



THE SAFETY NET ON THE EDGE

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Executive Summary

The federal Health Centers program is one of the few remaining legacies of President Lyndon B. Johnson's declared "War on Poverty." The goal then, as it is now, was to break the cycle of sickness and poverty by reaching poor communities beyond the reach of traditional medicine. With a modest federal investment, the Community Health Centers program transformed the nation's health care delivery system. Now in its 40th year, the program cares for 15 million traditionally underserved people in rural and urban areas across the nation. A host of independent studies repeatedly confirm that health centers improve access to high-quality and cost-effective primary and preventive care. At a time when consumers are paying more for fewer health care options and are increasingly underinsured or uninsured, health centers offer affordable and accessible health care that is community-driven – features that are a rarity in America's complex health care marketplace.

Over the years health centers expanded their reach as the health care landscape became increasingly inaccessible for underserved populations. Demand for their services is on the rise, especially among at risk populations that may be costlier to treat.

- The number of patients treated by health centers increased by 46% between 1999 and 2004, the most significant and rapid growth in the program's history.
- The number of low-income patients at health centers grew *four times as fast* as the number of low-income Americans between 1999 and 2003. Over the same time, the number of uninsured patients grew nearly *three times as fast* as the uninsured nationally.
- The number of health center patients with chronic diseases has increased dramatically over the last few years. Currently, 26% of medical visits are for treatment of a chronic condition.

As the numbers of low income and uninsured Americans continue to rise, demand for health center care will also continue to rise. Yet even as health centers carry on their original mission to serve more and more medically underserved communities, certain trends pose a challenge to the future of America's safety net as a whole. Among those trends:

- Health centers are not immune to the rising health care costs seen across the health care system, and continue to rely on a diverse mix of revenue sources.
- As a whole, their operating margin is negligible and tends to be less than other provider types. One unexpected event, such as a public health outbreak or natural disaster, can easily put a health center in deficit.
- Declining federal and state grants are stretching health center budgets. The average annual cost of treating a patient is \$230 more than what the federal health center grant actually pays per uninsured.
- Payments from Medicare, other public insurance, and private insurance are on the decline. While Medicaid is the most reliable payer, paying an average of 87% of health centers' costs, private insurance is the worse payer, covering only 57% of costs. As the largest insurer of health center patients, adequate Medicaid payments are essential to a health center's financial wellbeing. Moreover, cuts in Medicaid enrollment adversely affect health centers' capacity to treat their patients.

These trends threaten health centers' ability to provide the same level of services or even stay open. How these trends will shape the future of the safety net and America's health care delivery system depends largely on the crosscurrents of policy changes underway at the state and federal level. Congress and national leaders are considering proposals that could dramatically restructure Medicaid. States are already enacting their own Medicaid cuts to trim budget costs, swelling the ranks of uninsured. With eroding public insurance, and the attrition of other revenue sources, health centers will not be able to meet the health care needs of a nation that, by all accounts, is gripped by a deepening health care crisis.

The public health consequences of a crippled safety net will impact not just health centers alone, but also the rest of America's health care system. The loss of primary care providers will cause racial and ethnic health disparities to soar, leading to more avoidable illness and increased mortality. Hospital emergency rooms – already challenged by long lines and uncompensated care costs – will be forced to care for a growing number of low income and uninsured patients who will have no place else to go.

Introduction

Now in its 40th year, the federal Health Centers program is the largest national network of safety net primary health care services. How a program that started out as a small pilot project during President Lyndon B. Johnson's "War on Poverty," and then revolutionized the delivery of health care in America is an enduring example of how investing in affordable health care can transform a nation. Health centers today remain unchanged from how the early health care leaders envisioned them: they are locally-owned, non-profit and community-oriented health care providers that improve access to health care for millions of low-income and medically underserved Americans. No one is turned away regardless of their insurance status or ability to pay. They are a medical home to 15 million patients who live in rural and urban areas around the country. No two health centers are exactly alike, but they all share a common purpose: to serve their communities. In the increasingly complex and fragmented U.S. health care system – where continuity of care can pose a challenge for consumers regularly faced with uncertain insurance coverage and health care premiums that are growing much faster than personal income¹ – health centers offer "one stop shopping". A patient can find dental, mental health, substance abuse, vision, hearing, and pharmacy services all in one place. Health centers also offer services that many other providers do not, such as transportation, translation, and culturally sensitive health care that can overcome common barriers.

