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Geiger Gibson Program in Community Health Policy

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at http://sphhs.gwu.edu/projects/geiger-gibson-program or at rchnfoundation.org.

Executive Summary

The implementation of the Affordable Care Act (ACA), which includes both the creation of the new health insurance marketplaces (exchanges) as well as state Medicaid expansions, will expand health insurance coverage for millions of Americans. A related policy challenge is to ensure that the capacity of the health care system is sufficient to care for both the newly insured, as well as those who remain uninsured. Analyses indicate that the nation could face a shortfall of primary care providers in coming years, due to overall population growth, aging of the Baby Boomers and the health insurance expansions. Most health experts believe that expanding access to affordable primary and preventive health care is particularly vital. After Massachusetts expanded health coverage several years ago, community health centers and safety net hospitals became even more important as sources of ambulatory care.[1] The status of the health care safety net will affect patients' ability to obtain the primary care they need.

This brief analyzes the effect of federal and state policy decisions on the capacity of community health centers to meet future health care needs. It focuses on two particularly important policy issues: (1) *the level of federal grant funding for community health centers* and (2) *whether states expand Medicaid coverage*. This paper estimates the number of patients who could be served in health centers in 2014 and 2020, depending on the outcome of these federal and state policy decisions.

Both higher federal grant funding and more state Medicaid expansions strengthen the capacity of health centers to offer primary care (as well as related services such as behavioral and dental care) to needy patients in medically underserved areas. With sufficient support from both sources, health centers could come close to doubling their capacity for patient care by 2020, but these findings indicate that ability of health centers to expand and meet their communities' needs could be curtailed by the failure of some states to expand Medicaid and inadequate federal funding support.

Health Center Grant Funding. Because of concerns about the nation's capacity to address needs in medically underserved areas – areas with high health needs and not enough primary care providers, the ACA bolstered core funding for health centers (Section 330 grants) with mandatory funding[2] reaching $3.6 billion in 2015, which would be added to regular appropriations levels. This policy is consistent with a tradition of bipartisan support for community health centers; the Bush Administration supported funding to double the size of health centers. In 2012, health centers nationwide served 21 million patients, more than double the 10 million served in 2000.

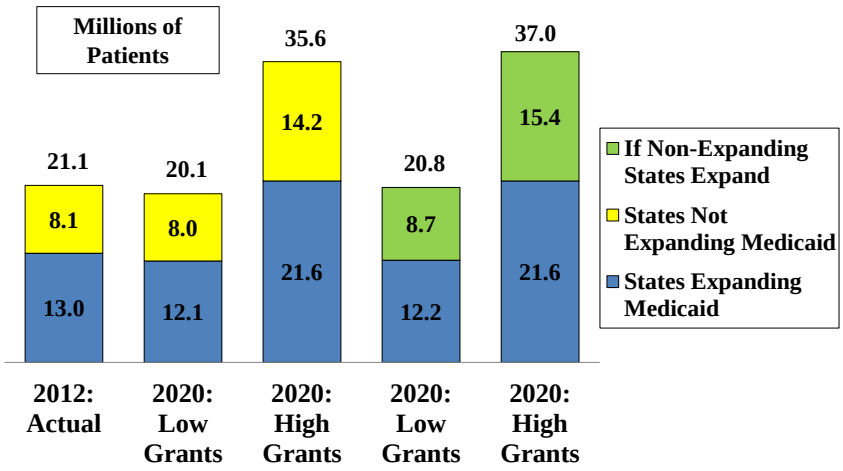
However, the mandatory funding for health centers expires after 2015 and, given the current debate over the federal budget, future funding levels for health center grants are uncertain. We examine two alternative funding options: a "high" and a "low" funding scenario for Section 330 grants. The high funding scenario assumes that federal grant funding continues

[1] Ku L, Jones E, Shin P, Burke FR, Long S. The Role of the Safety Net after Health Reform: Lessons from Massachusetts. *Archives of Internal Medicine,* 2011 Aug 8; 171(15): 1379-84.

[2] Mandatory funding means that those funds are authorized by the ACA, not by annual appropriations laws. The combined mandatory and appropriated funds establish the total level of Section 330 funding for health centers.

to support growth for health centers in 2014, 2015 and in subsequent years. The low funding scenario assumes that funding is held down in 2014 and that appropriations do not increase to counteract the loss of mandatory funding after 2015.

