

medicaid and the uninsured

MARCH 2012

Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities

Executive Summary

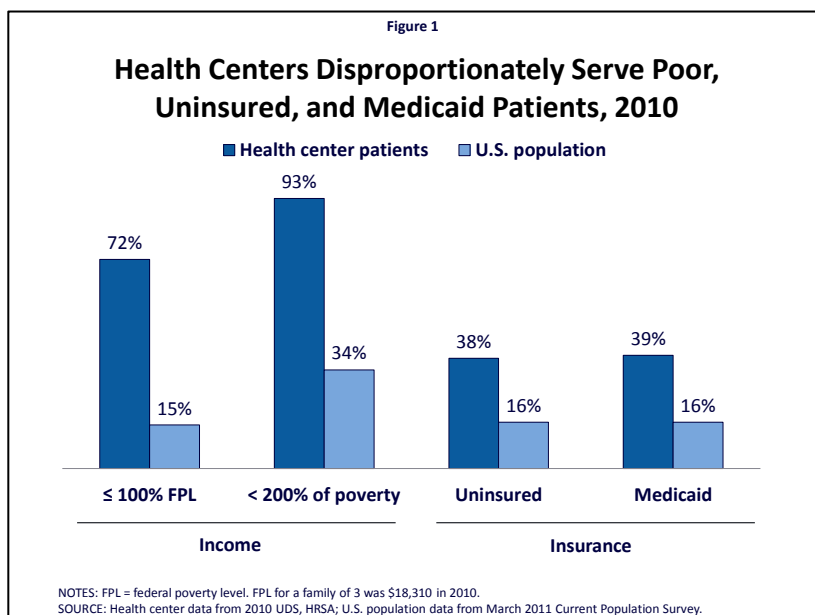
Strong primary care capacity and access are the bedrock of a health care system that is characterized by high performance and offers the potential to reduce health care costs. Where medically underserved communities are concerned, the core of the nation's investment in primary care is the community health center program. Over 1,200 health centers across the country serve a predominantly low-income population, about three-quarters of whom are uninsured or covered by Medicaid (Figure 1).

Revenues from Medicaid and other public as well as private insurance provide key operational support to health centers, but it is the basic federal health center appropriation that anchors the program in thousands of urban and rural communities that otherwise lack access to comprehensive primary care, and that supports such care for the uninsured and under-insured (Figure 2). In 2010, the Affordable Care Act established a Health Center Trust Fund (HCTF), investing \$11 billion in new,

mandatory federal spending over the five-year period 2011-2015. The purpose of the HCTF was to support significant expansion of health center capacity to meet expected greater demands for care, especially as millions of uninsured Americans gain Medicaid or private coverage beginning in 2014.

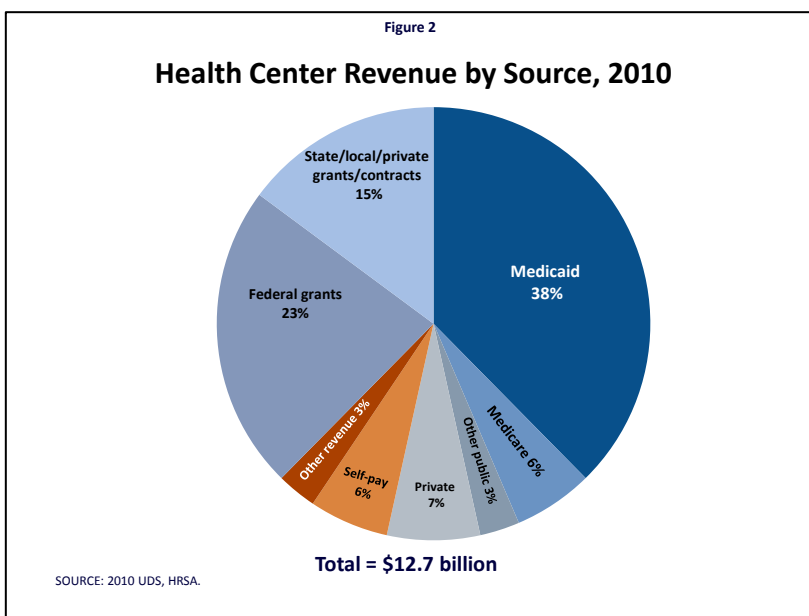
In 2011, the federal health center appropriation was reduced by \$600 million – more than a quarter. As a result, a large share of the FY 2011 allotment from the HCTF had to be diverted to finance existing health center operations. For the program to meet current and expected needs, and for health centers to participate fully in emerging new delivery and payment systems, a number of conditions are key:

- Restoration of the cuts in federal appropriations would help to ensure that HCTF dollars are not used further to replace basic funding for existing operations, and remain available for expanded capacity as planned.
- Expenditure of HCTF dollars as scheduled would provide support for much-needed additional dental and mental health care, as well as general capacity. Building health center capacity to provide care to a burgeoning number of Medicare patients and to serve as health homes for patients with chronic conditions is also a priority.



- Coordination of new National Health Service Corps investments with health center resources can help optimize efforts to ramp up health centers' clinical capacity. Health center strategies that involve partnering with training and residency programs to recruit and retain health care professionals and build health care teams, and reform of state laws to permit health professionals to practice "at the top of their license," are key to ensuring an adequate health care workforce, particularly in medically underserved communities.

- As millions of health center patients gain private insurance through the new exchanges, shortcomings of private insurance that depress payments to health centers relative to the costs of care for privately insured patients, warrant attention. The ACA requirement that exchange plans pay health centers Medicaid rates may mitigate current shortfalls somewhat,



but continued and adequate grant funding will remain important, not only to subsidize care for the uninsured, but also to help cover the revenue gaps that can be expected from high-deductible plans that lack first-dollar coverage for most services.

- It is important that health center efforts to partner with specialized providers and institutions be fostered, to ensure access to a full range of necessary primary and specialty care for health center patients. These partnerships strengthen health centers' capacity to care for patients with chronic conditions and may reduce avoidable hospital care by improving access to comprehensive primary care.
- Although prospective cost-based payment has ensured that health centers can recapture the cost of the services they provide, new payment models may be needed, consistent with growing interest in payment approaches that strengthen incentives for efficiency, such as payment for episodes of care rather than for individual encounters, and that reward high-quality while also providing adequate support for efficient operations so that resources to support uncompensated care are not diverted to cover shortfalls.

Health centers' high performance, rapid assimilation of technological and delivery system improvements, and ability to expand quickly, provide support for the ACA vision of health centers as integral to a national strategy for strengthening access and care, reducing health care costs, and improving the health of Americans. Full funding of the program consistent with its expected larger role in the coming years would help to ensure that health centers continue to bring essential primary care services to millions of medically underserved people, regardless of their insurance coverage or ability to pay, and can expand their reach to offer access and care to millions more.

Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities

Introduction

Community health centers represent one of the nation's most prominent and enduring investments in the effort to build and sustain access to comprehensive primary health care for medically underserved communities and populations. A focus of policy initiatives undertaken by Republican and Democratic Administrations alike, health centers have achieved steady growth, more than quadrupling their capacity since 1980, and doubling their capacity over the 2000-2010 time period alone. By and large, health center growth can be traced to three major expansionary cycles that began in the 1990s and coincided with successive expansions of Medicaid eligibility for pregnant women, children, and parents over time. Expansion of the health center program was accelerated in 2010, when the Patient Protection and Affordable Care Act (ACA) established the Health Center Trust Fund, a major new federal investment that augmented health centers' regular federal appropriation.

Despite the larger role for health centers envisioned by the ACA, in 2011, health centers experienced their first federal funding setback in more than 30 years when Congress enacted a major reduction in health centers' regular federal appropriation. This cut took place despite evidence showing that the number of people residing in medically underserved communities outstripped the number of patients actually reached by health centers by nearly a five-to-one ratio.¹ To protect these communities from the loss of health center capacity that would otherwise have resulted, hundreds of millions of dollars had to be diverted from the new Trust Fund to support existing capacity, reducing the resources available for expansion. This retrenchment in federal support carries major policy and practical implications in light of the size of the medically underserved population, the enormous gap in the current supply of primary health care, the expected surge in demand for primary care once public and private insurance coverage expand in 2014, and the importance of improving health care quality and the efficiency of care. In short, the reduction risks slowing progress toward national goals of improving health care access and quality, reducing disparities in health and health care, and controlling costs.

This policy brief profiles health centers and the patients they serve, discusses how health centers are funded, and traces the history of health center growth. It closely examines the recent reduction in both federal appropriations and state grants for health centers, state cutbacks in benefits for adult Medicaid beneficiaries, and the anticipated impact of President Obama's FY 2013 request for federal funding for health centers. Finally, it looks ahead to both the challenges and opportunities health centers face as the nation prepares for 2014, when the ACA will be fully implemented.

