clinicians, including clinicians serving in health centers, implement and become adopters and meaningful users of certified electronic health record technology. These federally-supported centers and networks operating within states can assist in the achievement of state goals around health information technology and quality improvement.

**Linking Health Centers with Information Technology**

In Florida, the HCCN, Community Health Centers Alliance (CHCA), has been operating since 1999. CHCA works to implement and support the adoption of technologies that allow its members to expand access to health care while improving quality. In 2009, CHCA had nine members serving 281,235 patients with a total of 1.15 million visits, and served 52 percent of Florida's rural areas. CHCA has projects and committees focused on electronic health and oral health records adoption and health information exchange. With ARRA funds, CHCA implemented the Enhanced Electronic Health Record Project to support eligibility for meaningful use designation for members, and established the REC for Northern and Rural Florida, The Center for the Advancement of Health IT (AHIT).

Although FQHC designations and federal grant funding decisions are made without significant state involvement, a state has many levers that can be used to optimize the role of these entities as partners in achieving state access, cost and quality goals.

## Convening Stakeholders

A state's ability to bring together broad groups of stakeholders is an important means for sharing expertise and resources and working toward a high performance health system. Many states have a strong history of bringing together diverse stakeholders through steering groups or workgroups that include representatives from state PCAs or FQHCs to help design and implement broad initiatives like state health reform, or more focused initiatives such as medical home projects. In a number of states, health centers have played a leadership role in helping to advance new medical home initiatives among stakeholder groups.[91]

## Engaging Health Centers in Delivery System Reform

As states work to improve access to and quality of care in their health care delivery systems, health centers can be important partners, especially looking towards changes under the ACA. The ACA mandates some changes to a state's delivery system and offers other opportunities for further improvement. There exist many opportunities to work with health centers through partnerships on initiatives and federal funding opportunities to help improve access, cost and quality.

### State Funding to Improve Quality Through Medical Homes

Most states have or are planning to have initiatives that seek to improve quality and reduce rising costs through improved funding of new models of primary care.[92] These models – known as patient centered medical homes, advanced primary care, health care homes or health homes – all refer to primary care in which care teams, led by a primary care provider, attend to the multifaceted needs of patients and provide whole-person, comprehensive, coordinated and patient-centered care. Payment reform is a central aspect of these initiatives, with most states providing new Medicaid payments to providers that meet new qualification standards aimed at changing care delivery at the practice level while helping states meet population goals. By tying Medicaid payments to qualification standards, states have an important lever to ensure that Medicaid providers are high performers. Seventeen states are using state-developed or national medical home tools, i.e. National Committee for Quality Assurance (NCQA), and health centers are taking part in most of these initiatives.[93]

These payments are often accompanied by other kinds of support, including access to information technology such as electronic medical records or patient registries, learning collaboratives and new support staff. Most of these initiatives - many of which are multi-payer - have included one or more health centers as providers. Health centers represent a provider group whose high numbers of Medicaid enrollees can present an advantage for certain medical home initiatives, particularly for those that are Medicaid-only or that require a critical mass of enrollees to help test or launch a new pilot or program.

For instance, states will need to partner with their Medicaid providers if they are interested in applying for the ACA Section 2703 State Option to Provide Health Homes for Enrollees with Chronic Conditions.[94] This option provides states with enhanced federal funding (90/10 Medicaid match) for two years if they expand or implement a new initiative that will serve Medicaid enrollees with chronic conditions – provided

certain criteria are met. The 2703 health home criteria build upon traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses.[95] Health centers are a provider group that has strengths in many of these areas, particularly in providing behavioral health care – something that many private Medicaid practices lack – and may prove to be an asset for Medicaid agencies seeking to apply and qualify for this enhanced Medicaid match.

