
NATIONAL ACADEMY
for STATE HEALTH POLICY

FEDERAL COMMUNITY HEALTH CENTERS
AND STATE HEALTH POLICY:
A Primer for Policy Makers

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FEDERAL COMMUNITY HEALTH CENTERS AND STATE HEALTH POLICY: A PRIMER FOR POLICY MAKERS

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EXECUTIVE SUMMARY

Federally funded community health centers connect 16 million people throughout the U.S. and its territories with primary health care services and form much of the fabric of the country's health care safety net. Although the federal community health center program was initiated with very little state input and involvement more than 40 years ago, this relationship is changing. The ties between state governments and health centers have grown over the years as states have worked to increase coverage and access to care, and as the health centers' dependence on state Medicaid payments and grants has increased.

States can influence the viability, quality, and performance of health centers. States can foster collaboration through their primary care offices and primary care associations. States also have many levers, including licensing, purchasing, funding, and regulation, to help integrate health centers into state health care systems and reform plans.

This overview of federally funded community health centers will assist state policy makers in using their state's influence and levers to work with health centers as an important component of their state's health system and reform plans. This primer was developed through a National Cooperative Agreement (NCA) sponsored by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC).

BACKGROUND

In the 1960s, the federal health center program was established to provide primary care to the poor and was viewed as complementary to the newly created Medicaid program, which established federal/state matching payments to pay for the care of the poor.¹ Federal grants supported those health centers that were established in medically underserved areas, and which provided a detailed scope of primary care and supportive services, provided services to all based on ability to pay, and were governed by a majority board of community users of the centers.² Until the 1980s, there was little intersection between the states and the health centers – health center operations were guided and funded largely by the federal government. This would change as Medicaid revenues supplanted federal grants to become the health centers' largest single source of income due to the Omnibus Budget Reconciliation Act (OBRA) of 1989, which established the Federally Qualified Health Center (FQHC) reimbursement designation.³

OBRA was passed because Congress was concerned that, due to inadequate reimbursement rates, health centers were shifting federal grant funds meant to care for the poor and uninsured to cover the costs of caring for Medicaid and Medicare patients. Health centers and other qualified health clinics receiving the FQHC designation (including Look-Alike health centers⁴ that meet criteria around location, services, payment, and governance, and certain tribal health centers), began receiving enhanced Medicaid and Medicare reimbursements for actual costs—including overhead expenses such as mortgage and utilities, regardless if these expenses were covered by other sources. Previously they had received a reimbursement according to a predetermined fee schedule.

FQHCs were also provided access to the National Health Service Corps and J-1 Visa Waiver Program (foreign medical graduates) to address workforce shortages. Also, FQHCs are able to use the 340B Drug Pricing Program to purchase pharmaceuticals at prices lower than the Medicaid rebate price.⁵

Today, more than 16 million people receive care at more than 1,100 federally funded health centers across the nation. Health centers provide comprehensive primary care that results in lower Medicaid costs, and

they deliver regular, coordinated care that helps reduce disparities in access to care related to race, income, and insurance status.⁶

STATE ROLES AND LEVERS IN WORKING WITH HEALTH CENTERS

States have the unique role of licensing health care facilities and health professionals

- : In addition to ensuring that federally qualified health centers meet minimum standards, many states hold health centers to additional requirements such as reporting patient safety data.
- : State regulators can close doors to unqualified health professionals through professional licensure requirements, but they also can open doors to the state to bring new kinds of practitioners to address critical workforce shortages.

States have significant purchasing authority

Medicaid payments, coverage, and eligibility policies have strong influence on the operation of health centers. Other state purchasing tools include:

- : Encouraging or requiring health plan contract language to favor federally qualified health centers (FQHCs).
- : Providing wraparound payments to supplement private insurance.
- : Developing default enrollment policies to assign new Medicaid enrollees to plans that favor health centers to help health centers become more financially stable.
- : Encouraging creation of community health center affiliated health plans.

States can appropriate funds and direct federal grants to health centers to achieve state objectives

- : States will provide nearly \$590 million in FY2008 to support health center capacity, including funding uninsured or indigent care, capital projects, and health information technology.
- : States can provide grants to meet state-specific objectives, such as reducing disparities and addressing workforce issues.
- : States can channel federal block grants to supplement the safety net on a competitive basis in order to achieve state and federal objectives.

States can use FQHCs to reach the uninsured who are eligible for public coverage

States that are seeking to expand coverage to the uninsured may look to health centers to help them enroll eligible populations.

FUTURE CHALLENGES FOR STATES AND FEDERALLY FUNDED HEALTH CENTERS

Health care reform

Health centers can provide a source of primary health care for the newly insured, but they must maintain their role as the safety net for those who are publicly insured, live in underserved rural and urban areas, and those who fall between the cracks and remain uninsured.

Health information technology

Implementing new technology such as electronic health records to enable health information exchange for purposes such as care coordination, quality and patient safety monitoring will be a financial challenge for most health centers.

Health care workforce

A chronic shortage of practitioners at health centers is being exacerbated by the current push to expand new and existing centers, and this situation will continue to be an important challenge for states and health centers. Addressing adequate provider capacity to deliver primary health care to those newly insured under health care reform will add to the strain.