Legislative history of the program

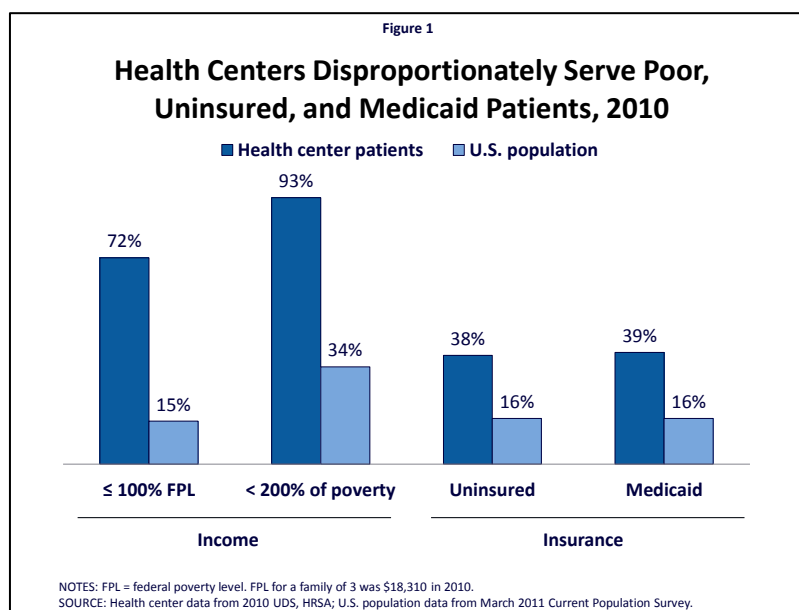
Community health centers were originally established as a small demonstration program in 1965.² The federal health centers program was formally authorized as §330 of the Public Health Service Act in 1975 (Pub. L. 94-63), and the program has been amended numerous times over the years. In 2010, the health centers authorization was made a permanent part of the Public Health Service Act.³

By statute, health centers must operate in or serve medically underserved communities and populations. In addition, they must prospectively adjust fees according to a schedule adjusted for family income and be governed by a board, a majority of whose members are patients of the health centers. Today, health centers represent the nation's single largest investment in comprehensive primary health care for urban and rural communities and populations designated as medically underserved, defined in terms of poverty, evidence of unmet need for primary health care, and shortages of primary health care professionals.⁴

The health center "family" includes not only federally funded health centers, but also "look-alike" health centers, which meet all federal health center requirements but receive their core support from state and local sources of funding, rather than a §330 award. The Centers for Medicare and Medicaid Services (CMS) certifies both federally funded health centers and look-alike health centers as "federally qualified health centers (FQHCs)" for Medicare, Medicaid and CHIP coverage and payment purposes. Today, over 1,200 health centers, including 1,124 federally funded health centers and 100 look-alike health centers, are in operation in more than 8,100 service delivery sites. Overall, in FY 2010, these sites served nearly 20 million patients and provided almost 77 million visits.⁵ All federally funded health centers report basic data on service use, patients, staffing, and revenues into the national Uniform Data System (UDS).^{*} CMS and the states are also important sources of data on health centers.

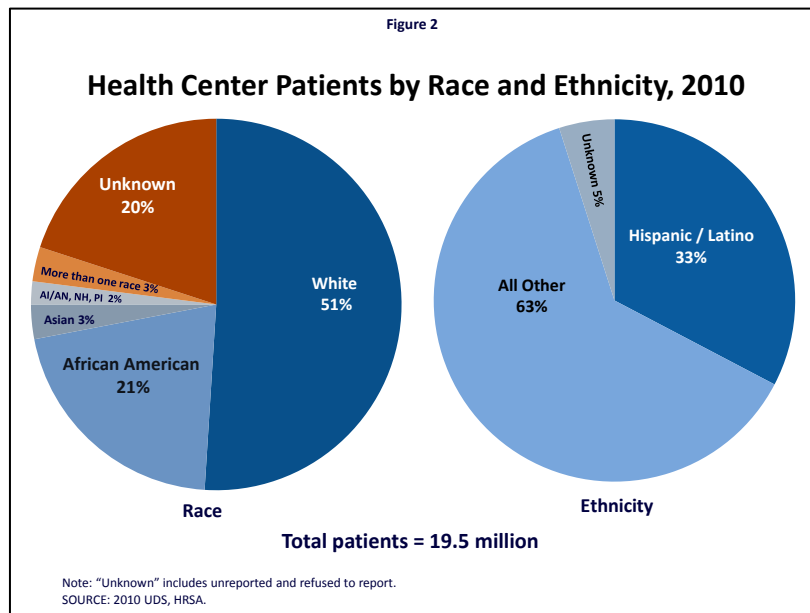
Profile of health centers

Health center patients. By definition, health centers provide care to medically underserved communities, and the profile of the patients they serve reflects the important safety-net role that health centers play. Compared to the U.S. population overall, health center patients are nearly five times as likely to be poor, more than twice as likely to be uninsured, and two-and-a-half times as likely to be covered by Medicaid. The vast majority (93 percent) of health center patients have income below twice the poverty level, or \$36,620 for a family of three in 2010. About 75 percent of all health center patients are uninsured or covered by Medicaid (Figure 1).⁶



* Beginning in 2011, the UDS system will also include information on "look-alike" FQHCs.

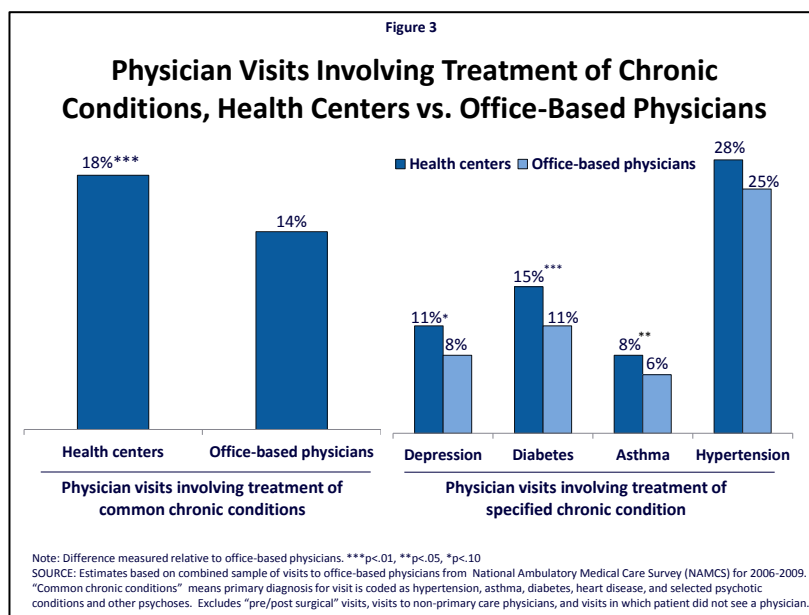
Minority populations are over-represented among health center patients. African-Americans account for 21 percent of all health center patients, and Latinos make up over one-third (Figure 2). Children under age 15 and women of childbearing age (age 15-44) each make up over a quarter of all health center patients, and adults age 45-64 account for about a fifth. The elderly account for only 7 percent of health center patients, but their numbers have doubled to 1.3 million since 1996, when data on this issue were first collected; over the same period, the total elderly population grew by 19 percent.



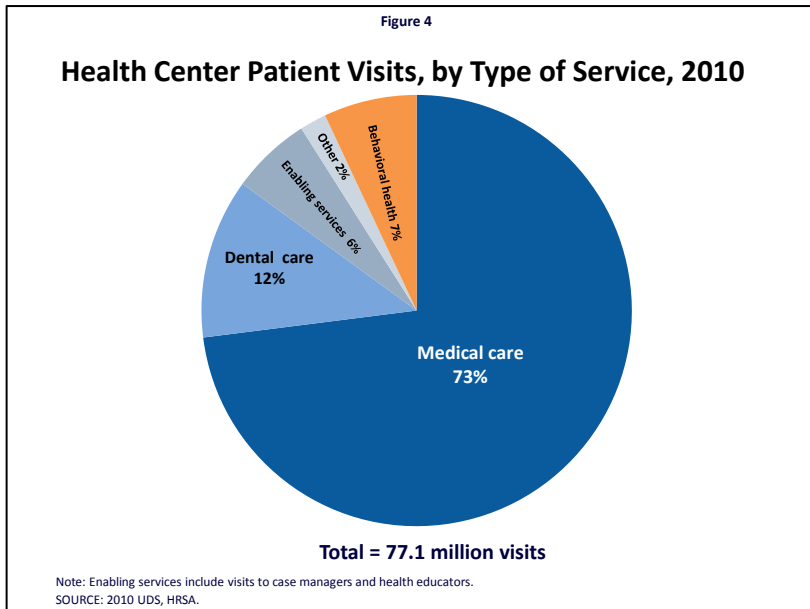
Chronic conditions are prevalent among health center patients, and physician visits in health centers are significantly more likely than office-based physician visits to involve treatment for one or more serious and chronic conditions. Rates of mental illness, diabetes, asthma, and hypertension are all higher in visits to health center physicians, compared with visits to office-based physicians (Figure 3).