Figure 1. Effects of Health Center Grant Funding and Medicaid Expansion on Total Number of Patients Served



As seen in Figure 1, under the low funding scenario, if Medicaid expansion plans do not change, national health center capacity would decline by one million patients by 2020, falling from 21.1 million in 2012 to 20.1 million in 2020. The caseload declines would be even larger, except that some growth is anticipated due to the planned Medicaid and health insurance marketplace (exchange) expansions and we assume that other grant funding, such state and local grants, continue to grow. Even with the additional support from other sources, health center capacity would be diminished and there could be no further growth to meet additional needs. The reductions would occur across the board, regardless of each state's decision to expand Medicaid. In contrast, under the high federal funding scenario, total health center capacity would rise to 35.6 million patients in 2020 (under current Medicaid expansion patterns), about two-thirds higher than 2012 levels.

Medicaid Expansions. As of late October 2013, 25 states and the District of Columbia have chosen to expand Medicaid eligibility for non-elderly adults to 133% of the federal poverty line beginning in 2014. The remaining 25 states are not currently planning to expand Medicaid, although some states are still considering the issue.[3] These expansions increase the number of Medicaid patients and reduce the number of uninsured patients in each state, increasing health centers' revenue and reducing their uncompensated care costs. Thus, they can expand operations to serve more total patients with all types of insurance. While there would be fewer uninsured residents in the states that expand Medicaid, health centers would continue to serve a disproportionate share of the residents who remain uninsured. In Massachusetts, heath centers served an increasing proportion of the state's uninsured population after health reform was enacted.[4]

As seen in Figure 1, if all of the non-expanding states implemented Medicaid expansions, their health centers could serve as many as 15.4 million patients in 2020, compared to 14.2 million without Medicaid expansions under the high funding scenario. In total, health centers

[3] See the Methodology section for more detail about how state Medicaid expansion decisions were classified for this report.
[4] Ku, Jones, et al., *op cit.*

would serve 37 million patients. Under the low funding scenario, Medicaid expansions would permit the overall number of patients in non-expansion states to grow slightly compared to 2012 levels, while health center caseloads in expansion states would fall.

Conclusions. Both the level of future Section 330 federal grant funding and each state's decision regarding Medicaid expansion have strong effect on future health center growth. While Section 330 grants are not health centers' largest source of revenue (Medicaid is the largest), they constitute core funding that supports infrastructure and operations that enable the health centers to serve both insured and uninsured patients. If further funds are not appropriated to replace the expiring mandatory ACA funding to sustain future growth, health centers will not be able to meet future needs. Similarly, the opening of health insurance marketplaces in all states and Medicaid expansions in about half the states will help bolster health centers so that they can serve more total patients. If states that are currently not planning to expand Medicaid instead opt to adopt an expansion, this will further increase the capacity of health centers in those states.

About one-third of the nation already lives in a medically underserved area and primary care shortages in those areas would be particularly exacerbated if primary care capacity does not improve.[5] The need for primary care will grow appreciably in future years and will affect all patients across the nation. One study estimated a 17% increase in the number of primary care physicians needed by 2020, driven by overall population growth, the aging of the baby boomers and health insurance expansions.[6] That study assumed that medical practice patterns remain similar to today. If, as many expect, reliance on primary care grows in the future, the need for increases in primary care capacity could be larger.

Continued growth of community health centers is a critical element of policies to support the primary care infrastructure of the nation. Growth would permit not only an expansion of current health centers, but support new centers and services in medically underserved rural and urban areas that currently do not have any. The refusal of some states to expand Medicaid and inadequate federal support could undercut current capacity and severely hinder the potential for growth into new areas, exacerbating access problems in communities that are already medically underserved.

[5] Rosenbaum S, Jones E, Shin P, Ku L. National Health Reform: How Will Medically Underserved Communities Fare? Issue Brief No. 10. Geiger Gibson /RCHN Community Health Foundation Research Collaborative Policy Research. July 12, 2009.