Independent studies over the course of the last four decades have documented that the care received at health centers is ranked among the most cost-effective.² The Department of Health and Human Services gave health centers one of its top ratings as competitive grant program for fiscal year 2006.³ The Institute of Medicine (IOM) has also repeatedly cited the program for effectively and efficiently meeting the needs of low-income and diverse patients who often face multiple and complex barriers to care.⁴ The cost savings that health centers have generated has produced dividends elsewhere in the health care system. Because people are treated before they become ill, health centers reduce the need for more expensive hospital, emergency or specialty care.

Health centers are doing an excellent job controlling costs wherever they can, even as they expand the services they provide in response to the needs of a growing patient population that tends to be sicker than other Americans. Nevertheless, certain trends are emerging that pose a distinct challenge to health centers and the future of the safety net. Among those trends is a retrenchment among certain health care payers, including Medicare, private insurance, and non-Medicaid public insurance. Although Medicaid has held its own over the years, the public insurance program shows ominous signs of becoming more like private insurance, which pays health centers on average a little more than half (57%) of the cost of treating patients. Adequate Medicaid reimbursement (through a prospective payment system) ensures that health centers' grant revenues can be dedicated to care for the uninsured. Medicaid beneficiaries, who are poor and thus at risk for adverse health outcomes, require comprehensive health services. Yet cuts in Medicaid eligibility and benefits jeopardize the ability of health centers to continue to provide care to all patients at current levels. Compounding the financial pressures on health centers is diminishing grant revenues. The average annual cost of treating a patient is \$230 more than what the federal health center grant actually pays per uninsured. Direct funding from the states has also dramatically decreased

Adding to the growing financial strain on health centers, however, is skyrocketing patient demand. Health centers are experiencing rising numbers of uninsured, low-income, and chronically ill patients. The number of uninsured and low-income health center patients has exploded, growing faster than the number of uninsured and low-income people nationally. These patients tend to be costlier to treat, often because they delay needed care. Consequently, they require comprehensive primary care as well as a myriad of other needed services, including outreach, translation, case management, and transportation. These worsening trends prompted the IOM to warn five years ago that growing uninsured patient loads and shrinking grants for the uninsured posed major threats to health centers' financial viability.⁵ Given that poverty and uninsurance are on the rise nationally, health centers are a microcosm for the national health care crisis and stand at the intersection between poverty and health care. Health centers are currently surviving financially but their future, and the future of their patients, depends on the crosscurrents of policy changes underway at the state and federal level.

The Growth of Medically Vulnerable Patients

Volume of Care

Health centers effectively provide care to populations beyond the reach of traditional medicine. Located in every state and territory, they serve 15 million patients who would otherwise experience complex and compounding barriers to care, such as cost, culture and language, and lack of providers. These patients represent:

- one in seven low-income persons, including one in four at or below poverty;
- one of every eight uninsured Americans, including one in five low-income uninsured;
- one in nine Medicaid beneficiaries;
- one in ten minorities; and
- one in ten rural residents.

Health center patients are disproportionately low-income, uninsured or publicly insured, racial and ethnic minorities, as seen in Table 1 below. While 31.1% of the US population is poor (at or below 200% of poverty), nearly all (91.1%) health center patients are poor. The percentage of health center patients who are uninsured (40.1%) is more than double the national average (15.6%). Health center patients also suffer from poorer health than the general population.⁶

Table 1
Proportion of Vulnerable Populations at Health Centers and in the US

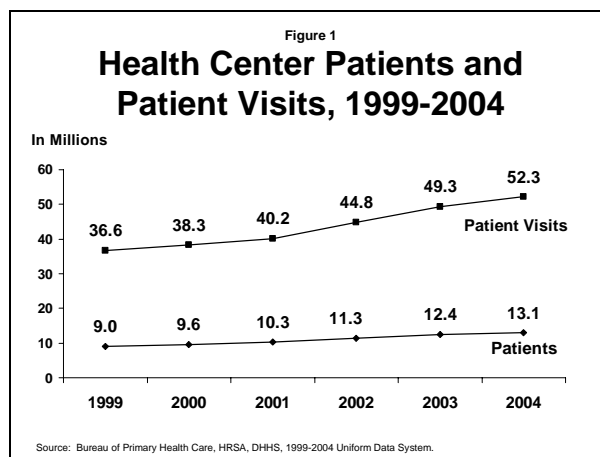
	Health Centers, 2004	US Population, 2003*
Income		
At or Below 100% of poverty [#]	70.5%	12.5%
At or Below 200% of poverty	91.1%	31.1%
Insurance Status		
Uninsured	40.1%	15.6%
Medicaid	35.7%	12.4%
Non-White	63.5%	32.2%

* Most recent year available.