Health centers play a particularly important role in the Medicaid program. As shown earlier, Medicaid beneficiaries make up 39 percent of all health center patients and, nationwide, an estimated 14 percent of all Medicaid beneficiaries, or about one in every seven, receive care at health centers.⁷ Nearly a fifth (18 percent) of the primary care physicians who have a high share of Medicaid patients (defined as physicians who derive more than 25 percent of their practice revenues from Medicaid) work in health center settings.⁸ In many communities, health centers dominate the networks of Medicaid managed care plans; in 2010, 29 percent of health centers reported participating in capitated Medicaid managed care arrangements, and 58 percent reported participating in some type of Medicaid managed care arrangement.⁹

Health center services. Health centers are obligated by law to furnish a comprehensive range of services; FQHC services are defined as the "services of physicians, physician assistants, nurse social workers, and ancillary services and



supplies, when furnished by a federally qualified health center.”¹⁰ Close to three-quarters of health center visits are for medical care, but patient visits for dental and behavioral health care and for “enabling services” such as case management and health education also account for millions of health center encounters (Figure 4). Over the last decade, the number of health center visits for mental and dental health care has grown at an extremely high rate, a reflection of the high level of need for these services and the absence of other sources of such care in medically underserved communities. Between 2000 and 2010, while the number of patient visits for medical care rose by about 90 percent, visits for dental care tripled, and visits for mental health care increased four-fold.



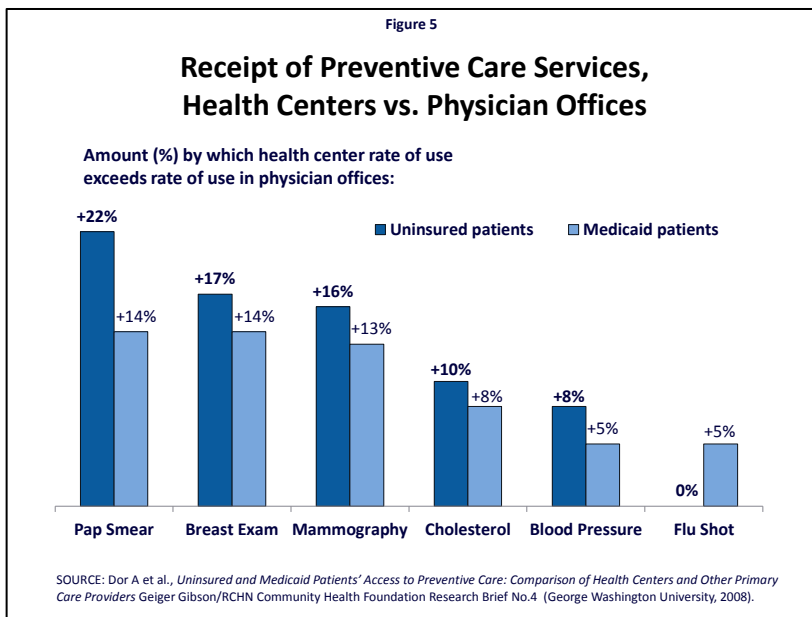
Health center providers. Essential to the viability of health centers is a sufficient supply of health professionals and administrative personnel to maintain as well as

expand capacity. Today, health centers employ nearly 132,000 staff, including approximately 9,600 physicians, 2,900 dental providers, 3,800 nurse practitioners, and 1,300 licensed clinical social workers. Over 5,800 of the health professionals working at health centers are members of the National Health Service Corps (NHSC).¹¹ The ACA made a five-year \$1.5 billion investment in the NHSC, supporting scholarships and loan assistance for approximately 16,000 additional professionals practicing in underserved areas. This expansion of the NHSC was intended to coordinate with the expansion of the health centers.¹² However, even with strong coordination, health centers face enormous recruitment challenges to meet increasing demands for care.

Health center performance. Numerous studies have documented high performance in health centers on measures of preventive and primary care, equal to or exceeding the performance of office-based physicians.¹³ Over the last decade, health centers have demonstrated improved performance in prenatal care, with the percentage of pregnant health center patients beginning prenatal care in the first trimester rising from 58 percent in FY 2000 to 69 percent in FY 2010. This improvement, which exceeded the federal target, is notable especially considering the higher-risk prenatal profile of the health center population.¹⁴

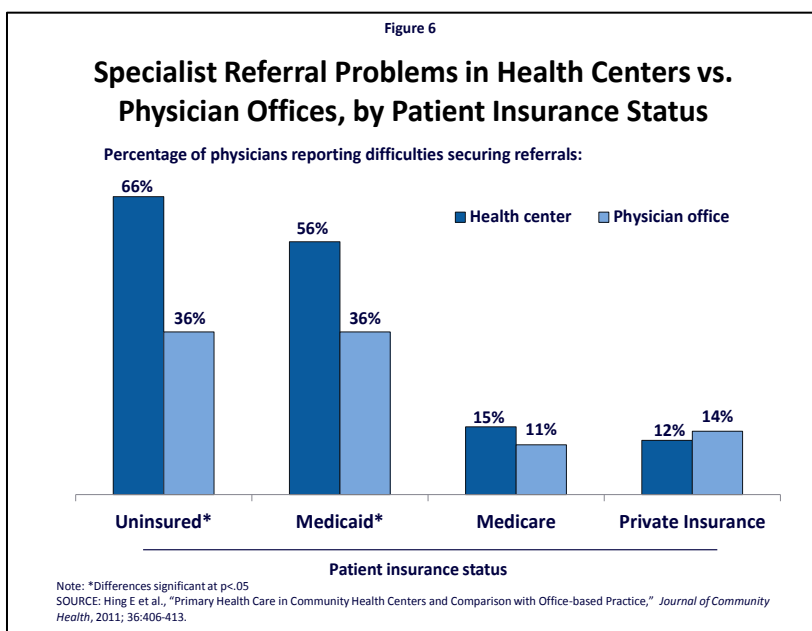
Health centers make a major difference in access for the uninsured. Uninsured health center patients are more likely than similar patients nationally to report a generalist physician visit in the past year (82 percent versus 68 percent) and to have a regular source of care (96 percent versus 60 percent).¹⁵ Rural counties with a health center site have been shown to have a third fewer uninsured emergency department visits per 10,000 uninsured residents than rural counties without a health center site, as well as fewer emergency department visits that could have been avoided with timely primary care.¹⁶ The uninsured served in health centers experience better rates of recommended preventive care. Compared to uninsured women treated in other primary care settings, uninsured women served in health centers are 22 percent more likely to receive a Pap smear, 17 percent more likely to receive a

breast exam, and 16 percent more likely to receive a mammogram. Controlling for age and race, gender, poverty level, and health-related limitations, uninsured health center patients are 8 percent more likely to get cholesterol screening and 8 percent more likely to be screened for high blood pressure than uninsured patients in other primary care settings. The same pattern emerges from data on patients covered by Medicaid (Figure 5).



While health centers have a strong record of connecting patients with appropriate preventive and primary care, their ability to secure specialist referrals remains a substantial challenge. Health centers report significantly more difficulty referring their uninsured and Medicaid insured patients for specialist care than office-based physicians do, although they have no more difficulty in securing referrals for their Medicare and privately insured patients (Figure 6).¹⁷ Access to specialist care is a problem system-wide, attributable to health care workforce shortages, geographic maldistribution of the workforce, and physician participation behavior. But the problem is exacerbated in the case of health centers by their location in medically underserved areas, the heavy representation of uninsured and publicly insured patients in these settings, and the low income and greater social and clinical complexity typical of health center patients.

Commonly reported barriers to referral are refusal on the part of specialists to accept Medicaid, a requirement for payment at the time of service for uninsured patients, and coverage limitations or exclusions (e.g., Medicaid exclusion of adult dental services) that render even insured individuals uninsured for some care.¹⁸ The fact that the uninsured rate in communities served by health centers is 25 percent or higher means that health centers confront specialist referral problems routinely, as distinct from office-based physicians, who treat only the occasional uninsured patient for whom they may have trouble securing a referral.



Health center quality and efficiency. Health centers play a key role in the efforts now underway in many states to improve quality and lower costs through various models of highly coordinated primary care, such as patient-centered medical homes, advanced primary care, and health homes. In most states pursuing these initiatives, which couple payment reform with specific improvements aimed at strengthening the quality of care delivered, health centers are directly involved.¹⁹ A growing number of health centers have earned NCQA accreditation as a patient-centered medical home – as of the end of 2011, nearly one in five health centers had done so, or had an application pending.²⁰

Health centers have made substantial infrastructure investments oriented toward improving quality. Adoption and use of electronic health records (EHR) is associated with improvements in the quality of care, as well as gains in efficiencies.²¹ A national survey of health centers found that, as of 2011, 69 percent of all health centers had adopted EHRs, with 45 percent of them reporting that EHRs were fully operational at all their sites. In addition, health centers that had adopted EHRs had high rates of compliance with federal “meaningful use” measures of HIT adoption, qualifying them for Medicare and Medicaid incentive payments under the HITECH Act.