[6] Petterson S., et al. Projecting US Primary Care Physician Workforce Needs: 2010-2025. *Annals of Family Medicine.* 2012 Nov-Dec; 10(6): 503-509

Background

Community health centers are a critical element of the nation's health care delivery system; these nonprofit organizations increase access to health care for patients in medically underserved communities by providing services without regard to patients' ability to pay.[7] Health centers provide primary care services as well as comprehensive services such as dental and mental health services, plus an array of other social and enabling services to meet the complex needs of patients in vulnerable communities. Health centers provide high quality care and can be effective in controlling chronic diseases and medical expenditures for disadvantaged patients.[8,9]

About two-fifths (39%) of health center patients are covered by Medicaid and 36% are uninsured/self-pay patients. Medicare and privately-insured patients are also served. As a result of the diversity in patient types, community health centers have complex funding sources. In 2011, the majority (59%) of the $13.9 billion in total revenue reported by the 1,128 health center grantee organizations around the nation was derived from reimbursements for patient care ($8.2 billion), while 41% came from grants and contracts. The 59% of revenue attributable to reimbursements for patient care services includes insurance payments from Medicaid, Medicare, CHIP and private insurance, as well as patients' out-of-pocket payments, including insurance copayments and sliding scale fees from low-income patients.

About one-sixth (17%) of total health center revenue was supported by grants from the Bureau of Primary Health Care (BPHC) of the Health Resources and Services Administration, pursuant to Section 330 of the Public Health Service Act. These grants comprise the "core" funding for community health centers, helping to provide access to uninsured patients, as well as supporting infrastructure and administrative costs and other critical services, such as enabling services, for vulnerable patients. Other sources of grant funding include the federal Ryan White program for HIV care and prevention, Title X family planning, the Women, Infants and Children (WIC) nutrition program, state and local grants, and funding under the American Recovery and Reinvestment Act (ARRA) for health center capital improvement and for electronic health record adoption and meaningful use.

Grant funding is critically important because payments collected from insurers typically fail to cover the full costs of providing health care and enabling services to health center patients. As seen in Table 1, the average reimbursements received from Medicaid, Medicare, CHIP, and private insurers in 2011 were well below the estimated total costs of care.[10] Medicaid, CHIP,

[7] This paper focuses on health center grantees funded by the Bureau of Primary Health Care under Section 330 of the Public Health Services Act. Care delivery sites operated by these grantee organizations are certified by CMS as federally qualified health centers (FQHCs). Similar non-profit health providers that do not receive these grants exist (FQHC lookalikes). Lookalikes are not included in this study because of the lack of detailed data about their finances and patient caseloads.

[8] Richard P, Ku L, Dor A, Tan E, Shin P, Rosenbaum S. Cost Savings Associated with the Use of Community Health Centers. *Journal of Ambulatory Care Management*, 2012 Jan-Mar. 35(1):50-59.

[9] Goldman, LE, Chu P, Tran H, Romano M, Stafford R. Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures. *American Journal of Preventive Medicine* 2012;43(2):142–149.

[10] These data, as well as most of the data used in this report, are based on Uniform Data System (UDS) reports filed annually by health centers to BPHC.

and Medicare reimburse health centers using a cost-related prospective payment system (or alternative payment mechanism) that differs from rates paid to physicians' offices or outpatient hospital clinics.

Table 1. Insurance Coverage of Health Center Patients and Gaps in Patient-Related Payments and Costs by State Medicaid Expansion Status, 2011

Medicaid Expansion (25 States + DC)

	Health Center Patients		% Gap in Patient-Related Payments and Costs
	Number	Percent	
Medicaid	5,298,105	42.6%	-19.8%
Medicare*	894,226	7.2%	-39.1%
Other Public	378,337	3.0%	-38.4%
Private Insurance	1,704,487	13.7%	-44.3%
Self-pay/Uninsured	4,162,079	33.5%	-79.3%
TOTAL	**12,437,234**	**100.0%**	**-39.4%**

No Current Medicaid Expansion (25 States)

	Health Center Patients		% Gap in Patient-Related Payments and Costs
	Number	Percent	
Medicaid	2,652,010	34.1%	-18.2%
Medicare*	674,324	8.7%	-37.6%
Other Public	112,610	1.4%	-49.8%
Private Insurance	1,146,497	14.7%	-41.1%
Self-pay/Uninsured	3,202,082	41.1%	-77.1%
TOTAL	**7,787,523**	**100.0%**	**-44.0%**

Note: Medicare payments to FQHCs are expected to rise 30% under a proposed rule.
Source: Analysis of 2011 Uniform Data System reports

In 2011, there were 18% to 20% gaps between the average Medicaid payment and total costs of care for Medicaid patients. The gaps for Medicare, other public programs and private insurance were even greater, ranging between 37% and 50%.[11] The largest gaps (77% to 79%) are for uninsured and self-pay patients, since the sliding scale fees paid by the patients themselves are generally far below the costs of the care provided. Under the ACA, payments that will be made to FQHCs by plans operating under the health insurance marketplaces are to be based on the Medicaid prospective payment system, unless health centers agree to a lower rate.