**State Funding to Achieve State Specific Objectives**

States can use grants, contracts and other mechanisms to strengthen the safety net's role in achieving specific objectives within a state's delivery system. For instance, in Iowa, a safety net program was created in partnership with health centers to help the state transition to the Medicaid expansion under the ACA. In October 2010, through a legislative mandate, the state began piloting an expansion of IowaCare, a limited health care program that covers adults ages 19-64 who would not ordinarily be covered by Medicaid.[96] The IowaCare Medical Home pilot will increase the current IowaCare program provider network of two hospital providers and add 13 FQHCs in order to assign every IowaCare member to a centrally located medical home.[97] With the IowaCare Medical Home program, enrollees will also have significantly expanded access to comprehensive primary care services. Health centers and other providers will need to meet new state-based medical home criteria but in return, will receive a monthly care management fee and performance-based payments, layered on top of fee-for-service payments.[98] The expansion of IowaCare serves as a transition program and an opportunity to pilot the medical home model in Medicaid, building on the strengths of health centers with the goal of replication.[99]

**Building an Integrated Delivery System**

Recently, there has been a great deal of interest focused on developing integrated or accountable models of care in which groups of providers are jointly held responsible for achieving measured quality improvements and reductions in the rate of spending growth. CMS' Innovation Center's release of the final rules for Medicare Shared Savings[100] has resulted in many kinds of providers, including health centers, considering how they might partner to become part of accountable care organizations (ACOs) with this Medicare program or forthcoming demonstrations from CMS. The Innovation Center is exploring other potential models to pilot for Medicaid and for safety net providers to participate in new integrated delivery system models.

Colorado is an example of one state that has looked to its safety net providers for the core infrastructure on which to base a new integrated delivery system model. Through partnership with health centers and other providers, Colorado Medicaid is transforming its delivery system by coordinating and integrating care among providers, between programs and through all phases of life. Colorado's version of an ACO is known as an Accountable Care Collaborative.[101] To create Accountable Care Collaboratives, the Medicaid agency divided the state into seven care regions and competitively selected four entities to serve as Regional Care Collaborative Organizations (RCCOs). Health centers are serving as both RCCOs and core primary care medical providers in this initiative currently underway. The RCCOs receive a $13 per-member/per-month payment to coordinate care by working with primary care medical providers, hospitals, pharmacies, physical therapists and occupational therapists, among others, to deliver comprehensive, integrated care to Medicaid enrollees. The primary care medical providers receive a $4 per-member/per-month payment to commit to state medical home criteria as well as partner with their RCCO to share data and take mutual responsibility in case management and care coordination. Each RCCO has a target of enrolling 8,600 Medicaid patients in the pilot year.

## Directing State and Federal Grant Funds

States are facing numerous challenges that include significant fiscal constraints, rising costs in Medicaid due to increasing enrollment, high-cost populations, inflation[102] and implementation of the ACA. In fiscal year 2012, 42 states and the District of Columbia had to close $103 billion in budget gaps.[103] States can direct appropriations and channel federal grant monies to health centers to help them continue to achieve state priorities in improving access and outcomes even in this currently challenging environment.

### State Funding to Support Health Center Capacity

In most states, health centers receive state funding for various purposes including operations, uncompensated care and service expansions;[104] in FY 2011, 33 states provided funding to health centers.[105] However, state budget pressures have resulted in cuts to many of these programs. Total state funding for health centers in FY 2008 was slightly more than $626 million, but this dropped to $364 million in FY 2011.[106,107]

Incubator programs, whose purpose is to get health clinics in the pipeline ready to acquire FQHC payment designation when federal expansion opportunities arise, are one of the programs that have experienced cuts. For instance, the Texas FQHC Incubator Program provided $3.5 million in 2011 to enhance the growth and eligibility of 17 FQHCs for upcoming federal expansion grants, but funding was eliminated in fiscal years 2012 and 2013.[108] Incubator programs provide a possible mechanism for states to leverage federal dollars to help meet delivery system capacity issues which, if not addressed, will be compounded when the Medicaid expansion occurs in 2014.

### Directing States' Federal Grant Funds to Health Centers

Health centers can help the state achieve important health goals, such as meeting immunization and newborn screening targets. To help achieve these goals, many states choose to direct or make available on a competitive basis to health centers and other safety net providers federal grant funds that states receive. These funds include Title V Maternal and Child Health Block Grants, Title X Family Planning Grants and Title IV Ryan White CARE Act AIDS grants, to name a few.