The availability of a broad range of services under a single roof and health care teams practicing in staff-model arrangements enable health centers to deliver primary care that is clinically integrated, and also contribute to their highly efficient delivery of care. A recent analysis of data from the Medical Expenditure Panel Survey found that, controlling for health status, health insurance coverage, income, age, and other factors, patients receiving a majority of their ambulatory care in community health center settings had 25 percent lower ambulatory care expenditures, and 24 percent lower total annual medical expenditures, compared with patients who receive most of their care in other primary care settings.²² Still, as mentioned earlier, health centers’ difficulty in connecting their patients to specialty care remains an important challenge, especially because of their high shares of Medicaid and uninsured patients. In addition, many health center patients face gaps in covered benefits and interruptions in their Medicaid coverage, which hinder efforts to deliver continuous and comprehensive care.²³ Coordinating care for special populations, such as homeless patients with mental illness and migrant farmworkers who regularly travel across states, entails extra challenges – and costs that may not be recognized by payers.

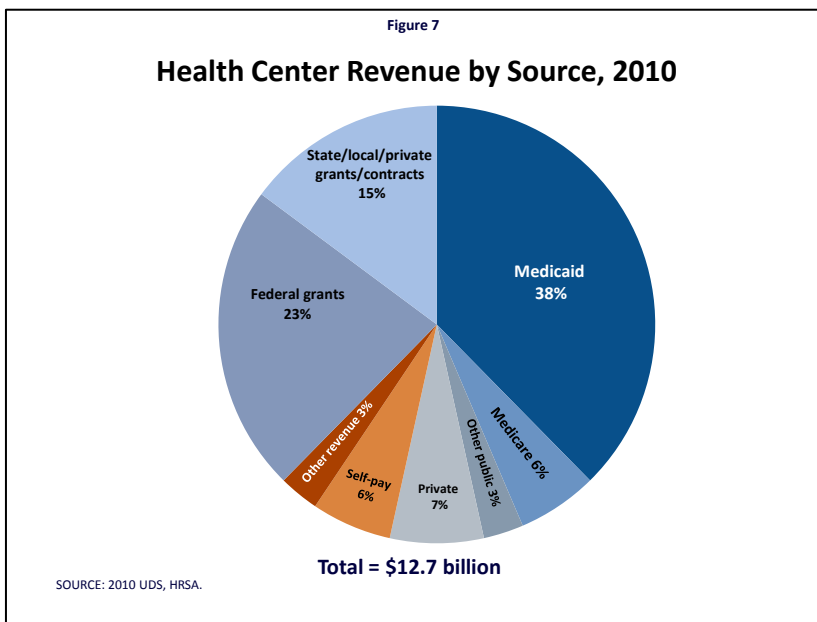
Patients report high levels of satisfaction with health center services.²⁴ Evidence from a recent study of patients’ care-seeking practices following implementation of Massachusetts’ health reform law suggests that many previously uninsured patients receiving care at health centers and other safety net providers stayed with these providers after acquiring health insurance, citing their convenience, their affordability, and the comprehensiveness of their care; only one in four patients in this study gave as a reason for remaining with their current provider that they could not secure an appointment elsewhere.²⁵ These findings are consistent with patient satisfaction data collected in health center settings. Evidence showing the sizable share of health center patients (16 percent) who have private insurance also suggests high patient satisfaction.

Health centers as an economic engine. Economic analyses indicate that, in terms of the employment and the economic activity they generate, health centers produce an 8:1 return on investment.²⁶ Between 2000 and 2010, as the health center program expanded, the number of medical staff working in health centers more than doubled, from slightly more than 21,000 health professionals to more than 46,000. Dental staff grew from 3,000 professionals to more than 9,400, and the number of mental health professionals working in health centers more than tripled, from 1,450 to 5,000.

Funding for health centers

Health centers are established with funding from multiple sources – grants from regular federal appropriations, state and local grants, private philanthropy, and private investment, such as community development financing.²⁷ HRSA estimates that up to \$650,000 is needed to establish a new health center site.²⁸ The initial investment needed for a new site to deliver comprehensive primary and preventive care, known as a “new access point” (NAP), varies depending on whether it is a fully staffed satellite health center, a smaller center in an outreach location such as a school; or a mobile clinic serving an isolated population such as farmworkers, residents of public housing, or homeless individuals. In 2010, each federal health center grantee operated an average of seven access points, although the actual number per grantee ranged from one to dozens.²⁹ About one-quarter of all health center access points are designed to reach highly mobile or hard-to-serve populations.

Once operational, health centers are expected to become financially viable. Because health centers typically receive only a modest level of ongoing federal, state, and local support for operations, third-party payments from public and private health insurers are critical to their survival. Annual federal grants to health centers now provide about 23 percent of their total operating revenues. Medicaid constitutes the single largest source of financing, accounting for nearly 38 percent of a typical center’s operating revenues, while private third-party payments make up 7 percent (Figure 7). Other sources of operating revenues include: state, local, and private grants and contracts (15 percent); Medicare (6 percent); and other public coverage (3 percent). Fees collected from uninsured patients represent only 6 percent of health center operating revenues, reflecting the low income of these patients.



Medicaid as dominant source of financing. Over the past 25 years, a major shift in the main source of financial support for health center operations has taken place. In 1985, federal grants accounted for health centers’ total operating revenues and Medicaid provided just 15 percent. However, by 2010, the share of revenues from federal grants had dropped to 23 percent and the share from Medicaid had increased to 38 percent (Figure 8). Medicaid’s emergence as the principal source of health centers’ revenues can be traced to three important developments. First, significant expansions of Medicaid eligibility for pregnant women, children, and (in some states) parents during the 1980s and 1990s provided new third-party payments to health centers on behalf of many previously uninsured patients. Second, federal legislation enacted in 1989 made FQHC services a mandatory Medicaid benefit. And third, that same legislation also required state Medicaid programs to pay health centers for FQHC services and other Medicaid-covered ambulatory services in accordance with a prospectively established rate that reflects the reasonable cost of care.³⁰ Together, these reforms in Medicaid eligibility, benefits,

and payment substantially increased both the share of health center patients with Medicaid coverage – from 28 percent in 1985 to 39 percent in 2010 – and Medicaid revenues per Medicaid patient.

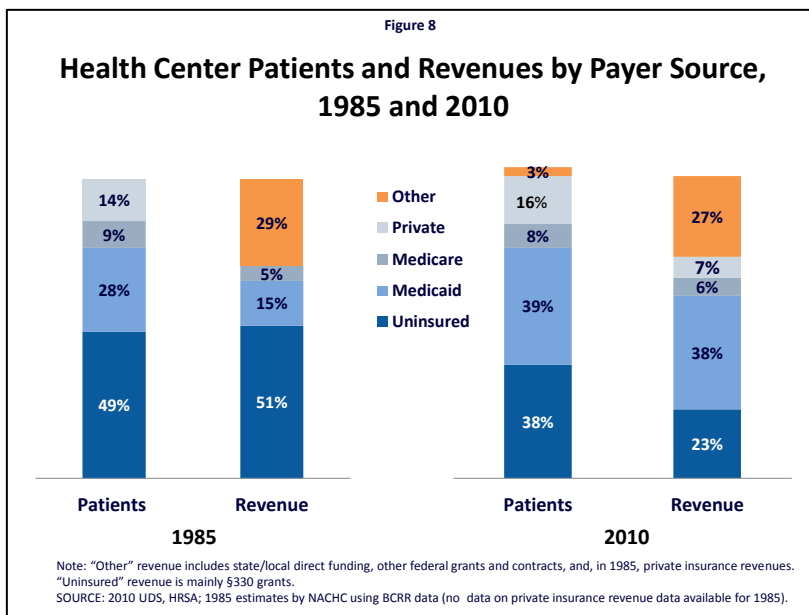
Federal grants freed to fund expanded operations. As revenues from Medicaid have increased, federal grant funding previously used to help defray uncompensated costs associated with caring for Medicaid patients, have become available instead to increase the number of uninsured patients health centers serve. In addition,

the federal government has been able to invest grant dollars in new grantees, NAPs, and expanded services (e.g, addition of oral health, mental health, vision, or on-site pharmacy services, or increased hours of operation). Medicaid financing also has allowed many states to reserve their own grant investments in health centers for service to additional populations and services that Medicaid does not cover, as well as for expansion into new communities.

The relative importance of different sources of revenue depends, in part, on health centers' location and attributes of their patients. For example, health centers in states with more limited Medicaid eligibility for adults could be expected to generate fewer resources from Medicaid and rely more heavily on federal (and to a lesser but significant extent, state and local) grant funding.³¹ Health centers serving large farmworker and homeless populations would also be expected to depend more on grants, given lower Medicaid penetration in highly mobile populations. By contrast, health centers in communities with dense concentrations of poor, young families with children are more likely to receive a larger proportion of their operational funding from Medicaid.