[#] For a family of three, \$15,260 annual income in 2003 and \$15,670 for in 2004.

Sources: Health Centers, 2004: Bureau of Primary Health Care, HRSA, DHHS, 2004 Uniform Data System. US Population, 2003: US Census Bureau. Historical Poverty Tables. "Table 5. Percent of People By Ratio of Income to Poverty Level: 1970 to 2003." www.census.gov/hhes/www/poverty/histpov/hstpov5.html. Historical Health Insurance Tables. "Table HI-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1987 to 2003." www.census.gov/hhes/www/hlthins/historic/hihist1.html. Annual Estimates of the Population by Race Alone and Hispanic or Latino Origin for the United States and States: July 1 2003. SC-EST2003-2004. Released September 30, 2004. www.census.gov.

As Figure 1 demonstrates, the numbers of health center patients and patient visits have grown significantly between 1999 and 2004 (45.6% and 42.8%, respectively). The number of patients served by federally-funded health centers grew 5.9% nationally between 2003 and 2004, though many health centers reported even higher increases. At least 133 (15.1%) health centers recorded increases of over 20%.



The number of patient visits has increased faster than the number of patients each year since the start of the President's bipartisan-supported initiative to expand the health centers program in 2002. The surge of visits may be attributed to the growing variety of health center

services, such as oral and behavioral health care. Notably, a recent study found that between 1994 and 2001, health centers provided more preventive services and treated more chronically ill, near-elderly, and uninsured patients than ever before.⁷

The total number of patients served grew 45.6% over the past six years, as illustrated in Figure 2. The number of low-income patients (defined as those at or below 200% of poverty, or \$31,340 for a family of three in 2004) and the number of uninsured patients rose nearly as fast, at 40.1% and 42.5%, respectively. Nearly 2.8 million more low-income people and nearly 1.6 million more uninsured people are seeking care at a health center. Most of the growth took place after the initiative to expand health centers began in 2001.

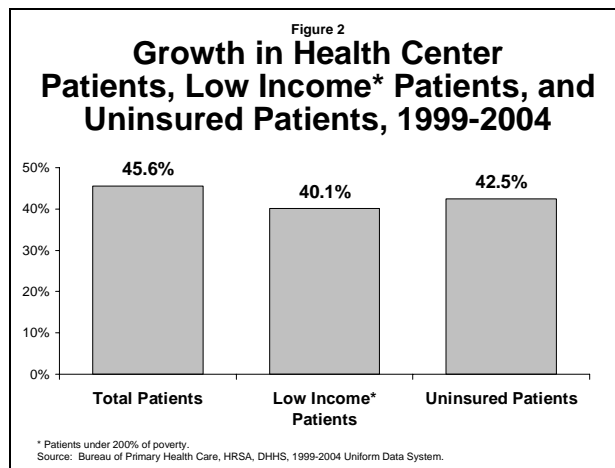
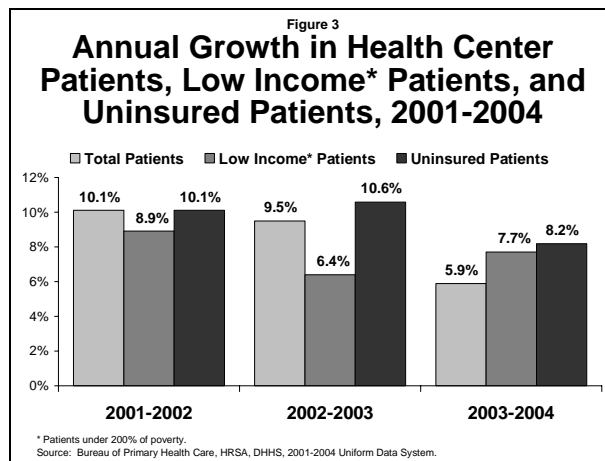