## Health Care Purchasing

A state purchases a significant share of health care through Medicaid, the Children's Health Insurance Program (CHIP), State Employees Benefit Plans and other programs. This purchasing power can be used to ensure that health centers are providing safe, quality patient care. Since up to 41 percent of a health center's operating revenue comes from Medicaid and CHIP, these programs' payment, coverage and eligibility provisions are very important to health centers. At the same time, states control additional purchasing mechanisms which can influence the operation of health centers to help a state achieve health care access, quality and cost goals.

### Using MCO Contracting to Support State Integration Goals

States can further their efforts to integrate care through contracting language. Tennessee's Medicaid program, TennCare, developed contract language that specifically required MCOs to integrate behavioral health and primary care for enrollees.[109] Such efforts allowed for an environment in which models of care such as Cherokee Health Systems could develop. Cherokee Health Systems is a nationally recognized model for primary care and behavioral health in eastern Tennessee, in which a licensed behavioral health consultant is a member of the primary care team and linked through shared electronic medical records.

Cherokee Health Systems grew out of community mental health centers (CMHCs), but these CMHCs now hold dual designation status as FQHCs.[110] This model has shown improved health outcomes, a stronger focus on patient responsibility and behavioral change, and greater provider and patient satisfaction.[111]

### Developing Default Enrollment Policies

States can automatically assign new Medicaid enrollees to plans that favor health centers. Michigan uses auto-assignment as a carrot, along with payment bonuses, to reward plans whose providers – many of which include health centers – meet certain performance measures. This value-based purchasing program has prompted managed care plans to develop provider profiling, as well as provider and enrollee incentive programs.[112] To help support informed consumer choices of health care services, the state publishes a report card of provider plans through an easy-to-find annual report card called "A Guide to Michigan Medicaid Health Plans" on its Medicaid website.[113]

### Encouraging Creation of Health Center Affiliated Health Plans

Policymakers interested in preserving the safety net for both Medicaid enrolled and uninsured individuals can encourage the development of health center affiliated health plans through regulation. Some states have provided seed capital for some of the start-ups.[114] There also is a regulatory role that Medicaid officials can play to level the playing field for those health center affiliated plans that may not have as much financial reserve as commercial plans. The state may also amend licensing requirements to make it easier for these plans to be responsive to requests for proposals.

## Licensing Health Care Facilities and Health Professionals

Licensure laws help protect the public by ensuring that health care facilities meet minimum health, safety and quality standards, and that health care professionals meet standards with regards to education and qualifications. Licensure laws also can be used to help states meet objectives that improve access to health care.

### Health Facilities Licensing

In addition to ensuring that health centers meet minimum operational standards, many states monitor patient safety for all licensed health care facilities by requiring them to report patient safety data directly to the state.

In Massachusetts, the state requires that health centers (which are licensed under clinic regulations) report incidents that seriously affect patient health and safety.[115] The intake staff in the complaint unit review each report and consumer complaint to determine whether an on-site investigation is

**Retail Clinics and Health Centers**

The recent growth of retail clinics (conveniently located health clinics that offer walk-in, after hours and weekend care, and provide a limited range of services) across the United States presents opportunities for states to consider how these clinics might help address access, costs and quality issues within their health delivery systems. Some states are using regulatory and licensing strategies to promote, structure, or limit the growth of retail clinics.[116] There is opportunity for states to consider if health centers could provide a new kind of role in state delivery systems providing urgent care.[117] Health center-led retail clinics combine the advantages of a patient-centered medical home model with the convenience of the retail clinic model. Some health centers have opened these kinds of clinics; there are other health centers considering if this is a good business model to pursue. Resources have been developed for health centers including a toolkit to help make informed decisions about opening a retail clinic.[118]

required to assess compliance; whether issues or questions exist that can be resolved through "off-site" intervention; or whether some other action, such as a referral to a professional board in regards to licensed staff, is most appropriate. If an on-site investigation is required and the health center is found to be deficient, a correction plan may be required. If no corrective action is taken, then the state could proceed with license revocation.

States also have the power to ensure health facilities are meeting quality standards by requiring that they meet medical home standards as previously discussed.