Even before the implementation of Medicaid expansions in some states in 2014, health centers in the expanding states had higher caseloads of Medicaid patients (42.6% of total patients) than centers in non-expanding states, where 34.1% of health center patients are covered by Medicaid, on average. States that are not expanding Medicaid typically had more restrictive Medicaid eligibility criteria even before the decisions to not expand Medicaid. As a result, centers in non-expanding states had a larger fraction of uninsured/self-pay patients (41.1% of total patients) than health centers in states expanding Medicaid, where an average of 33.5% of patients were uninsured. States' Medicaid expansion decisions will increase the disparities in insurance coverage across states.

Because the non-expanding states historically had fewer Medicaid patients and more uninsured patients, the gap between total patient-related revenues and actual costs is much higher in states that are not expanding Medicaid (44.0%) than in the Medicaid expanding states (39.4%), even before the expansions are implemented. That is, health centers in the non-expansion states are even more reliant on grant funds, since they receive less revenue from insurers. Despite these funding gaps, health centers serve millions of patients because they also earn revenue from grants and contracts.

[11] Gaps between payments and costs vary for many reasons, including variation in states' Medicaid payment rates and rules and in the cost structures of different health centers. However, the total gaps in payment to cost levels is strongly affected by the higher level of uninsured/self-pay patients in non-expansion states.

Policy Options Examined in This Paper

This paper estimates the impact of two key federal and state decision points on health center capacity and future patient caseloads:

- The level of future federal Section 330 funding levels, and
- State decisions regarding whether to expand Medicaid.

Methodology. Based on detailed 2011 data from the Uniform Data System, the administrative reports filed annually by community health centers with BPHC, we tabulated patient and financial data as the basis for future year projections.[12] Since future federal Section 330 grant funding levels are not yet established, we developed two scenarios for future grant funding for health centers by estimating projected "low" and "high" funding levels for Section 330 grants from BPHC in 2014 and 2020. While the total amount of grant funds is smaller than patient-related revenues, the level of grant funding helps define how many patients can be served. Since health centers are, by law and core principles, required to serve patients without regard to their ability to pay, grant funding levels help determine the total number of both uninsured and insured patients who can be served. Higher grant funds enable health centers to expand capacity to serve Medicaid, privately insured and uninsured patients. If there are not enough grant funds, health centers must reduce their total patient capacity.

Table 2 shows that in 2014, the high scenario assumes $3.66 billion in Section 330 funds are available, while the low scenario assumes $300 million less, or $3.36 billion. For 2020, the high funding scenario assumes $6.25 billion in Section 330 funds are available; this is based on an assumption that appropriations are sufficient to replace the loss of mandatory funding after 2015 and there is additional funding is available for continued growth, leading to $6.25 billion in

Table 2. High and Low Funding Scenarios by State Medicaid Expansion Status, 2014 and 2020

(millions of $)	2014 with High Sec. 330 Funding			2014 with Low Sec. 330 Funding		
	Total	Medicaid Expansion	No Medicaid Expansion	Total	Medicaid Expansion	No Medicaid Expansion
Bureau of Primary Health Care	**$3,661**	**$2,006**	**$1,655**	**$3,361**	**$1,842**	**$1,519**
Other Federal Grants	$630	$387	$243	$630	$387	$243
State, Local, Private Grants	$2,269	$1,556	$712	$2,269	$1,556	$712
Non-Patient Funding	$619	$491	$128	$619	$491	$128
Total Grants, Contracts, Etc.	**$7,178**	**$4,493**	**$2,685**	**$6,878**	**$4,305**	**$2,573**
	2020 with High Sec. 330 Funding			**2020 with Low Sec. 330 Funding**		
	Total	Medicaid Expansion	No Medicaid Expansion	Total	Medicaid Expansion	No Medicaid Expansion
Bureau of Primary Health Care	**$6,250**	**$3,425**	**$2,825**	**$1,461**	**$801**	**$660**
Other Federal Grants	$844	$518	$326	$844	$518	$326
State, Local, Private Grants	$3,041	$2,086	$955	$3,041	$2,086	$955
Non-Patient Funding	$829	$658	$171	$829	$658	$171
Total Grants, Contracts, Etc.	**$10,964**	**$6,862**	**$4,102**	**$6,175**	**$3,865**	**$2,310**