INTRODUCTION

Federally funded community health centers reach some of the nation's most vulnerable. The centers connect 16 million people throughout the U.S. and its territories with primary health care services and form much of the fabric of the country's health care safety net. The Institute of Medicine recognizes federal, state, and locally supported community health centers, along with public hospital systems and local health departments, as "core safety net providers." These providers have two distinguishing characteristics:

1. By legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and
2. A substantial share of their patient mix is uninsured, served by Medicaid, and other vulnerable patients.⁷

Although the federal community health center program was initiated and to a large extent is operated without significant state involvement, state governments' relationship with these safety net providers has grown over the years as states have worked to increase coverage and access to care. As state Medicaid programs have grown, so too has the dependence of health centers on Medicaid's federal-state payments. Medicaid funding accounts for a significant portion of a typical health center's operating revenue (37 percent); direct aid from states accounts for an additional 9 percent.⁸ Thus, states have a considerable hand in financing and sustaining these core safety net providers. States can also affect the viability, quality, and performance of health centers as part of a state's health care system and efforts to reform that system through levers such as licensing and regulation.

This overview of federally funded community health centers⁹ will assist state policy makers in using the influences and levers they have in working with health centers as an important component of their states' health system and reform plans. As state activity in health care reform builds, this is an opportune time to consider how health centers and the safety net fit within a state's health care system and how they can contribute to a reformed system.

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

HEALTH CENTER FUNDAMENTALS

HISTORY

The first health centers took root more than 40 years ago when two Tufts University physicians secured a federal grant to open health centers in two poor communities: the first in urban Boston, Massachusetts and the second in rural Mound Bayou, Mississippi.¹⁰ Federal grants and local community resources and involvement were the seeds of the subsequent growth of health centers and their mission of providing primary health care for the poor. At the time, health centers were viewed as complementary to the newly created Medicaid program, which established federal-state matching payments to pay for the care of the poor.¹¹ While parallel in mission, there was little intersection between state Medicaid and health centers at the time – health center operations were funded primarily by the federal government. This relationship would ultimately change as Medicaid revenues supplanted federal grants to become the health centers’ largest single source of income.¹²

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

In the late 1980s, hard economic times challenged both state governments and health centers. States turned to managed care to help control costs and comply with federal mandates to cover more people. Health centers struggled with financial trouble, closures, and organizational changes due in part to their initial experiences with managed care contracting.¹³ But in 1989, health centers received a shot in the arm with the passage of the Omnibus Budget Reconciliation Act (OBRA), which established the Federally Qualified Health Center (FQHC) reimbursement designation.

At the time, Congress was concerned that health centers were shifting federal grant funds meant to care for the poor and uninsured to cover the costs of caring for Medicaid and Medicare patients because of inadequate reimbursement rates. Not a popular decision with many state Medicaid officials, who questioned the reasoning, cost-based reimbursement was nevertheless established.¹⁴ Health centers and other qualified health clinics (see What Is An FQHC?) that were given the FQHC designation could now receive enhanced Medicaid and Medicare reimbursements for actual costs – including overhead expenses such as mortgage and utilities, regardless if these expenses were covered by other sources. This payment schedule replaced the previously used predetermined fee schedule, and as a result, health center revenues increased sharply.¹⁵

What is an FQHC?

The term “Federally Qualified Health Centers” (FQHC) applies to three types of clinics:

- : Community Health Centers, also known as health centers, are public and private non-profit clinics that meet certain criteria under the Medicare and Medicaid Programs and receive federal grant funds under the Health Center Program, Section 330 of the Public Health Service Act (PHSA).
- : Look-Alike Health Centers are public and private non-profit clinics that meet certain criteria under the Medicare and Medicaid Programs and meet the definition of “health center” under Section 330 of the PHSA, but do not receive federal grant funding.
- : Tribal or Urban Indian Federally Qualified Health Centers are outpatient health programs or facilities operated by tribal or urban Indian organizations.

THE “101” ON SECTION 330 HEALTH CENTERS

In 1996, the Health Centers Consolidation Act combined all health center types – community, migrant, homeless, and public housing health centers – under one umbrella, in section 330 of the Public Health Service Act (PHSA). This law authorized competitive federal grants – which now provide an average 25 percent of their operating revenue – to health centers that meet these statutory requirements:

- : Are located in a medically underserved area (MUA) or serve a medically underserved population (MUP);
- : Provide a detailed scope of primary health care as well as supportive services (education, translation, transportation, etc.) services described in 42 U.S.C. 254 b (b)(1);
- : Provide services to all based on ability to pay; and
- : Are governed by community members composed of a majority (51 percent or more) who represent the population served.¹⁶

Health centers were also given access to a number of other programs to support their mission, including the Health Center Federal Tort Claims Act (FTCA) Program and federally backed loan guarantees for capital improvement projects. The FTCA insures providers so they do not need to purchase private medical malpractice insurance, thus saving health centers an estimated \$1.05 billion on malpractice insurance premiums from 1993 to 2003.¹⁷ Health centers are able to recruit physicians through the National Health