### Health Professionals Licensing

State regulators can close doors to unqualified health professionals working in their state through professional licensure requirements, but they also can open doors to bring new kinds of practitioners into the state to address critical workforce shortages. This state role is crucial to safety net providers such as health centers that encounter many barriers to recruiting and retaining the workforce they need. States can use their regulatory authority to recruit and retain scarce health care professionals through some of the following means:

- Offer temporary licensure for providers moving from out of state.
- Recognize some professionals' foreign training and education as equivalent to that conducted in the U.S.
- Support establishment, education and licensing of new midlevel practitioner models such as dental health therapists.
- Expand permitted scope of practice of non-physician health professionals such as pharmacists, nurse practitioners, physician assistants, psychologists and dental hygienists.

In Pennsylvania, former governor Ed Rendell established "Prescription for Pennsylvania," a set of integrated practical strategies for improving the health care of all Pennsylvanians, making the health care system more efficient and containing its cost.[119] Within this larger body of work was a significant focus on assessing and making changes to scope of practice requirements within the state. The goals of the work were to "relieve shortages of primary care providers; ensure access to cost-effective healthcare for citizens of all racial, ethnic, and language backgrounds; improve access to healthcare services in evenings and weekends; and, increase the diversity of the healthcare workforce."[120] Resulting legislation from this initiative succeeded in removing restrictions that prevented licensed health care providers from practicing to the fullest extent of their education and training, helping the state successfully address workforce shortages.

## Reaching the Uninsured Who Are Eligible for Public Coverage

As states look towards 2014 and enrolling newly eligible populations into Medicaid and subsidized health plans, they may want to look to health centers for assistance. Under Medicaid law, states are required to pay for the processing of applications to enroll low-income pregnant women, infants and children at outreach locations such as health centers in order to reach vulnerable populations. Health centers are poised to serve nearly 20 million additional individuals under the ACA,[121] and states may benefit from improving their partnerships with health centers around enrollment to ensure states meet their coverage goals.

In recent years, Oregon has shown the success a state can have in reaching enrollment goals by partnering with health centers and other community-based organizations. Through a 2009 CHIPRA outreach grant,[122] Oregon provided support to public health departments, school-based health centers and safety net health

providers, including health centers, to reach and enroll eligible uninsured children.[123] In 2009, Oregon's uninsured rate for children ages 0-18 was 11.3 percent; by 2011 this rate decreased significantly to 5.6 percent.[124] Much of the success in enrolling eligible but uninsured children is attributed to the application assistance provided by health centers.[125]

State policymakers can draw upon these collaborative tools and levers to better integrate the safety net with the state's health care system, improve access to care for underserved state residents, and enhance health centers' contributions to achieving state health objectives. Policy challenges that will benefit from collaboration between states and health centers include health care reform implementation, shortages and capacity issues in the health care workforce and health information technology.

## Health Care Reform

Safety net providers, including health centers, can help states meet their health care reform goals. Health centers can provide a source of primary health care for the newly insured through state exchanges while maintaining their role as the safety net for those that are publicly insured – which will include a significant number of new individuals through the Medicaid expansion – and for those who will remain uninsured. Already serving more than seven million uninsured and more than seven million individuals on Medicaid, health centers can be a resource for states as they expand coverage under the ACA and connect people with primary care providers.[126] As states work to meet the challenge of providing better care at a lower cost to a significant number of newly insured individuals, health centers will be important partners for the state.

However, health care reform implementation comes at a challenging time for states and health centers. States have been experiencing significant budget deficits and will continue to be severely resource limited in the years to come. There is also limited state agency capacity to lead and manage all aspects of health care reform implementation. Stakeholders in a state delivery system, including health centers, operate within different cultures and with differing incentives, and the strained capacity at the state level limits a state's ability to align what can be sometimes differing agendas around health care reform implementation.[127] This difficult environment makes collaboration to achieve state health care reform goals even more important. Understanding and building on the resources being invested in health centers to expand access to care, improve the primary care workforce and develop integrated care delivery models will assist states in meeting their state health reform goals and implementing the provisions of the ACA.

### Care for the Remaining Uninsured

In 2020, it is estimated that 23 million nonelderly individuals will remain uninsured.[128]

About one-third will be undocumented immigrants who are not eligible to participate in Medicaid or the health insurance exchanges, about a quarter will be eligible for Medicaid but not enrolled, and the remaining individuals will be those who are ineligible for subsidies, exempt from the mandate to obtain insurance, or who choose not to comply with the mandate.[129] The uninsured likely also will include vulnerable populations, such as the homeless and mentally ill, who can face challenges in obtaining coverage and accessing care. Given the remaining uninsured populations after ACA implementation, health centers will continue to need federal and state support to serve as the safety net for these individuals.