Important but deficient revenues from private insurance. Sixteen percent of health center patients have private insurance, yet private third-party payments provide only 7 percent of health center revenues. This discrepancy likely reflects several factors: relatively high patient deductibles and copays under private insurance; more limited benefits compared to Medicaid; lack of coverage and payment for care furnished by nurse practitioners, physician assistants, psychologists, and social workers (care furnished by these practitioners is expressly included in Medicaid's definition of FQHC services); and payment rates that may not cover actual costs, as payment under Medicaid is calculated to do. Finally, even if health centers are the sole or main providers in their areas, they may lack the clout of office-based physician practices to negotiate higher rates.³² Health center losses associated with privately insured patients have been estimated at more than \$5 billion over the period 1996-2007.³³

Impact of ACA coverage expansion on revenue base. The significant expansion of Medicaid eligibility under the ACA, along with subsidies for private coverage offered through the new insurance exchanges, can be expected to alter the revenue base for health center operations. By 2019, a projected 44 percent of all health center patients will be covered by Medicaid, and the share with private insurance, including



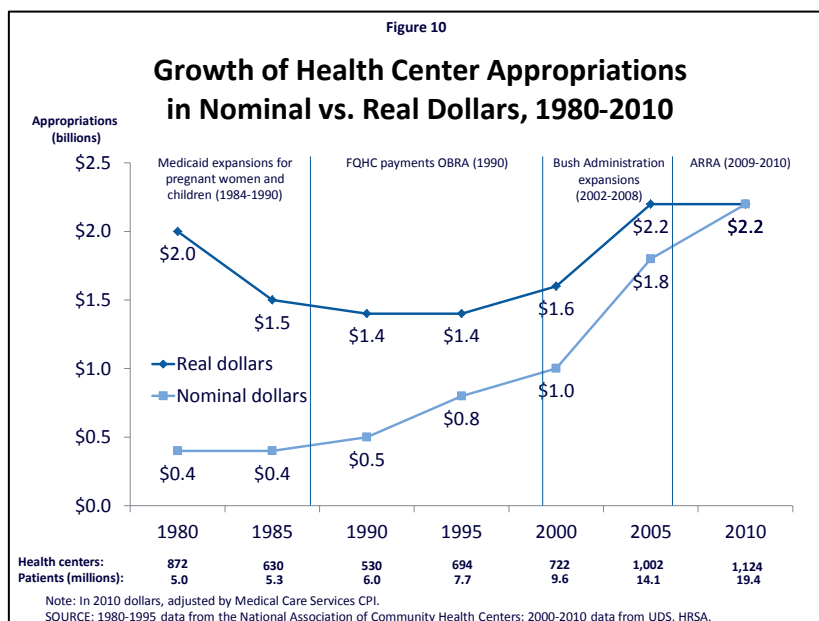
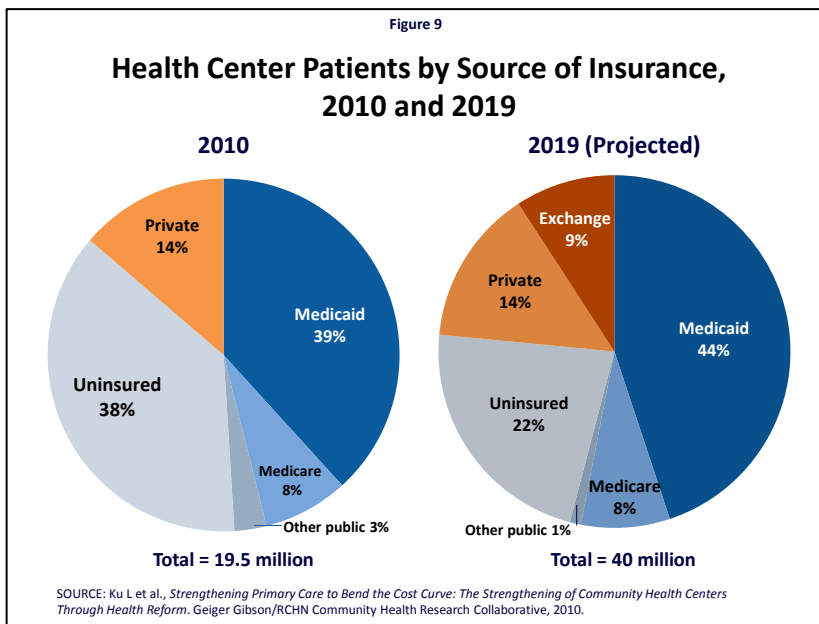
those covered by exchange plans, is projected to reach 23 percent (Figure 9). These higher rates of coverage will increase the flow of third-party payments into health centers; in addition, the ACA requirement that exchange plans pay health centers cost-related rates will enhance the revenues they receive on behalf of privately insured patients.

While health center revenues from third-party payers can be expected to improve as a result of expanded insurance coverage, continued federal grant support is crucial for the purpose of expanding health center capacity to meet the growing demand that wider coverage will stimulate. Data from the UDS indicate that, compared with uninsured health center patients, insured patients use health center services more. Thus, when uninsured health center patients gain coverage that lowers their financial barriers to care, increased utilization by these patients, as well as new utilization

by other newly insured patients who seek out health centers as their source of care, are likely. In addition, millions of people who will remain uninsured, or uninsured for needed care, even when the ACA is fully implemented, will continue to seek care at health centers. The Congressional Budget Office projects the non-elderly uninsured rate in 2019 to be 8 percent, but uninsured patients are expected to constitute 22 percent of health center patients that year, an indication of the critical safety-net role that health centers will continue to play in providing access to care for this population.³⁴ In Massachusetts, following the state's broad expansion of coverage, the demand for care at health centers continued to rise and the uninsured rate among health center patients remained more than nine times the statewide uninsured rate among nonelderly persons – about 19 percent versus 2 percent.³⁵

2000-2010: Three waves of health center growth

Following sharp cuts in 1981 that led to both a reduction in funding and a decline in the number of health centers, the last three decades have witnessed major growth in the number of health centers and health center patients (Figure 10). Over this period, federal funding for the health centers program rose steadily in



nominal dollars, from \$360 million in 1980 to nearly \$2.2 billion in 2010, but, in real dollars, federal appropriations fell steadily from 1980 to 1990, then began to rise in the early- 1990s, and plateaued around 2005 at about the 1980 level. The fact that the health center program expanded significantly over this period even though real appropriations barely increased, points to the vital contribution of Medicaid reimbursement to health centers' operational support, as discussed earlier. In short, while federal appropriations have been sufficient to sustain health center operations for uninsured patients and services, the infusion of Medicaid revenues from expansions of Medicaid eligibility, the inclusion of FQHC services as mandatory Medicaid benefits, and cost-related payment for health center services, has propelled a significant expansion of health centers. The combination of federal appropriations and Medicaid revenues has had a multiplier effect, permitting the health center program to add new grantees, access points, and services. In 1980, 872 health centers served a total of 5 million patients. By 2010, over 1,100 health centers were serving nearly 20 million patients.

In the most recent ten-year period, three notable waves of health center expansion have taken place, all of them characterized by the bipartisan nature of support for the program.

I. The Bush Administration initiative (2000-2008)

During the 2000 Presidential campaign, George W. Bush pledged to double the reach of the nation's health centers, and beginning with the FY 2002 budget, the Bush Administration oversaw a major expansion of health centers, nearly reaching the President's original aims. In FY2000, the first year of the Bush Presidency, the health center appropriation stood at slightly under \$1.02 billion, and 9.6 million patients were served at 3,800 sites connected with roughly 720 health centers. By the President's final year in office, the appropriation had risen to nearly \$2.1 billion and more than 17 million patients were served through more than 7,000 health center sites connected with 1,131 health centers.³⁶

II. The American Recovery and Reinvestment Act (ARRA)

The American Reinvestment and Recovery Act of 2009 (Pub. L. 111-5) provided an additional \$2 billion infusion into the health centers program over two years (FY 2009 and FY 2010). Of this amount, \$1.5 billion was earmarked for capital expenditures, including the purchase of additional equipment, renovation and repair of existing centers, and major construction of new facilities by existing grantees; more than 2,600 capital improvement projects were funded from these dollars. The remaining \$500 million was designated to fund expanded operations in existing health centers to meet increased demands for care, due largely to the recession and losses of insurance coverage; this funding supported awards to 1,100 existing health center sites to expand their operations, as well as grants to 127 new health center access points around the country. All told, the ARRA investment financed a surge in health center capacity, increasing the number of patients that health centers served by 4.4 million, and adding 18,600 new full-time positions to staff health centers in underserved communities nationwide.^{37, 38} The measurable impact of the ARRA investment demonstrated to policymakers that the health center program could deploy funding quickly and effectively, and that additional primary care capacity was needed in underserved communities.³⁹

III. The Patient Protection and Affordable Care Act

The ACA provided substantial new support for expansion of the health center program, establishing an \$11 billion mandatory Health Center Trust Fund to be spent over the FY 2011-2015 time period. The law also created a \$1.5 billion fund to expand the National Health Service Corps. Under the ACA, \$1.5 billion

of the Health Center Trust Fund is allocated for capital expenditures, including improvements at existing health centers as well as new construction, while \$9.5 billion is allocated to support expanded operations as health centers grow over the five-year period. Between the Trust Fund investment and the expansion of Medicaid and private coverage under the ACA, the number of health center patients is expected to double over the 2010-2019 time period, reaching 40 million.⁴⁰