TABLE 1: COMPARISON OF FEDERAL SUPPORT FOR SECTION 330 HEALTH CENTERS AND FQHC LOOK-ALIKE HEALTH CENTERS

	Section 330 Health Centers	FQHC Look-Alikes
Competitive application process	Yes	No
Receive direct funding from Federal government	Yes	No
Located in medically underserved area	Yes	Yes
Provide services based on ability to pay	Yes	Yes
At least 51 percent of governing board members represent active users of the health center	Yes [unless the requirement is waived]	Yes
Provide a detailed scope of primary health care and enabling services	Yes	Yes
Enhanced Medicaid/Medicare reimbursement	Yes	Yes
Access to National Health Services Corp/J-1 Visa Waiver programs	Yes	Yes
FTCA coverage	Yes	No
340B drug pricing program	Yes	Yes
Federal loan guarantee program	Yes	No
Comply with BPHC Uniform Data System (UDS) and Performance Review Protocols	Yes	No

Service Corps and J-1 Visa Waiver Program (for foreign medical graduates). The 340B Drug Pricing Program allows health centers and other federally qualified covered entities to purchase pharmaceuticals at prices lower than the Medicaid rebate price at about a 19 percent cost savings.¹⁸

The more than 100 FQHC Look-Alike Health Centers in the United States also play an important role in providing primary health care to the underserved. Congress authorized the enhanced Medicare and Medicaid payments for Look-Alikes in order to support and expand the safety net. Look-Alikes must meet the same four key statutory requirements under section 330 of the PHSA as stated above. However, they do not receive federal grant funds, usually because of limited available funding. Look-Alikes do have access to a number of other important federal programs, which are summarized in Table 1.

PRESIDENT'S HEALTH CENTERS INITIATIVE

During the 1990s, the number of health centers climbed to 700, with centers located in all 50 states, the District of Columbia, and U.S. territories and commonwealths. By decade's end they were treating 9 million patients annually.¹⁹ In 2002, President Bush launched the President's Health Center Initiative, with the goal of adding or expanding 1,200 health centers and doubling the number of patients served over five years.

According to HRSA, through FY 2006, the Health Center Initiative added more than 500 new access points (new sites or centers); awarded nearly 400 grants to expand the medical capacity of existing service delivery sites; and awarded 350 grants to existing grantee organizations to add or expand oral health, mental health, and substance abuse services.²⁰ According to the White House, the initiative resulted in the opening or expansion of 1,200 health center sites and awarded nearly \$2 billion in federal grants annually.²¹ From 2002-2006, the expansion contributed to:

- : A 60 percent increase in patients treated at all health centers (to an estimated 16.25 million treated in 2006),
- : An 80 percent increase in patients receiving dental services at health centers (to 2.6 million patients treated in 2006), and
- : A 170 percent increase in patients receiving mental health care at all health centers (to 470,000 patients in 2006).²²

The federal government's focus on increasing capacity has been welcomed by many, but some would argue that these efforts have not kept pace with the demand for services caused by rising poverty and uninsurance. For every uninsured, low-income patient that a health center treats, some estimates suggest there are four more who need services.²³ In FY 2004, less than one in ten qualified health center grant applications were approved.²⁴ In addition, while federal funds have strengthened the safety net in many communities, these investments have not been distributed evenly according to need. The application process tends to favor centers with strong, stable infrastructures and with access to grant writing expertise when compared to vulnerable, at-risk communities with fewer resources.²⁵

President Bush's High Poverty County Presidential Initiative, announced in August 2007, may help address some of these concerns. The Administration has focused on funding 80 new grants to expand satellite health centers into neighboring poor counties and open new health centers.²⁶ Most of these grants will establish new access points in low-income counties, and will reach an estimated 300,000 new patients.²⁷

At the time of this publication, reauthorization of section 330 of the Public Health Service Act, Health Centers Renewal Act of 2007, was pending Congressional action. This legislation would authorize a total of \$14.5 billion in funding distributed over the next five years.

HEALTH CENTER SNAPSHOT

In 2006, more than 16 million people received care at more than 1,100 health centers. These patients are predominantly minority, poor, uninsured, or covered by Medicaid. Although patients treated at health centers are relatively young (72.6 percent are below age 44), they tend to be in poorer health with more chronic conditions than the general population.²⁸ For a profile of health center patients, see Figure 1.

Nearly 75 percent of health center patients are either uninsured or covered by Medicaid. Health centers can provide important continuity of care for these individuals who often “cycle” on and off Medicaid coverage due to factors such as changing income, age, family status, and disability eligibility.²⁹ These individuals are often without insurance coverage for long periods of time. Health centers can bridge these gaps by providing uninterrupted coverage in spite of health insurance status.

Private health insurance covers approximately 15 percent of health centers’ patients. However, the payment received from private insurers falls far short of covering the costs of care. Between 1997 and 2005, the costs of providing care to privately insured patients at health centers was \$6.4 billion nationwide, yet only \$2.8 billion in payments were received, dealing the health centers with a total cumulative loss of \$3.6 billion.³⁰ Payment shortfalls could become more problematic for health centers located in states that are seeking to expand private health insurance to the uninsured as part of health care reform.