Given federal restrictions, health care for low-income, undocumented immigrants remains challenging for states. Federal law restricts use of federal Medicaid matching funds for care of undocumented immigrants to emergency room care and stabilization, and the ACA prevents undocumented immigrants from seeking coverage through exchanges. Thus, the undocumented likely will continue to turn to safety net providers, including health centers, for care.

### Workforce Shortages and Capacity Issues

Health centers have a chronic shortage of practitioners, exacerbated by the recent push to expand the health center system, and states have a chronic shortage of practitioners willing to serve Medicaid, uninsured and other vulnerable populations. Health care workforce shortages will continue to be an important challenge for states and health centers as health care reform is implemented and newly insured individuals enter the system. Because states and health centers share the common goal of ensuring access to care for the most vulnerable, working in partnership to address workforce shortages will be important. There are strategies that can be employed to address shortages and capacity limitations, including allowing providers to practice to the full limits of their scope of practice, and building the skill set needed for those within the current health workforce, as well as those in training, to perform in new team-based models of care delivery.[130] The ACA provides some funding and establishes new programs to help grow and strengthen the primary care workforce, such as investing in the National Health Service Corps and new health center-based residencies, and health centers and states can collaborate to maximize these resources.

### Technology Investments

Implementing new information technology systems to keep pace with care coordination, quality and patient safety monitoring, as well as to assist with enrollment and retention in coverage, is a challenge for most health centers. Like other providers, health centers must find ways to make prudent choices about technology investments, but must also take the time and effort to redesign their processes of care to incorporate the benefits from health information technology. Recent ARRA investments have enabled health centers to move forward in adopting health information technology, including electronic health record systems. A 2009 survey found that 40 percent of health centers used electronic medical records.[131] Yet, this same survey found that while adoption of electronic medical records in health centers was strong, their ability to use these systems to electronically order prescriptions and tests, create and maintain patient registries, and track patients and tests varied greatly.[132] Moving health centers further along in health information technology adoption will improve quality and delivery of care, and benefit the populations they serve. It will also be important for health centers as they participate in the movement to more integrated systems of care and new payment methodologies; these require more real-time ability to share, collect and analyze data about the quality and cost of care for groups of patients.

## Conclusion

Over the years, the relationship between health centers and states' health systems has grown. The significant challenges facing states in 2011, including tremendous fiscal and capacity constraints and the pressures of health care reform implementation, elevate the importance of continuing to strengthen the role of health centers in a state's health care system. While the ACA presents challenges for states, it also brings new resources and opportunities to reduce costs and improve access and quality of care. Health centers have a track record in providing coordinated, comprehensive primary care that has been shown to reduce disparities in care and lower costs.[133,134] By making use of policy levers to work with health centers and better integrating health centers into states' health systems, states will be well positioned to achieve both the aims and requirements of the ACA, as well as their own goals for an improved health system.

# Appendix

# Appendix

## Table A-1: Key State Level Data from 2010 on Federally-Funded Health Centers: Number of Centers, Patients Served, Medicaid Dollars Spent (Medicaid Revenue) and Percent of Total Charges that is Medicaid