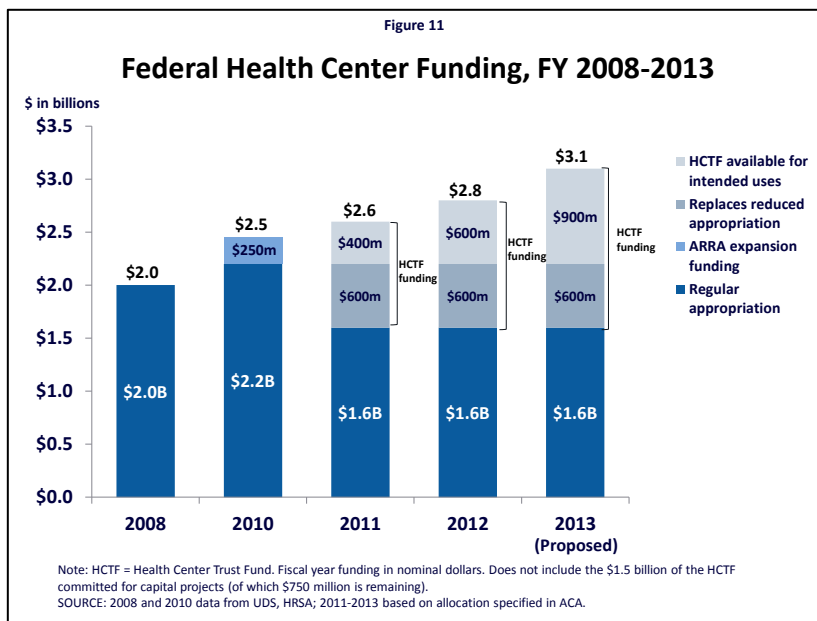
The thrust of the Health Center Trust Fund is to expand health centers' capacity to serve medically underserved populations, but even more, to invest in health centers as a strategy for building health care capacity in the U.S. as 32 million uninsured Americans – many of whom will be low-income and reside in underserved communities – gain coverage.⁴¹ Put another way, the fundamental aim of the Trust Fund is to help realize the ACA's promise of improved access to care, as well as coverage.

The 2011 Funding Retrenchment

The ACA allocated \$1 billion of the Health Center Trust Fund for FY 2011. Most of this funding, \$700 million, was intended to support new expansion of health center capacity, but \$250 million was targeted to sustain the expanded operational capacity financed in FY 2009 and FY 2010 with the ARRA funds. An additional \$50 million was set aside to supplement the Federal Tort Claims Act Judgment Fund.⁴² Together, \$2.2 billion in regular federal appropriations for health centers, combined with the additional funding made available through the Trust Fund, brought the total available to support health center growth and resulting larger operations to \$3.2 billion in FY 2011.

With this higher funding level, the Health Services and Resources Administration (HRSA), the federal agency that oversees the health center program, planned to significantly increase awards to establish NAPs, and to support expanded services (ES) at existing health centers. By the winter of 2011, HRSA had received more than 800 NAP applications and anticipated funding 350 awards. HRSA had also received ES applications from 1,100 health centers for purposes such as expanding hours of operation and increasing medical, oral and behavioral health, vision, and pharmacy services, and the agency planned to make ES awards of varying sizes to virtually all applicants.⁴³

In an unanticipated development, the budget agreement reached by Congress and the Obama Administration in April 2011 reduced the FY 2011 appropriation for health centers by \$600 million – or 27 percent – from \$2.2 billion to \$1.6 billion.⁴⁴ When Health Center Trust Fund dollars are included, the cut in appropriations represents a 19 percent reduction in federal funding available to support health centers in FY 2011, from \$3.2 billion to \$2.6 billion (Figure 11). This cut was the first actual retrenchment in federal health center funding since 1982.



To avert the sharp loss of service capacity that the \$600 million cut in regular health center appropriations would have caused, the Obama Administration diverted \$600 million of FY 2011 Trust Fund dollars to offset it. Thus, of the \$700 million initially available from the Trust Fund for new expansion in FY 2011, the lion's share was re-purposed to support ongoing operations, leaving only \$100 million for the ACA's intended investments in new health center capacity. With this amount, HRSA was able to fund only 67 NAP awards, about one-fifth of the 350 originally planned, and none of the ES applications could be funded.

The FY 2012 federal appropriation for health centers is \$1.6 billion – again, \$600 billion short of the \$2.2 billion level associated with sustaining pre-ARRA operational capacity. The ACA Trust Fund provides for \$1.2 billion in FY 2012, but as in FY 2011, \$600 million will have to be diverted to offset the reduced FY 2012 appropriation level, just to sustain pre-ARRA capacity, and \$250 million will again be used to sustain the ARRA-added capacity. Some of the \$350 million remaining will be required to support last year's NAPs and the rest is slated to fund approximately 220 NAPs.

President Obama's proposed budget for FY 2013 once again calls for \$1.6 billion in appropriations for the health center program, effectively reinforcing the reduced level of grant support. At this funding level, continued reliance on the Trust Fund to backfill the reduction will be necessary to sustain current health center operational capacity. For FY 2011 and FY 2012 alone, \$1.2 billion of the \$11 billion Trust Fund intended for investment in health center expansion will instead have been directed to support existing health center operations; if the reduced base of federal appropriations for the health center program persists over the entire 2011-2015 time period, the cumulative amount of Trust Fund dollars diverted will be \$3 billion – nearly a third of the \$9.5 billion committed for expanded operations.

Additional reductions in state funding and Medicaid

The 2011 reduction in federal appropriations for health centers cannot be viewed in isolation because other losses of financing for health centers have compounded its effects. As of November 2011, 35 states provided supplemental grants to health centers to support their operations, but according to an analysis by the National Association of Community Health Centers (NACHC), health center funding in these states declined for the fourth straight year, hitting a seven-year low. From its high point of \$626 million in FY 2008, state grant funding dropped more than 40 percent to an estimated \$335 million for FY 2012, and in six of the 35 states, health centers faced a one-year decline in state funding of 30 percent or more for FY 2012.⁴⁵

State cuts in Medicaid benefits have also had an adverse impact on health center financing. Strained by ongoing effects of the recession and faced with the expiration of ARRA's temporarily enhanced federal Medicaid matching rate,⁴⁶ some states responded by reducing optional benefits in Medicaid, particularly for adults. These state cuts have translated into lost health center capacity, particularly with respect to certain primary health care services. For example, California's decision in 2009 to eliminate dental benefits for adult Medicaid beneficiaries forced a number of health centers to close sites or scale back services and staff.⁴⁷ In a 2010 survey of 118 health centers by the California Primary Care Association, 92 respondents reported an aggregate loss of \$26 million from the state's dental benefit cuts in 2010 and the forced closure of 12 sites offering comprehensive primary health care.

Northeastern Rural Health Clinics, a health center located in Susanville, CA, offers an example (see Appendix). The clinic serves nearly 14,000 patients, of whom 30 percent are Medicaid beneficiaries. The center was forced to close two sites due largely to the elimination of adult dental benefits in Medicaid,

along with reductions in state grant funding. Then, as service capacity began to fall, the health center also reported a loss of 27 percent in patient visits. This case crystallizes the downward spiral that can begin when cutbacks in grant funds and Medicaid benefits lead to reduced clinic capacity, leading, in turn, to reduced patient revenues and reduced access to comprehensive primary health care that can maintain and improve health and potentially yield savings to the health care system as a whole.

Issues, challenges, and opportunities ahead

Strong primary health care capacity and access are the bedrock of a reformed health care system that is characterized by high performance and that offers the potential to reduce overall health care costs. Where medically underserved communities are concerned, the health center program represents the core of the nation's investment in primary health care. The foundation of this investment is federal grant financing; while public and private third-party revenues also represent key sources of operational support, it is the basic federal grant that anchors the program in thousands of urban and rural communities that otherwise lack access to comprehensive primary health care, and that supports such care for the uninsured and under-insured.