MEDICAID MATTERS

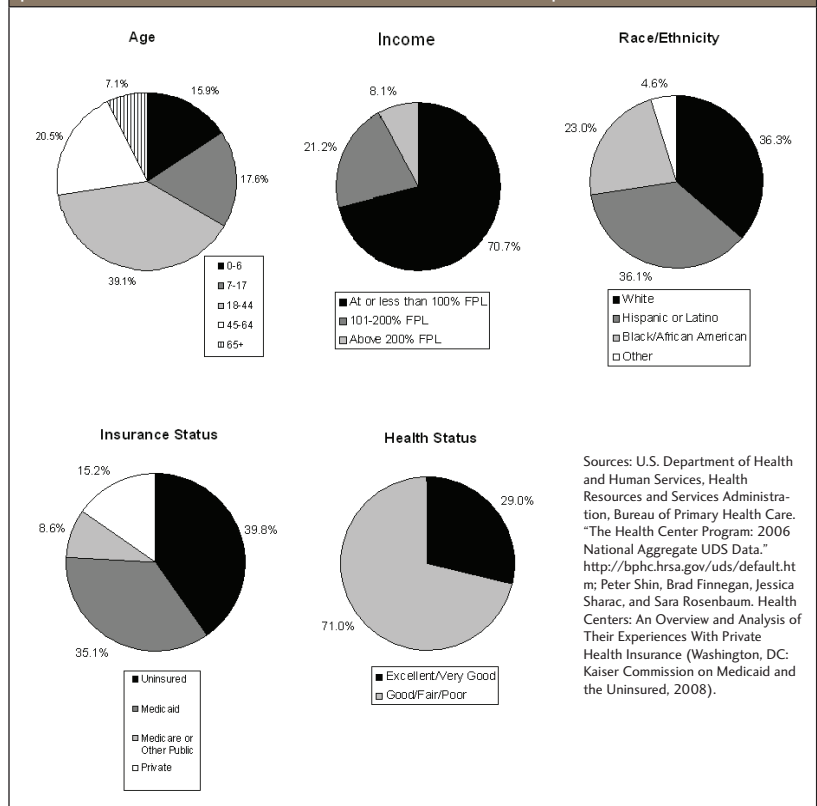
Medicaid is the largest source of health centers’ operating revenue (37 percent), providing far more funding than Medicare and other public insurance (8 percent), private insurance and self-pay (14 percent), and federal grants (22 percent).³¹ (See Figure 2.)

The volume of Medicaid patients also drives operating revenue. In some states, such as New York and Washington, a majority of the health center population is comprised of Medicaid patients. This caseload means heavy reliance on Medicaid’s favorable cost-based payments to cover operating revenue. (See the appendix for state-by-state data on health centers, patients served, Medicaid dollars spent, and percentage of revenue that is Medicaid.)

Medicaid is important to health centers for other reasons. The favorable reimbursement rate for FQHCs makes Medicaid their best third-party payer.³² According to the Institute of Medicine, these favorable rates are a “critical silent subsidy” that helps health centers pay for fixed overhead and infrastructure costs in

FIGURE 1: HEALTH CENTER PATIENTS, 2006

Patients receiving care at community health centers are likely to be young, poor, minorities, uninsured or have Medicaid, and be in poor health



addition to the services rendered, thus freeing up limited grant dollars to pay for the costs of caring for the uninsured.³³ This “silent subsidy” is not without controversy. Using limited state Medicaid dollars to pay for health center infrastructure instead of, for example, covering more Medicaid beneficiaries, has caused friction between state and federal officials on funding priorities.³⁴

Elements of Medicaid’s favorable reimbursement policies for FQHCs

Cost-based reimbursement: The Omnibus Budget Reconciliation Act (OBRA) of 1989 established a cost-based reimbursement methodology that set minimum payments for FQHCs at 100 percent of reasonable costs of an office visit or encounter. This payment reflects the operational costs of the FQHC for the visit, not just the time and resources of the provider. Changes in 2001 (P.L. 106-554) required states to pay prospectively to help control costs and better project expenses. Although less generous in payment, the prospective payment system (PPS) provides adequate Medicaid payments to FQHCs.³⁵

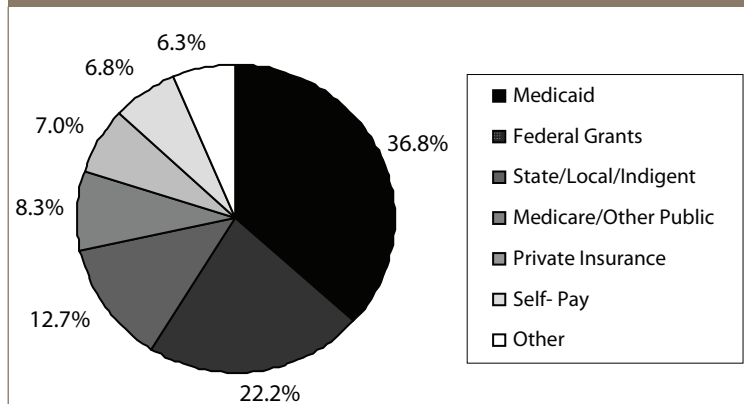
Alternative payment mechanism: States have the option of using an alternative payment mechanism (APM), provided the payment rate is not lower than what would be paid under the PPS. For example, states may opt to establish an alternative PPS or retain the original cost-based reimbursement system, provided the APM plan receives prior CMS approval.