Notes: See text for assumptions

[12] BPHC has posted some basic 2012 UDS data, but we mostly relied on the more detailed 2011 data available.

Section 330 funds in 2020. The low funding scenario assumes that there is no replacement for mandatory funding and Section 330 funding is frozen at $1.46 billion. Both scenarios assume all other grant and contract funding grow modestly. We assume that all other funds grow 5% per year after 2011 (except for a reduction in other federal funding due to the phase out of economic stimulus funding) and that the relative distribution of funds to health centers Medicaid expanding and non-expanding states remains consistent.

In this report, states are classified as expanding Medicaid or not based on status as of late October 2013.[13] In reality, the status of states' Medicaid decisions remains fluid. States counted as expanding Medicaid were: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Dist. of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington and West Virginia. Note that two states counted as expanding have submitted Section 1115 waivers to use health insurance marketplaces for their expansions (Iowa and Michigan), but their waivers have not yet been approved. Non-expanding states were: Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin and Wyoming. Pennsylvania's governor has said that the state will submit a waiver, but Pennsylvania is not counted as expanding since the waiver has not been filed yet. Some other states, such as New Hampshire, are still in a decision mode. In this analysis, Medicaid programs in the U.S. territories were treated as not expanding.

Based on the assumption that the gaps between patient-related revenues and costs by insurance type must balance against the expected levels of grant/contract funding, we estimated the number of patients who could be served by health centers in 2014 and 2020. Since health centers are non-profit, their overall revenues and expenditures are expected to balance. That is, if a center loses $1 million associated with insurance and self-payments, this should be balanced out by the use of $1 million in grant and other funds. Like other nonprofit entities, health centers have positive balances in some years and negative ones in other years, but it is reasonable to expect an overall balance.

We modified the Medicare payment gap by assuming that Medicare payments to FQHCs rise by 30%, in accordance with a recent proposed regulation.[14] We also assumed that health center patients covered by health insurance marketplace plans are paid based on the prospective payment rule.[15]

[13] Centers for Medicare and Medicaid Services. State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014. Oct. 1, 2013. On October 21, 2013, Ohio approved a Medicaid expansion. http://www.huffingtonpost.com/2013/10/21/ohio-medicaid-expansion_n_4138618.html

[14] Centers for Medicare and Medicaid Services. *Federal Register*. 78(184): 58386-414, Sept. 23, 2013.

[15] Federal regulations require that the Medicaid payment system be used unless health centers agree to accept a lower rate. It is not yet clear how reimbursement will be handled for health centers in marketplace plans.

In reports issued in 2009 and 2010, we analyzed the potential impact of health reform on health center caseloads and overall medical expenditures.[16, 17] At that time, we assumed that all states would expand Medicaid and that there would be relatively generous Section 330 funding for health centers (reaching $6.4 billion by 2019). Since then, the Supreme Court ruled that the expansion of Medicaid was optional for states, so it now appears that about half the states are expanding Medicaid and half do not have current plans to expand. Health centers experienced cuts in their appropriations in 2011.[18] Since the debate over the federal budget and sequestration continues to rage, there is less certainty about future funding levels.

Results

Health Center Funding Levels

In 2014, the "high" funding scenario assumed $3.66 billion in Section 330 funding: $2.2 billion in mandatory ACA funds plus the 2013 appropriations level of $1.46 billion for a total of $3.66 billion. In the low scenario, a total of $3.36 billion in Section 330 grant funding is assumed, $300 million less than in the high scenario (see Table 2).