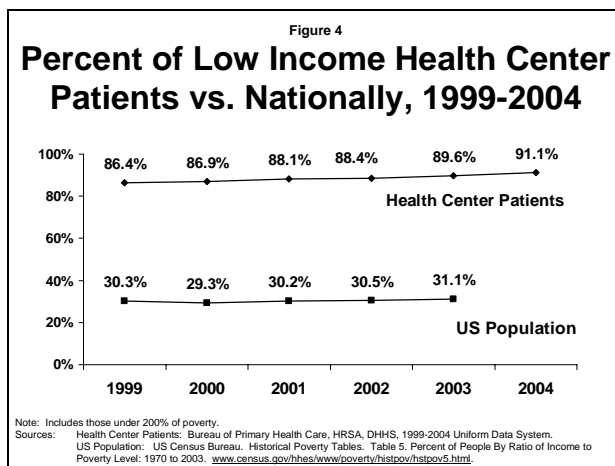
Figure 3 shows annual growth for all, low-income, and uninsured patients between 2001 and 2004. This recent surge in patients is the first time both the number of low-income patients and the number of uninsured patients grew faster than total patients.



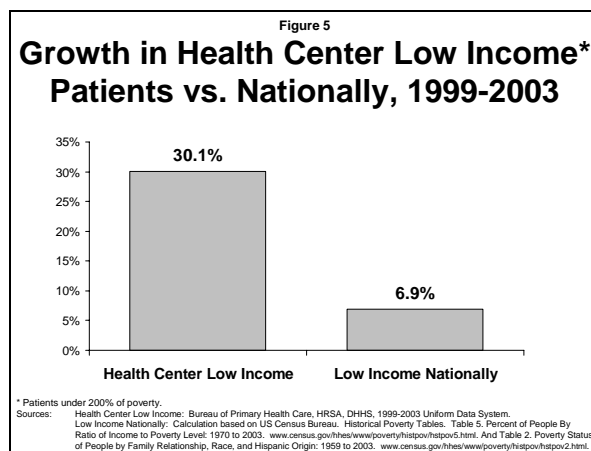
Moreover, the emerging data show that America's poorest and sickest are seeking care at health centers in increasing numbers, as is discussed below. These new patients are more likely to be uninsured, low-income and chronically ill, and therefore among the most difficult and costly to treat.

Poverty

Nearly all health center patients are poor, compared to less than a third of the U.S. population. As Figure 4 shows, the percent of health center patients who are poor has grown consistently since 1999, paralleling the rise in the rate of low-income Americans, and continuing to rise even as the percent of low-income Americans fell in 2000.



As Figure 5 illustrates, the number of low-income patients health centers served grew *four times as fast* as the number of low-income Americans between 1999 and 2003, the most recent year of comparable data.