Wrap-around payments: States are required to make supplemental or “wrap-around” payments to FQHCs for care of Medicaid managed care patients. These wrap-around payments cover the difference between the rates paid by managed care plans and the FQHC prospective payment rate. Fifty-three percent of all Medicaid beneficiaries served by health centers are enrolled in managed care – either in managed care organizations or primary care case management programs.³⁶ This federal requirement circumvents states’ authority to develop alternative delivery mechanisms and legally waive cost-based reimbursement for FQHCs under managed care granted to them under federal section 1915(b) and 1115 waivers.³⁷

Mandatory Medicaid services FQHC benefit: Federal Medicaid law requires states to reimburse FQHCs for the comprehensive package of primary and preventive care services the centers provide to Medicaid beneficiaries. This includes primary and preventive health care, prenatal services, dental care, laboratory tests, X-ray, and pharmacy services, as well as outreach and health education, transportation, and translation services. The emphasis on primary, comprehensive health care services results in lower emergency department utilization, outpatient costs, lengths of stay, and costly admissions, as well as reduced disparities in care related to race, income, and insurance status. Medicaid patients can be treated at health centers for 30-33 percent less in total costs than Medicaid patients treated elsewhere.³⁸

No cost sharing: Historically, under Medicaid, there has been little or no cost sharing through co-payments, which places health centers under less financial risk. However, health centers must often absorb costs for privately insured patients who are required, but are unable, to pay some portion of care. This is changing. Within

FIGURE 2: HEALTH CENTER OPERATING REVENUE



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. “The Health Center Program: 2006 National Aggregate UDS Data.” Exhibit A.

FEDERAL AND STATE ROLES AND MEANS FOR COLLABORATION

the Deficit Reduction Act of 2005 there are provisions that allow states greater flexibility in allowing cost sharing through such things as co-payments. How this will affect health centers is not clear yet.³⁹

The federal government has worked directly with health centers, with limited involvement from state governments, to build a safety net to serve the poor. But over the years, there has been increased recognition of the important role that states can play and the need for communication and collaboration among federal and state agencies and health centers in efforts to improve access to primary care. Toward this end, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services entered into cooperative agreements with each state and territory to establish and support Primary Care Offices (PCO), generally within the state public health agency. The charge of the PCOs is to “assist in the coordination of local, state, territorial, and federal resources that contribute to improving primary care service delivery and workforce availability in the state or territory to meet the needs of underserved populations.”⁴⁰

PCOs are responsible for collecting data to secure federal designation of Health Professional Shortage Areas, Medically Underserved Areas, Medically Underserved Populations, and Mental Health and Dental Professional Shortage Areas. These designations allow communities to apply for federal funds to start or expand health centers and services or to address workforce shortages by accessing the National Health Service Corps. Many states use their own resources to augment these efforts. For instance, New Mexico’s PCO contracts with the nonprofit New Mexico Health Resources (NMHR) – a clearinghouse for workforce recruitment for underserved areas. NMHR matches individual practices or clinics with approximately 45 new providers per year.⁴¹

State Primary Care Offices collaborate with the state and regional Primary Care Associations (PCA). Also funded by HRSA cooperative agreements, PCAs are private, non-profit organizations that represent safety net providers and provide expert support and technical assistance. PCAs and PCOs often work together to identify and coordinate scarce resources to protect and expand the safety net. For instance, in New Mexico this partnership led the PCO to give seed funding to help grow Look-Alike centers, National Health Service Corps sites, and tribal sites into section 330 FQHCs.⁴² In Mississippi, the PCO and PCA jointly hired a research assistant to collect health disparity information that was used to support both federal and state objectives.

PCA staff are a resource to state policy makers. In Massachusetts, the Community Health Center Steering Committee – made up of the Massachusetts Department of Public Health/PCO, Medicaid (MassHealth), Massachusetts Division of Health, Finance and Policy, the PCA (Massachusetts League of Community Health Centers), and the University of Massachusetts Medical School – meet monthly to discuss and review programs and policies.

HRSA also has entered into National Cooperative Agreements (NCAs) to better work with national, state, and local organizations, including NASHP, to advance the mission of providing health care to the underserved. NCA partners help HRSA to achieve its mission, because they are uniquely positioned to work with providers, policy makers, program administrators, and communities to improve the health of underserved communities and vulnerable populations.⁴³

STATE LEVERS FOR WORKING WITH FEDERALLY QUALIFIED HEALTH CENTERS TO ACHIEVE STATE AND FEDERAL POLICY OBJECTIVES

A state has many levers – including licensing, purchasing, and funding – that can help it assure that FQHCs are an integral part of its health care system and thus contribute to achieving performance goals for that system.