In 2020, the high funding scenario assumes $6.25 billion in Section 330 funding, based on continued growth from the combination of mandatory and appropriated funds. The low funding scenario assumes that there is no replacement for mandatory funds and those appropriations provide only $1.46 billion total Section 330 funds. Both scenarios assume, however, similar levels of moderate growth in other federal, state and local funding.

Estimated Insurance Coverage Patterns in 2014 and 2020

Based on estimates of insurance coverage anticipated under the ACA for the general population[19], we estimated insurance coverage patterns in health centers in 2014 and 2020, as shown in Table 3. We assume that insurance coverage rates rise over the years as ACA expansions are more fully implemented.

We assume that a percentage of patients gain coverage under the new health insurance marketplaces in all states.[20] In states that do not expand Medicaid, eligibility for federal premium assistance tax credits is slightly broader (from 100% to 400% of the poverty line) than in Medicaid expansion states. Eligibility in the expanding states generally begins at 133% of

[16] Ku L, Shin P, Rosenbaum S. Estimating the Effects of Health Reform on Health Centers' Capacity to Expand to New Medically Underserved Communities and Populations. Issue No. 11. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Washington, DC. Jul 23, 2009.

[17] Ku L, Richard P, Dor A, Tan E, Shin P, Rosenbaum S. Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform, Brief No. 19. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, June 30, 2010.

[18] Shin P, Sharac J, Alvarez C, Rosenbaum S. Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth. Kaiser Commission on Medicaid and the Unisured, March 2013.

[19] Congressional Budget Office. CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage, May 14, 2013

[20] Because the health insurance marketplaces are so new, there is greater uncertainty about the number of patients who will be covered by qualified health plans under the marketplaces.

poverty; adults with lower incomes are Medicaid-eligible. We estimated that there would be a slight increase in Medicaid participation even in non-expansion states, due to outreach and coordination of enrollment with health insurance marketplaces, combined with the individual responsibility mandate.

Table 3. Estimated CHC Patient Distribution by Health Insurance Type & State Medicaid Expansion Status: 2014 & 2020

	2014 Estimated		
	Total	Medicaid Expansion	No Medicaid Expansion
Medicaid	41.2%	45.7%	34.1%
Medicare	7.8%	7.2%	8.7%
Other Public	2.4%	3.0%	1.4%
Private	10.7%	10.6%	10.8%
Health Ins Marketplaces	6.3%	6.3%	6.3%
Self-Pay/Uninsured	31.6%	27.2%	38.7%
Total	100.0%	100.0%	100.0%

	2020 Estimated		
	Total	Medicaid Expansion	No Medicaid Expansion
Medicaid	43.0%	48.2%	35.2%
Medicare	8.7%	8.1%	9.6%
Other Public	2.5%	3.2%	1.4%
Private	8.1%	7.6%	8.8%
Health Ins Marketplaces	16.9%	16.5%	17.5%
Self-Pay/Uninsured	20.8%	16.4%	27.5%
Total	100.0%	100.0%	100.0%

We also created scenarios about what would happen if all states adopt Medicaid expansions before 2020; that is, if non-expansion states decided to expand Medicaid eligibility. In that case, the insurance patterns for health centers in the non-expanding states would become very similar to those of the expansion states, although there are some differences due to the underlying socioeconomic and market environment differences across the states.

Estimated Health Center Patient Caseloads in 2014 and 2020

The results of our caseload models are shown in Table 4. Results are presented for six scenarios. In all of the scenarios, we assume that health centers serve a disproportionately large number of Medicaid and uninsured patients, as they do today, because of their mission of increasing access for underserved patients and communities.

2014: High Section 330 Funding (with current Medicaid expansion status). The first two scenarios are for 2014, the coming year. This scenario assumes $3.66 billion in Section 330 funding in 2014. The number of patients who can be served nationwide is 25.8 million, or about 4.7 million more than in 2012. Growth occurs in both Medicaid expansion and non-expansion states, in part because of the additional Section 330 funding and in part because of the impact of Medicaid and health insurance marketplace expansions. We anticipate new revenues associated with health insurance marketplace expansions even in states that are not expanding Medicaid.

2014: Low Section 330 Funding (with current Medicaid expansion status). This scenario assumes $300 million less in Section 330 funding, but the funding level is still higher than in 2012 because of the mandatory ACA funding. The number of health center patients still rises by 3.6 million over the 2012 level. Still, about one million fewer patients will be served than under the high funding scenario and both expansion and non-expansion states have lower patient capacity.