The 2011 reduction in health center appropriations was the first-ever cut in the federal government's direct investment in primary health care capacity since 1982. It remains to be seen whether this funding will ultimately be restored, or whether the health center program will face downsizing rather than expansion in the long term, if Health Center Trust Fund dollars intended for growth to reach new populations and communities, especially as coverage expands, continue to be used instead to replace reduced appropriations. For the health center program to meet current needs and expected demands for care in the years ahead, and for health centers to participate fully in the innovative care delivery and payment systems that are now emerging, a number of conditions are key:

- First, restoration of the cuts in federal appropriations going forward would help to ensure that Health Center Trust Fund dollars are not used further to replace basic appropriations funding for existing operations, and remain available for expanded capacity as planned. The President's proposed budget for FY 2013 calls, again, for the sharply lower level of regular appropriations level enacted in 2011, raising the specter that the Trust Fund will again be tapped to fill the funding gap for ongoing operations.
- Second, if appropriations funding could be restored, then scheduled expenditures of the Health Center Trust Fund could proceed, with commitments to both new health center grants in communities that currently lack sites and expanded capacity at existing health centers. Trust Fund dollars would provide support for much-needed additional dental and mental health care capacity, as well as increased general capacity. Developing health center capacity to provide primary care to a growing number of Medicare beneficiaries, as well as to serve as health homes for children and adults with serious and chronic physical, mental, and developmental health conditions, is also a priority. Health centers have already demonstrated their ability to deliver high-quality primary and preventive care; their involvement in medical home demonstrations and rapid adoption of HIT suggest their potential to further improve the care they deliver to meet these added challenges.
- Third, coordination of the National Health Service Corps investment with health center resources can help optimize efforts to ramp up health centers' clinical care capacity. Expansion of current health center strategies that involve partnering with training and residency to recruit and retain physicians and other health care professionals and build health care teams, and reform of state

licensure laws to permit health professionals to practice “at the top of their license,” are key to ensuring an adequate health care workforce, particularly in medically underserved communities.⁴⁸

- Fourth, as millions of people served by health centers gain private insurance through Qualified Health Plans (QHPs) in the new exchanges, shortcomings of private insurance that currently depress payments to health centers relative to the costs of care provided to privately insured patients, warrant attention. Compared with Medicaid, private insurance covers a far smaller proportion of the cost of primary care, due to the impact of deductibles and out-of-pocket charges, coverage exclusions and limitations, non-coverage of primary care services furnished by providers other than physicians, and payment rates that fall below the cost of care. The ACA requirement that QHPs pay health centers their Medicaid rates for the covered services they furnish may mitigate current shortfalls somewhat, if implemented as intended.⁴⁹ However, continued and adequate grant funding will remain important, not only to subsidize care for uninsured patients, but also to help health centers cover the revenue gaps that can be expected to accompany high-deductible health plans that lack first-dollar coverage except for specified preventive services, such as mammograms and hypertension screening.
- Fifth, fostering health center efforts to partner with specialized providers and institutions can help to ensure that their patients have access to a full range of necessary primary and specialty health care. These partnerships, which are evolving in many communities, strengthen health centers’ capacity to care for complex patients with chronic conditions and have the potential to reduce avoidable and costly hospital inpatient and emergency department care for ambulatory care-sensitive conditions by improving access to comprehensive primary care.⁵⁰
- Finally, although prospective, cost-based payment has ensured that health centers can recapture the cost of the services they provide, new payment models may be needed, consistent with growing interest in payment approaches that strengthen incentives for efficiency (e.g., payment for episodes of care over time rather for individual encounters), and that reward high quality while also providing adequate support for efficient operations so that resources to support uncompensated care are not diverted to cover shortfalls.

Health centers’ high performance, their rapid and effective assimilation of technological and delivery system innovations to improve care delivery, and their ability to expand quickly to meet growing demands, provide strong support for the ACA vision of the health center program as a vital part of the effort to advance the nation’s broadest health care goals – to promote better care, reduce health care costs, and improve the overall health of Americans. Moving forward, full funding of the program consistent with its expected larger role in the coming years would help to ensure that health centers continue to bring essential primary care services to millions of medically underserved people, regardless of their insurance coverage or ability to pay, and, as intended, expand their reach to provide access and care to millions more.

This issue paper was prepared by Peter Shin and Sara Rosenbaum of George Washington University, and Julia Paradise of the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured. Additional support for this issue paper was provided by the RCHN Community Health Foundation.

Appendix

Northeastern Rural Health Clinics

Northeastern Rural Health Clinics (NRHC) has been serving patients in rural northern California since 1977. One of the only primary care settings in the area, NRHC has provided a wide spectrum of care, including primary medical, dental, behavioral health, home health care services, and hospice services. The main site is located in Susanville; two satellite sites are located within 40 miles. The main site is next door to a critical access hospital and operates an urgent care clinic for emergent cases. The largely low-income local population had an unemployment rate of nearly 13 percent in 2011, compared to 10.9 percent statewide.⁵¹ Despite low income and high unemployment, NRHC patients are largely privately insured and the share of Medicaid and uninsured patients is relatively small.

Reduced access to primary care results from state cuts

In 2009, California made several drastic cuts to its state budget that directly affected health centers. The budget eliminated several optional Medicaid benefits, including adult dental services. It also cut the direct state grants that health centers count on by \$70 million in the 2009-2010 fiscal year.⁵² For NRHC, these cuts represented nearly a \$400,000 loss, resulting in layoffs of 20 percent of the staff and, ultimately, the closure of two satellite clinics – Westwood Family Practice, 21 miles west of Susanville, and Doyle Family Practice, 42 miles to the southeast.

The loss of these two satellites – each, the sole source of primary care in its community – has substantially set back access to essential primary care in rural northeastern California. NRHC lost five physicians and other health professionals and provided an average of 10,000 fewer patient visits annually. Many patients experienced a complete loss of access. While a small percentage of affected patients sought care at the main Susanville site, a large share simply stopped coming in for care. In addition, after adult dental benefits in Medicaid were eliminated, a dramatic reduction in pediatric dental visits by families whose parents lost this coverage was observed.

California's state budget cuts have had lasting effects on both NRHC operations and the delivery of care for underserved patients. In the years since the cuts, the health center has reopened one of its satellite clinics to serve patients three days a week, rotating providers from its main site. Through grant assistance from a private foundation and redirected NRHC funds, the satellite clinic has been able to serve 20-25 patients per day on the days it is open. Despite this recovery, however, additional infrastructure, staffing, and operational support are needed to build back capacity to meet the pent-up demand for services since the clinic's closure. In the last fiscal year, NRHC operated at a loss of \$1.5 million on its \$8.7 million annual operating budget and provided about 49,000 visits, down from an average 62,000 visits annually prior to the budget cuts.

While NRHC, like many health centers around the country, received additional federal funding for capital investment through the American Recovery and Reinvestment Act (ARRA), it has faced difficulty sustaining these investments. ARRA funds helped NRHC acquire and implement an Electronic Health Record (EHR) system in 2010, but did not cover the full implementation costs or the ongoing costs to maintain it. Nor was there additional operations support to mitigate reduced productivity stemming from EHR implementation. Reduced reimbursement rates and local budget cuts have posed further financial challenges.

Looking ahead: emerging challenges and the role of state and federal support

As NRHC continues to navigate the economic straits in California, several considerable challenges still lie ahead. As the state moves more Medicaid beneficiaries into managed care, rural patients may be more limited in where they can obtain care, depending on plans' provider networks.⁵³ Also, under the Governor's current budget proposal, health center executives expect managed care plans to reduce the prospective payment rate by an additional 10 percent or more, straining NRHC's ability to sustain the current scope of services it offers. Although there is a perception that health centers can bear state and local funding cuts because they receive substantial federal funding, federal dollars tend to support capital expansion rather than provide the operational support needed to sustain infrastructure and increase capacity. And federal funding is often fixed; it does not increase to fill gaps left by state and local reductions. Health centers – and their patients – will continue to depend on both federal and state support to maintain the health center program's mission of providing high quality health care to vulnerable populations.