LICENSING HEALTH CARE FACILITIES AND HEALTH PROFESSIONALS

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

Health facilities licensing

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

In Massachusetts, the state requires that FQHCs (which are licensed under clinic regulations) to report incidents that seriously affect patient health and safety.⁴⁴ The intake staff in the complaint unit review each report and consumer complaint to determine whether an on-site investigation is required to assess compliance; whether issues or questions exist that can be resolved through “off-site” intervention; or whether some other action, such as a referral to a professional board in regards to licensed staff, is most appropriate. If an on-site investigation is required and the health center is found to be deficient, a correction plan may be required. If no corrective action is taken, then the state could proceed with license revocation.

States also have the power to ease regulatory oversight to help facilities meet their mission. For instance, New Mexico has given certain health centers more flexibility in their pharmacy operations in areas such as supervision, hours of operation, and dispensing guidelines to address access and workforce shortage needs.

Health professionals licensing

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

- : Offer temporary licensure for providers moving from out of state. New Mexico offers licensing by credentials and waives licensing exams for these providers after they have practiced for several years with a temporary license.
- : Recognize some professionals’ foreign training and education as equivalent to that conducted in the U.S.
- : Expand permitted scope of practice of non-physician health professionals such as pharmacists, nurse practitioners, physician assistants, psychologists, and dental hygienists.
- : Support establishment, education, and licensing of new midlevel practitioner models, such as dental health therapists.

HEALTH CARE PURCHASING

A state purchases a significant share of health care through Medicaid, the State Children’s Health Insurance Program (SCHIP), State Employees Benefit Plans, and other programs. This purchasing power can be used to help health centers become more self-sufficient and to ensure that health centers are providing safe, quality patient care. Since up to 40 percent of a health center’s operating revenue comes from Medicaid and SCHIP, these programs’ payment, coverage, and eligibility provisions are very important to health centers.

At the same time, there are other levers states control and which can influence the operations of health centers.

Encouraging or requiring health plan contract language to favor FQHCs

States can help health centers increase their volume or capacity by encouraging or requiring contracted health plans to include health centers in their networks. Minnesota requires all plans that serve Medicaid beneficiaries to include FQHCs and other safety net providers in plan networks.⁴⁵ Other states provide incentives to managed care organizations (MCOs) to contract with providers that meet many of the criteria unique to health centers, such as a location in an underserved area or provision of supportive services.⁴⁶ By mandating the inclusion of health centers in managed care networks, health centers might gain more leverage in negotiating adequate reimbursement rates from commercial insurers.⁴⁷

Providing wrap-around payments to supplement private insurance

Payment shortfalls from private insurance companies to health centers can affect care for the uninsured. Private insurance payments, although generally a small percentage of a health center’s total revenues, can vary in some states. (If state officials do not know the case mix of their health center population, they can check with their state primary care association.) For beneficiaries who are eligible for both Medicaid and private insurance, some states provide wrap-around payments, similar to what is required to supplement payments from Medicaid managed care organizations. For instance, Wisconsin provides supplemental payments up to the Medicaid cost payment level for beneficiaries covered by both private insurance and Medicaid.⁴⁸ This coordination of payment lessens the sting for health centers receiving inadequate private insurance reimbursement and keeps health centers from shifting costs from other programs to make up for the loss.

Developing default enrollment policies

States can automatically assign new Medicaid enrollees to plans that favor health centers. Michigan uses auto-assignment as a carrot, along with payment bonuses, to reward plans whose providers – many of which include FQHCs – meet certain performance measures. This value-based purchasing program has prompted managed care plans to develop provider profiling as well as provider and enrollee incentive programs.⁴⁹ The state publishes a report card of provider plans through an easy to find annual report card called, “A Guide to Michigan Medicaid Health Plans,” on its Medicaid Web site to help support informed consumer choices of health care services.⁵⁰

Encouraging creation of community health center affiliated health plans

Policy makers interested in preserving the traditional safety net for both Medicaid and uninsured beneficiaries can encourage the development of community health center affiliated health plans through regulation. Some states have provided seed capital for some of the start-ups.⁵¹ But there is a regulatory role that Medicaid officials can play as well to level the playing field for those health center affiliated

plans that may not have as much financial reserve as commercial plans. The state may also amend licensing requirements that make it easier for these plans to be responsive to requests for proposals.

DIRECTING STATE AND FEDERAL GRANT FUNDS

States can direct appropriations and channel federal grant monies to health centers to achieve state priorities in improving access and outcomes.

State funding to support health center capacity

Many states fund health centers through grants funded primarily by general funds or tobacco tax settlements. In FY2008, 36 states and the District of Columbia provided nearly \$590 million in direct non-Medicaid funding to their health centers to cover costs such as uninsured or indigent care, capital projects, and health information technology.⁵² For instance, Colorado directs a portion of its tobacco settlement to a primary care fund that is then distributed in proportion to the number of poor or uninsured patients served by each provider. In FY 2007, Colorado gave more than \$62 million to health centers for uncompensated care, capital projects, and unrestricted use.⁵³

Through grant funding, states can hold health centers accountable for achieving state specific standards and benchmarks. For instance, New Mexico, through its Rural Primary Health Care Act, appropriated \$14.5 million last year to support the operations of community-based primary health centers, including FQHCs. Health centers receiving these funds must provide monthly documentation to demonstrate compliance with state requirements such as after-hours coverage, staff education and training, and ability to make appropriate referrals. Grantees are subject to periodic site visits to ensure compliance.