Table 4. Estimated CHC Patients by Health Insurance Type and State Medicaid Expansion Status: Actual 2011 and 2012 and Estimated 2014 and 2020 (millions of patients per year)

	2011 Actual		
	Total	Medicaid Expansion	Medicaid Non-Expansion
Medicaid	7.95	5.30	2.65
Medicare	1.57	0.89	0.67
Other Public	0.49	0.38	0.11
Private	2.85	1.70	1.15
Self-Pay/Uninsured	7.36	4.16	3.20
Total	**20.22**	**12.44**	**7.79**
	2012 Actual*		
Total	**21.09**	**13.00**	**8.09**

Medicaid Expansion Status (as of October 2013)

	2014 with High Sec. 330 Funding			2014 with Low Sec. 330 Funding		
	Total	Medicaid Expansion	No Medicaid Expansion	Total	Medicaid Expansion	No Medicaid Expansion
Medicaid	10.64	7.28	3.36	10.20	6.98	3.22
Medicare	2.00	1.15	0.85	1.92	1.10	0.82
Other Public	0.63	0.48	0.14	0.60	0.46	0.14
Private	2.76	1.69	1.07	2.64	1.62	1.02
Health Ins Marketplaces	1.63	1.00	0.62	1.56	0.96	0.60
Self-Pay/Uninsured	8.15	4.33	3.82	7.81	4.15	3.66
Total	**25.81**	**15.94**	**9.87**	**24.73**	**15.27**	**9.46**
Growth (Loss) Since 2012	**4.72**	**2.94**	**1.78**	**3.64**	**2.27**	**1.37**

	2020 with High Sec. 330 Funding			2020 with Low Sec. 330 Funding		
	Total	Medicaid Expansion	No Medicaid Expansion	Total	Medicaid Expansion	No Medicaid Expansion
Medicaid	15.42	10.42	5.00	8.69	5.87	2.82
Medicare	3.12	1.75	1.36	1.75	0.99	0.77
Other Public	0.90	0.69	0.21	0.51	0.39	0.12
Private	2.89	1.64	1.25	1.63	0.93	0.70
Health Ins Marketplaces	6.05	3.57	2.49	3.41	2.01	1.40
Self-Pay/Uninsured	7.45	3.55	3.90	4.19	2.00	2.20
Total	**35.83**	**21.62**	**14.21**	**20.18**	**12.18**	**8.00**
Growth (Loss) Since 2012	**14.74**	**8.62**	**6.12**	**-0.91**	**-0.82**	**-0.09**

If All States Expand Medicaid Before 2020

	2020 with High Sec. 330 Funding			2020 with Low Sec. 330 Funding		
	Total	Expansion Now	Later Expansion	Total	Expansion Now	Later Expansion
Medicaid	17.65	10.42	7.23	9.94	5.87	4.07
Medicare	3.23	1.75	1.48	1.82	0.99	0.83
Other Public	0.91	0.69	0.22	0.51	0.39	0.12
Private	3.00	1.64	1.35	1.69	0.93	0.76
Health Ins Marketplaces	6.11	3.57	2.54	3.44	2.01	1.43
Self-Pay/Uninsured	6.07	3.55	2.52	3.42	2.00	1.42
Total	**37.01**	**21.62**	**15.39**	**20.84**	**12.18**	**8.67**
Growth (Loss) Since 2012	**15.92**	**8.62**	**7.30**	**-0.25**	**-0.82**	**0.57**

* Detailed insurance status data are not yet available for 2012.

2020: High Section 330 Funding (with current Medicaid expansion status). The remaining four scenarios examine caseloads in the year 2020, where there is much more uncertainty about future federal and state policy decisions. This scenario assumes that there is federal support to sustain the growth of health centers, even after the expiration of mandatory ACA funds. If Section 330 funding in 2020 equals $6.25 billion and Medicaid expansion decisions remain as they are today, the model indicates that 35.8 million patients will be served, 14.7 million more than in 2012. There will be substantial capacity expansions, but the total capacity of health centers in non-expanding states will be held down because they will continue to have to serve a high proportion of uninsured patients.