| State | No. of CHCs | No. of Patients Served | Medicaid $ Spent (Medicaid Revenue) | Percentage of Total Charges that is Medicaid |
|---|---|---|---|---|
| Alabama | 14 | 310,673 | 38,848,060 | 30.0% |
| Alaska | 25 | 87,802 | 20,333,220 | 27.8% |
| Arizona | 16 | 384,287 | 140,810,281 | 50.0% |
| Arkansas | 12 | 150,669 | 18,966,985 | 31.2% |
| California | 118 | 2,937,212 | 862,838,796 | 50.6% |
| Colorado | 15 | 458,075 | 110,359,131 | 39.2% |
| Connecticut | 13 | 298,268 | 132,141,463 | 64.9% |
| Delaware | 4 | 33,123 | 6,999,196 | 42.5% |
| D.C. | 5 | 109,612 | 25,527,939 | 36.1% |
| Florida | 44 | 1,040,464 | 173,964,015 | 39.5% |
| Georgia | 27 | 312,039 | 33,263,767 | 27.4% |
| Hawaii | 14 | 130,309 | 52,815,591 | 64.6% |
| Idaho | 11 | 121,329 | 15,240,064 | 25.0% |
| Illinois | 36 | 1,092,164 | 283,629,381 | 63.7% |
| Indiana | 19 | 258,867 | 58,234,534 | 50.2% |
| Iowa | 13 | 170,925 | 32,228,575 | 36.3% |
| Kansas | 13 | 133,765 | 10,732,367 | 24.2% |
| Kentucky | 19 | 275,179 | 61,582,078 | 31.2% |
| Louisiana | 24 | 206,960 | 35,758,933 | 46.4% |
| Maine | 18 | 175,180 | 34,482,228 | 33.5% |
| Maryland | 16 | 266,172 | 91,883,907 | 51.6% |
| Massachusetts | 23 | 588,064 | 176,283,377 | 43.6% |
| Michigan | 29 | 537,847 | 138,384,759 | 45.1% |
| Minnesota | 15 | 168,750 | 49,883,816 | 41.7% |
| Mississippi | 21 | 314,612 | 28,715,575 | 31.3% |
| Missouri | 21 | 392,785 | 108,789,241 | 48.7% |
| Montana | 15 | 96,682 | 8,662,095 | 18.0% |
| Nebraska | 6 | 63,033 | 6,775,659 | 33.8% |
| Nevada | data not available | | | |
| New Hampshire | 10 | 65,810 | 10,154,397 | 27.4% |

| State | No. of CHCs | No. of Patients Served | Medicaid $ Spent (Medicaid Revenue) | Percentage of Total Charges that is Medicaid |
|---|---|---|---|---|
| New Jersey | 20 | 432,328 | 94,811,047 | 54.5% |
| New Mexico | 15 | 275,748 | 49,727,503 | 36.5% |
| New York | 51 | 1,417,414 | 499,825,441 | 58.4% |
| North Carolina | 27 | 409,709 | 39,653,997 | 25.2% |
| North Dakota | 4 | 30,797 | 3,901,724 | 36.2% |
| Ohio | 32 | 455,669 | 78,273,102 | 45.2% |
| Oklahoma | 17 | 131,649 | 27,536,537 | 38.7% |
| Oregon | 25 | 277,605 | 124,645,604 | 47.7% |
| Pennsylvania | 35 | 617,646 | 129,229,544 | 49.5% |
| Rhode Island | 8 | 122,337 | 32,095,731 | 45.5% |
| South Carolina | 20 | 312,135 | 46,916,746 | 31.5% |
| South Dakota | 6 | 61,049 | 8,428,466 | 29.2% |
| Tennessee | 23 | 375,694 | 50,896,700 | 33.9% |
| Texas | 64 | 948,685 | 157,798,919 | 30.7% |
| Utah | 11 | 114,877 | 10,625,490 | 20.7% |
| Vermont | 8 | 112,761 | 21,506,962 | 35.5% |
| Virginia | 25 | 273,431 | 26,987,600 | 22.9% |
| Washington | 25 | 753,269 | 310,134,242 | 54.2% |
| West Virginia | 28 | 363,677 | 47,155,641 | 26.7% |
| Wisconsin | 16 | 265,924 | 157,962,906 | 66.4% |
| Wyoming | 6 | 20,725 | 2,140,317 | 17.1% |

Source: 2010 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services. Accessed 16 August 2011. http://bphc.hrsa.gov/healthcenterdatastatistics/statedata/index.html.

Separate data for Nevada is not available.

The federally-funded Federally Qualified Health Centers (FQHCs) meet federal health center grant requirements and are required to report administrative, clinical and other information to the federal Bureau of Primary Health Care. Other health centers known as "FQHC Look-Alikes" or facilities operated by tribal or urban Indian organizations are not included here because they do not receive federal health center grants and do not report to the Bureau of Primary Health Care. The data provided here consequently underreport the services provided by FQHCs. There are approximately 100 FQHC Look-Alikes across the United States.

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