State funding to achieve state-specific objectives

States also use grants to strengthen the safety net's role in achieving state-specific priority health objectives.

- : Through its Institute for Improvement of Geographic Minority Health and Health Disparities Program, Mississippi addresses health disparities faced by rural disadvantaged and minority populations. The program awarded the state's PCA a grant to recruit and retain licensed minority medical students throughout their professional training programs and improve access to primary and preventive medical care for all state residents.
- : Alaska is addressing statewide workforce shortages by doubling its support of medical training slots for its Family Practice Residency Program, which is operated through the University of Washington's WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) program.⁵⁴ The WWAMI, a partnership between the University of Washington School of Medicine and the five states, provides access to publicly supported medical education across the five-state region. Students can have loans forgiven if they practice medicine for three years in a rural setting or five years in an urban location, which may include practice in an FQHC.
- : Maryland is spurring investments in FQHCs by offering public works grants for the renovation or purchase of capital equipment for an FQHC or conversion of a building to become an FQHC.⁵⁵

Federal grant funding to supplement the safety net

Many states choose to direct or make available on a competitive basis federal grant monies to health centers and other safety net providers using Title V Maternal and Child Health Block Grants, Title X Family Planning Grants, and Title IV Ryan White AIDS CARE Act grants, to name a few. In 2006, federal grants amounted to \$191 million for section 330 health centers.⁵⁶ In many states, health centers are seen as

important partners in the delivery of categorical federal public health programs such as VFC (Vaccines for Children), which provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay.

REACHING THE UNINSURED WHO ARE ELIGIBLE FOR PUBLIC COVERAGE

States that are expanding coverage to the uninsured may look to health centers to help them enroll eligible populations. Under Medicaid law, states are required to pay for the processing of applications to enroll low-income pregnant women, infants, and children at outreach locations such as FQHCs in order to reach vulnerable populations. Yet, many states struggle to comply with this mandate. States can collaborate with safety net providers through their PCO and PCA for expertise and technical assistance to improve these efforts.

FUTURE CHALLENGES

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

Health care reform

Safety net providers, including health centers, can help states meet their health care reform goals. Health centers can provide a source of primary health care for the newly insured while maintaining their role as the safety net for those that are publicly insured and those that fall between the cracks. (NASHP will be exploring the issues that state health care reform raises for health centers as well as the ways in which health centers can help policy makers meet their reform goals in a paper to be published in summer 2008.) Already serving more than 6.5 million uninsured, health centers serve as a ready connection for states working to expand coverage and connect people with primary care providers. Health centers provide comprehensive primary care that results in lower Medicaid costs and they deliver regular, coordinated care that reduces disparities in care related to race, income, and insurance status.⁵⁷

Several states are now considering financing expanded insurance coverage partly by redirecting funds now paid to safety-net providers or using cost sharing or deductibles to help finance expansions, actions made possible by the Deficit Reduction Act of 2005.⁵⁸ One goal of the DRA is to save more than \$26 billion in Medicaid expenditures over the next 10 years. How these savings are achieved is still evolving.⁵⁹ These actions should be measured carefully as the result could seriously threaten the integrity of the safety net.

The issue of coverage for low-income, undocumented immigrants looms large for many states.

Many immigrants seek care at safety net clinics such as health centers, but federal law restricts use of federal Medicaid matching funds for care of undocumented immigrants to emergency room care and stabilization. No federal matching funds are provided for routine or preventive care. There are some exceptions to this law, with some flexibility to access federal funds to provide health care to undocumented aliens at health centers.⁶⁰

States can use their own funding to provide health care to undocumented immigrants and to those low-income legal immigrants who have been in the United States for less than five years and who are not yet eligible for Medicaid. As of 2007, 17 states provided state-funded coverage to cover at least some groups of adult immigrants who are not eligible for Medicaid due to the immigrant eligibility restrictions.⁶¹ Other states and communities are expanding public health care coverage programs to include children regardless of immigration status.

Medicaid and SCHIP funding

The programs that contribute the most to the fiscal integrity of the health care safety net are Medicaid and SCHIP. Currently, these programs make up 40 percent of health centers' operating revenue. SCHIP is due for reauthorization in 2008. Key issues for states regarding funding levels, benefit modification, and eligibility rules will be debated during reauthorization. Included in the proposed reauthorization legislation is a section that will apply the Medicaid prospective payment system for FQHCs and Rural Health Clinics to SCHIP.⁶²

Technology investment

Implementing new technology, such as electronic health records to enable health information exchange to keep pace with care coordination, quality, and patient safety monitoring, will be a challenge for most health centers. Currently, HRSA allows grantees to use up to \$150,000 from their first year's budget on activities related to equipment or capital alteration; centers also have access to a loan guarantee program.⁶³ This modest assistance – in the face of aging equipment and facilities – places health information technology investments out of reach for many health centers. There are eight state Medicaid agencies that have received Medicaid Transformation grants focused on improving primary care for beneficiaries.⁶⁴ Hawaii included several FQHCs in its application request to develop health information exchange capabilities in order to better equip them to care for the underserved.