2020: Low Section 330 Funding (with current Medicaid expansion status). This scenario assumes that only $1.46 billion in Section 330 grants is available in 2020. Even though we assume gradual growth in other sources of grant funding and additional patient revenue from Medicaid and health marketplace expansions, total health center patient capacity will fall to 20.2 million, about 910,000 less than in 2012 (and 4.6 million fewer than in our 2014 low funding scenario). These reductions would be felt in both Medicaid expansion and non-expansion states.

Although the overall U.S. population will grow and the demand for primary care will rise by as much as 17%,[21] the capacity of health centers will erode by 4% between 2012 and 2020 (and 18% less than our estimate for 2014 under the low funding scenario). As a result, patients, particularly low-income patients, will have a much harder time getting primary care even if they are insured. The shortfall in funding will effectively rule out the development of new health centers, so that many medically underserved communities will face even greater difficulties obtaining care.

2020: High Section 330 Funding (with all states expanding Medicaid). This scenario assumes that all states expand Medicaid before 2020. This only changes assumptions for non-expanding states and assumes that total Section 330 funding is the same as in the earlier high funding scenario for 2020. If Medicaid expansions are permitted in the 25 non-expanding states, their health center capacity will grow from 14.2 million (without an expansion) to 15.4 million and the number of Medicaid patients served would rise by about 50 percent. Overall, the health centers in these states would able to serve roughly twice the number of patients served in 2012.

2020: Low Section 330 Funding (with all states expanding Medicaid). The final scenario is based on the low level of Section 330 funding in 2020, but assumes that the Medicaid non-expansion states decide to expand Medicaid. This decision would expand total patient capacity in the non-expansion states from 8.0 million without expansions to 8.6 million with expansions. In addition, it actually allows these states to serve about 570,000 more patients in 2020 than in 2012, even though grant funding levels are low. In contrast, the model would expect that Medicaid expansion states would serve about 820,000 fewer patients than in 2012.

Although the models do not present estimates of the number of health centers (or health center sites) that are operational, larger Section 330 funding levels would permit continued growth of health centers into areas that are medically underserved but lack a health center,

[21] Petterson S, *op cit.*

whereas the cutbacks associated with the low funding scenarios in 2020 would severely hinder the potential for an expansion of health center locations.

Conclusions

The expansion of health insurance coverage under the ACA will help millions more gain access to affordable health care. Both Medicaid and health insurance marketplace expansions would add to the patient-related revenue collected by health centers and reduce uncompensated care burdens. The continued expansion of community health centers would both complement the health insurance expansions and help let the safety net keep pace with changing American demographics. Community health centers have enjoyed bipartisan support because of their record of success in providing high quality primary care services to vulnerable patients in underserved communities, where private practitioners are often difficult to locate or might be unwilling to serve uninsured and publicly insured patients.

This analysis shows the importance of two key policy issues on the future capacity of health centers: the level of federal Section 330 funding and state decisions about Medicaid expansion. Higher grant funding levels would permit health centers to expand the number of insured and uninsured patients that they can serve. Expanding Medicaid eligibility brings in more Medicaid revenue and reduces uncompensated care needs. These policies act synergistically to empower health centers to serve more patients in their communities. While policies about health insurance marketplaces are discussed less in this paper since the marketplaces and federal tax credits are available in all states, these policies also help support health center services and capacity expansions.

Health centers have a strong track record of providing high quality care for vulnerable patients in a cost-effective fashion. While the federal funding and state Medicaid policies are important in bolstering their capability to meet future needs, it is also important to consider the need for a sufficient supply of primary care clinicians and other health professionals who can staff health centers. This would require other changes in training and practice patterns of health professionals in the U.S., such as increased funding for the National Health Service Corps. But health centers are already ahead of the curve in their staffing pattern; they are more likely to use nurses and nurse practitioners, physician assistants, and medical assistants in innovative practice patterns that are both efficient and that improve the quality of care.[22]

Both the federal government and state governments can implement policies to support this critical health delivery system in order to meet tomorrow's health care needs. It is critical to continue fundamental support from Section 330 grants, as well as bolstering the insurance coverage of health center patients to reduce uncompensated care and increase patient-related revenue.

[22] Hing E, Hooker R, Ashman E. Primary Health Care in Community Health Centers and Comparison with Office-Based Practice. *Journal of Community Health.* 2012; 36:406–413