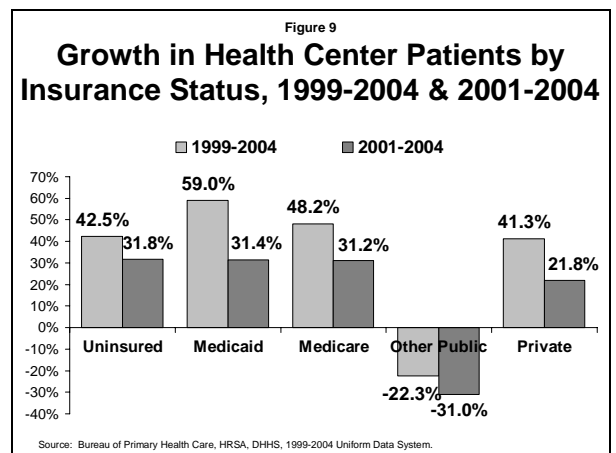
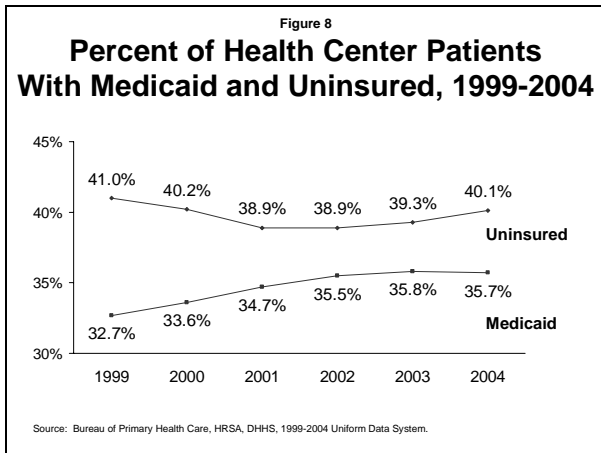
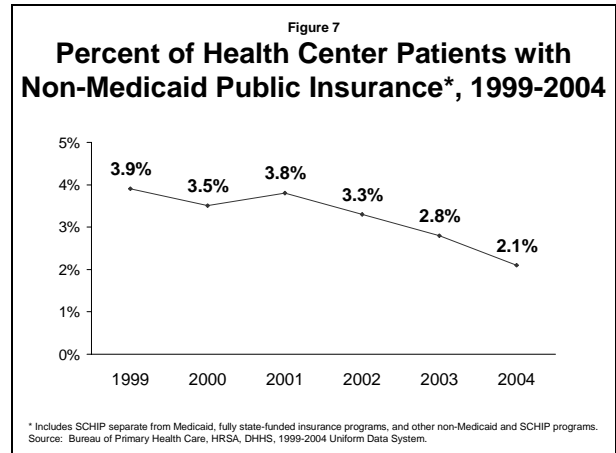
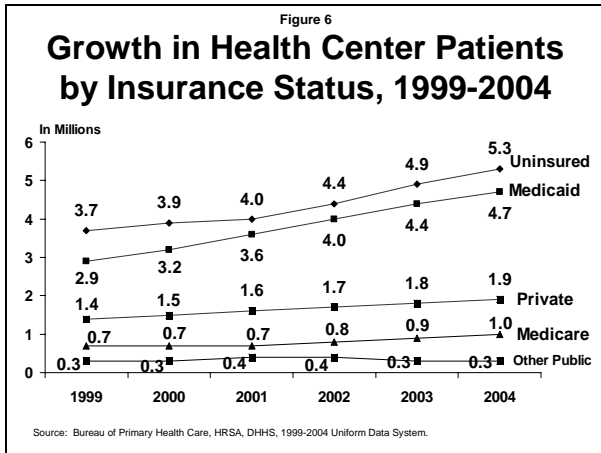


Between 2003 and 2004, the number of poor patients served by federally-funded health centers grew by 7.7%, or nearly 700,000 people. Yet many health centers have experienced far greater increases in the number of poor patients: at least 205 health centers (23.3% of all centers) experienced a rise of over 20% in the number of poor patients, with 39 of these centers (4.4% of the total) at least doubling the number of poor patients they serve.

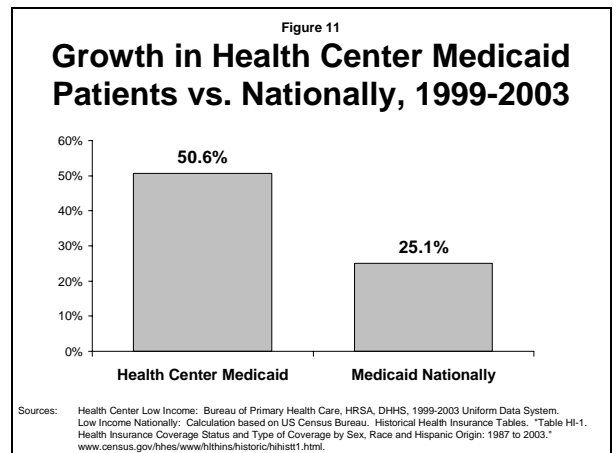
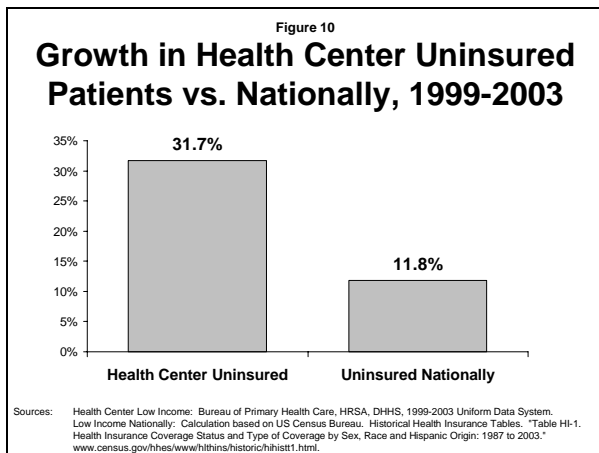
Medicaid and the Uninsured