Workforce shortages

Health centers have a chronic shortage of practitioners, which has been exacerbated by the recent push to expand the health center system. The workforce shortage issue will continue to be an important challenge for states and health centers. Addressing adequate provider capacity to deliver primary health care to those newly insured under health care reform will add to the strain.

APPENDIX

TABLE A-1: STATE DATA FROM 2006 ON HEALTH CENTERS: NUMBER OF CENTERS, PATIENTS SERVED, MEDICAID DOLLARS SPENT, AND PERCENT REVENUE THAT IS MEDICAID

STATE	No. of CHCs	No. of Patients Served	MEDICAID \$ SPENT	PERCENTAGE REVENUE THAT IS MEDICAID
Alabama	15	289,193	31,695,861	31.1
Alaska	24	80,329	15,907,837	16.7
Arizona	14	325,928	81,627,524	43.5
Arkansas	12	119,733	9,299,137	18.7
California	103	2,155,126	537,286,028	42.1
Colorado	15	396,382	87,708,653	32.6
Connecticut	10	211,693	59,724,828	43.9
Delaware*	4	26,581	unknown	31.1
D.C.	4	85,543	13,551,113	21.5
Florida	38	702,188	98,128,217	30.0
Georgia	24	248,205	23,260,035	23.8
Hawaii	13	98,536	32,086,782	39.6
Idaho	10	92,590	9,473,725	21.9
Illinois	34	852,366	168,376,684	44.2
Indiana	15	170,212	33,775,525	40.1
Iowa	11	104,259	17,599,815	33.8
Kansas	9	65,385	4,625,677	19.4
Kentucky	15	216,635	35,832,162	34.6
Louisiana	20	128,507	17,733,762	32.3
Maine	17	145,976	22,016,280	31.9
Maryland	14	194,768	53,987,319	40.6
Massachusetts	33	446,559	94,124,782	23.7
Michigan	28	440,885	86,792,578	41.6
Minnesota	14	148,061	27,985,181	32.4
Mississippi	22	305,260	27,238,302	24.5
Missouri	19	308,793	56,113,099	33.0
Montana	12	74,496	5,686,724	18.0
Nebraska	5	41,070	5,095,252	23.3
Nevada*	2	69,849	unknown	17.8
New Hampshire	9	63,211	8,251,798	21.7
New Jersey	18	273,894	52,675,254	37.6
New Mexico	14	231,397	29,599,849	22.9
New York	47	1,139,843	356,091,095	51.8

STATE	No. of CHCs	No. of PATIENTS SERVED	MEDICAID \$ SPENT	PERCENTAGE REVENUE THAT IS MEDICAID
North Carolina	24	333,283	32,671,192	23.9
North Dakota	4	22,565	2,127,658	21.4
Ohio	23	321,788	44,199,818	30.9
Oklahoma	11	98,580	11,519,859	26.8
Oregon	22	207,410	67,017,838	40.6
Pennsylvania	32	499,829	81,378,297	41.0
Rhode Island	8	105,177	25,475,529	45.5
South Carolina	21	294,821	39,442,367	29.8
South Dakota	6	52,314	4,961,953	22.5
Tennessee	23	273,135	40,581,820	38.1
Texas	49	703,518	87,002,184	24.6
Utah	11	88,742	8,721,387	19.6
Vermont	5	59,581	7,964,156	27.0
Virginia	21	204,891	18,944,705	19.9
Washington	23	591,581	216,165,078	51.1
West Virginia	27	307,272	36,754,681	26.1
Wisconsin	15	161,773	62,678,559	46.3
Wyoming	5	21,125	3,561,920	29.8

Sources: KFF statehealthfacts.org, from National Association of Community Health Centers, Incorporated (NACHC) analysis of the 2006 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services, Special Data Request, November 2007; and, 2006 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services, <http://bphc.hrsa.gov/uds/2006data/state/default.htm>

* Data specifically from statehealthfacts.org (not BPHC website).

Notes: Data are for calendar year 2006.

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

NOTES

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- 16 §1861 (aa)(4) of the Social Security Act [42U.S.C. 1395x (aa)(4)].
- 17 Taylor, *The Fundamentals of Community Health Centers*, 12.

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- 18 Braunstein, *The 340B Drug Pricing Program: Fact Sheet*.
- 19 Ann Zuvekas, *Community Health Center Affiliated Health Plans: A Viable Alternative for Medicaid Managed Care?* (Washington, DC: Association for Health Center Affiliated Health Plans, 2002), 1
- 20 Remarks to the National Association of Community Health Centers' Policy and Issues Forum by HRSA Administrator Elizabeth M. Duke March 19, 2007, Washington, D.C. <http://newsroom.hrsa.gov/speeches/2007/NACHCmarch19.htm>.
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