Endnotes

- ¹ Rosenbaum S et al., *National Health Reform: How Will Medically Underserved Communities Fare?* Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 10 (George Washington University, 2009). http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_5046C2DE-5056-9D20-3D2A570F2CF3F8B0.pdf
- ² Adashi E et al., "Health Care Reform and Primary Care – The Growing Importance of the Community Health Center," *New England Journal of Medicine*, 362:2047-2050 (June 3, 2010).
- ³ Patient Protection and Affordable Care Act §5601.
- ⁴ Health Resources and Services Administration, Medically Underserved Areas and Populations. <http://bhpr.hrsa.gov/shortage/muaps/> (Accessed online, February 7, 2012)
- ⁵ U.S. Department of Health and Human Services, Health Resources and Services Administration, Fiscal Year 2013 Justification of Estimates for Appropriations Committees, page 44.
- ⁶ Ibid.
- ⁷ Based on U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009 through 2011.
- ⁸ Sommers A and J Paradise, "Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians," *Medicare and Medicaid Research Review* 1:2 (2011) pp. E1-E17.
- ⁹ 2010 UDS.
- ¹⁰ SSA §1861(aa)(3)(A) and § 1861 (aa)(1)(A)-(B).
- ¹¹ HRSA datawarehouse (data as of 3/6/12).
- ¹² *Affordable Care Act bolsters the primary care workforce in medically underserved communities*, News Release, U.S. Department of Health and Human Services, November 22, 2010. <http://www.hhs.gov/news/press/2010pres/11/20101122b.html>.
- ¹³ Rothkopf J et al., "Medicaid Patient Seen at Federally Qualified Health Centers Use Hospital Services Less Than Those Seen by Private Physicians," *Health Affairs*, 2011; 30(7):1335-1342; Shi L et al., "Racial/Ethnic and Socioeconomic Disparities in Access to Care and Quality of Care for US Health Center Patients Compared with Non-Health Center Patients," *Journal of Ambulatory Care Management*, 2009 Oct-Dec; 32(4): 342-50; Dor A et al., *Uninsured and Medicaid Patients' Access to Preventive Care: Comparison of Health Centers and Other Primary Care Providers*. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 4 (George Washington University, 2008). http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/RCHN_brief4_8-13-2008.pdf; Falik M et al., "Comparative Effectiveness of Health Centers as Regular Source of Care," *Journal of Ambulatory Care Management* January 2006; 29(1):24-35.
- ¹⁴ U.S. Department of Health and Human Services, Health Resources and Services Administration, Fiscal Year 2013 Justification of Estimates for Appropriations Committees.
- ¹⁵ Shi L and G Stevens, "The Role of Community Health Centers in Delivering Primary Care to the Underserved: Experiences of the Uninsured and Medicaid Insured," *Journal of Ambulatory Care Management* 2007; 30(2): 159-170.
- ¹⁶ George R et al., "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties," *Journal of Rural Health*, Winter 2009 25(1):8-16.
- ¹⁷ Hing E et al., "Primary Health Care in Community Health Centers and Comparison with Office-based Practice," *Journal of Community Health*, 2011; 36:406-413.
- ¹⁸ Cook N et al., "Access to Specialty Care and Medical Services in Community Health Centers," *Health Affairs*, 2007; 27(5): 1459-1468.
- ¹⁹ Takach M, *Community Health Centers and State Health Policy: A Primer for Policymakers* (NASHP, 2012). http://nashp.org/sites/default/files/CHC_7-24-08.pdf.
- ²⁰ Ku L et al., *Transforming Community Health Centers into Patient Centered Medical Homes: the Role of Payment Reform*, Commonwealth Fund, 2011. <http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Sep/Transforming-Community-Health-Centers.aspx>.
- ²¹ Cunningham M et al., *Results of the 2010-2011 Readiness for Meaningful Use of HIT and Patient Centered Medical Home Recognition Survey*, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No.27 (George Washington University, 2011). http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_6461F0DD-5056-9D20-3D7593CB6AE409B5.pdf.
- ²² Richard P et al., "Cost Savings Associated with the Use of Community Health Centers," *Journal of Ambulatory Care Management* 2012; 35(1): 50-59.
- ²³ Ku L et al., *Promoting the Integration and Coordination of Safety Net Health Care Providers Under Health Reform: Key Issues*, Commonwealth Fund, 2011. http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Oct/1552_Ku_promoting_integration_safetynet_providers_under_reform_ib.pdf.
- ²⁴ Shi L et al., "Primary Care Quality: Community Health Center and Health Maintenance Organization," *Southern Medical Journal* 2003; 96(8):787-795.
- ²⁵ Ku L et al., "Safety-Net Providers After Health Care Reform: Lessons From Massachusetts," *Archives of Internal Medicine* 2011;171(15):1379-1384.
- ²⁶ Rosenbaum S and P Shin, *Community Health Centers and the Economy: Assessing Centers' Role in Job Creation Efforts*. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 25 (George Washington University, 2011). http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_A5C8D794-5056-9D20-3DD5D5A9CD2DAFD1.pdf.
- ²⁷ Shin P et al., *Financing Community Health Centers as Patient- and Community-centered Medical Homes: A Primer*. Commonwealth Fund, 2009. http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_A186E838-5056-9D20-3D9EA92EB75DAC24.pdf.
- ²⁸ Based on the annual New Access Point Applications. <http://www.hrsa.gov/grants/apply/assistance/nap/>

-
- ²⁹ Estimates from communications among George Washington University researchers, staff of the National Association of Community Health Centers, and staff of the Bureau of Primary Health Care.
- ³⁰ Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act as contained in the Consolidated Appropriations Act (P.L. 106-554).
- ³¹ Shin P et al., *Medicaid and Community Health Centers: the Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities*, Kaiser Commission on Medicaid and the Uninsured, March 2012. <http://www.kff.org/medicaid/8293.cfm>.
- ³² *Improving Commercial Reimbursement for Community Health Clinics: Case Studies and Recommendations for New York*, Manatt Health Solutions, RCHN Community Health Foundation and Manatt Phelps and Phillips, LLP, New York, New York, 2007.
- ³³ *Health Centers: An Overview and Analysis of their Experiences with Private Health Insurance*, Kaiser Commission on Medicaid and the Uninsured, 2008. <http://www.kff.org/uninsured/upload/7738.pdf>.
- ³⁴ Elmendorf D, Congressional Budget Office analysis of the Major Health Care Legislation enacted in March 2010 before the Subcommittee on Health Committee on Energy and Commerce, U.S. House of Representatives, March 20, 2011.
- ³⁵ Ku L et al., "Safety-Net Providers After Health Care Reform: Lessons From Massachusetts," *Archives of Internal Medicine*. 2011; 171 (15):1379-1384.
- ³⁶ Appropriations data provided by the National Association of Community Health Centers. Data on number of centers and sites from UDS, 2000 and 2009.
- ³⁷ HRSA, Health Center Quarterly Report Data (for the report period ending September 30, 2011). <http://bphc.hrsa.gov/recovery/increasepatients.html>.
- ³⁸ *Fiscal Year 2011 Summary of Performance and Financial Information*, page 6, U.S. Department of Health and Human Services. <http://www.hhs.gov/budget/hhs-performance-report-fy2013.pdf>.
- ³⁹ Shin P et al., *The Economic Stimulus: Gauging the Early Effects of ARRA Funding on Health Centers and Medically Underserved Populations and Communities*, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 17 (George Washington University, 2010). http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_C41AE130-5056-9D20-3D65728F2361CFAF.pdf.
- ⁴⁰ Ku L et al., *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers through Health Reform*, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 19 (George Washington University, 2010). http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_895A7FC0-5056-9D20-3DDB8A6567031078.pdf.
- ⁴¹ Shin P and S Rosenbaum, *The Role of Community Health Centers in Addressing the Needs of Uninsured Low Income Workers: Implications of Proposed Federal Funding Reductions*. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 22 (George Washington University, 2011). http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_B5E2CD0C-5056-9D20-3DC9B0C6B7EA7DE3.pdf; Rosenbaum S et al., *Who Are the Health Center Patients Who Risk Losing Care Under the House of Representatives Proposed FY 2011 Spending Reductions?* Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 20 (George Washington University, 2011). http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_B4FD331D-5056-9D20-3DEFF1D54B246805.pdf.
- ⁴² Federally funded community health centers receive medical and other liability coverage through the Federal Tort Claims Act rather than through private malpractice insurance coverage.
- ⁴³ New access point grants were available prior to ARRA and ACA. See *Health Centers: Competition for Grants and Efforts to Measure Performance Have Increased (GAO-05-645)*, Government Accountability Office, July 2005. <http://www.gao.gov/new.items/d05645.pdf>.
- ⁴⁴ Galewitz P, "Community Health Centers Hit Hard by Washington Deficit Cuts," *Washington Post/Kaiser Health News*, 6 October 2011.
- ⁴⁵ *Community Health Centers Face Growing Demand from Newly Uninsured Patients*, State Policy Report #39, National Association of Community Health Centers, November 2011. <http://www.nachc.org/client/2011%20State%20Funding%20Report%20SPR394.pdf>.
- ⁴⁶ *An Overview of Changes in the Federal Medical Assistance Percentages (FMAPs) for Medicaid*. <http://www.kff.org/medicaid/upload/8210.pdf>; *Enhanced Medicaid Match Rates Expire in June 2011*. <http://www.kff.org/medicaid/upload/8205.pdf>, Kaiser Family Foundation, 2011.
- ⁴⁷ Internal communication with the California Primary Care Association, February 3, 2012.
- ⁴⁸ *Future of Nursing: Leading Change, Advancing Health*, National Academies Press, Institute Of Medicine, 2010.
- ⁴⁹ PPACA §1302(g); 42 C.F.R. § 156.235(e).
- ⁵⁰ Rosenbaum S et al., *Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Providers*, Commonwealth Fund, 2011. http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Jul/1525_Rosenbaum_assessing_barriers_clinical_integration_CHCs.pdf; Takach M and J Buxbaum, *Developing Federally Qualified Health Centers into Community Networks to Improve State Primary Care Delivery Systems*, Commonwealth Fund, 2011; Ku L et al., *Transforming Community Health Centers into patient-Centered Medical Homes: The Role of Payment Reform*, Commonwealth Fund, 2011. http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Sep/1548_Ku_transforming_community_hlt_ctr_PCM_Hs_final.pdf.
- ⁵¹ U.S. Bureau of Labor Statistics (2012), Lassen County, CA Unemployment rate – not seasonally adjusted.
- ⁵² California Primary Care Association (2010), *California 2009-10 Budget Impacts on Community Clinics and Health Centers*. http://cpcac.org/cpac/assets/File/Policy-and-Advocacy/State-Budget/State-Budget/CPCA_2009_Budget_Impact_on_CCHCs-Final-1-27-10.pdf.
- ⁵³ California Department of Mental Health (2011), *Medi-Cal Mental Health Policy Consolidation and Managed Care*. http://www.dmh.ca.gov/services_and_programs/medi_cal/Consolidation.asp.

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

This publication (#8098-02) is available on the Kaiser Family Foundation's website at www.kff.org.



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.