Figures 6 through 9 below illustrate changes in insurance status among health center patients. Two in five patients were uninsured and another 35.7% relied on Medicaid coverage last year. Over the last several years, health centers have seen increases in the number of patients with all insurance types, except for patients who rely on public insurance (such as non-Medicaid expansion SCHIP and state-funded programs). In fact, the proportion of patients with other public insurance has been declining since 2001, with the greatest drop occurring between 2003 and 2004 at 21.8% (not shown). This drop is most likely linked to cuts in state-funded insurance programs and non-Medicaid SCHIP. Some of the decline over the last few years may be related to Medicaid expansions that covered those once enrolled in state-funded insurance programs, though increases in the percent or number of patients with Medicaid would follow. For example, **New York, Texas, and Vermont** experienced declines in their SCHIP enrollment of around 12% between 2002 and 2003.⁸ Health centers in these same states experienced slight declines in the number of patients with other public insurance during the same period, followed by even more dramatic declines the following year (-22.3%, -44.8%, and -100.0%, respectively). **Massachusetts** eliminated coverage for 10,000 state-funded adult immigrants in 2004.⁹ Health centers in the state saw their proportion of patients with other public insurance fall by more than half (59.7%) and the proportion of patients with Medicaid declined by about one percentage point. In addition, four states (**Kentucky, Maine, South Dakota, and Tennessee**) saw the number of health center patients enrolled in other public insurance programs fall to zero between 2003 and 2004 without a rise in the percentage of patients with Medicaid. Meanwhile, health centers in **North Dakota** and **Rhode Island** saw the number of other publicly insured patients fall by nearly 100%, while the percentage of patients with Medicaid also declined in those states. Clearly, recent decline in other public insurance is more likely related to actual program cuts rather than Medicaid expansions.

As the report noted earlier, the bulk of the increase in patient volume occurred after the President's initiative to expand health centers was set in motion. Of significant note, the growing percent of patients with Medicaid coverage tapered off in 2004. This is likely linked to national trends, since projected Medicaid enrollment growth slowed from 5.0% in 2003 to 2.4% in 2004.¹⁰ Even as the proportion of patients who had Medicaid coverage remained about the same, the proportion of patients who are uninsured continued to grow. With the rising cost of private insurance, the number of uninsured nationally is expected to continue growing. A recent analysis projected that by 2013, the number of uninsured people will soar from 45 million to 56 million, or even substantially higher if health care spending grows faster than expected and if enrollment in Medicaid and SCHIP falls. At 56 million, one in five non-elderly Americans will be affected, as will nearly one in three *working* non-elderly Americans. Moreover, this increase in the number of uninsured Americans will lead to 4,500 more deaths and up to \$32 billion lost in human capital each year.¹¹



Since the beginning of the President's initiative to increase the number of health center patients, the number of uninsured patients treated by health centers grew nearly *three times* faster than the uninsured nationally (Figure 10), while the number of health center Medicaid patients grew *twice as fast* as nationally (Figure 11). Between 2003 and 2004, the number of uninsured patients grew faster than the number of Medicaid patients for the first time over the study period 1999 to 2004 (8.2% for uninsured and 5.6% for Medicaid) (not shown).



Compounding the increases in total patients, many of whom are low-income, most health centers experienced a growth rate of uninsured much higher than the national average of 8.2%. Many also experienced significant declines in the number of patients with Medicaid between 2003 and 2004. During this time, an alarming 587 health centers experienced a rise in the number of patients without insurance. Over 230 (26.2%) reported an increase of 20% or more. Equally troubling, 314 health centers (35.6%) experienced a decline in Medicaid patients. Among the health centers with declining rates of Medicaid-covered patients, three out of five also experienced rising numbers of uninsured patients.

Over the last several years, every state has enacted at least one Medicaid programmatic change to control rising costs.¹² Many states have cut eligibility, or initiated new or higher cost sharing for patients, a move that almost always triggers reductions in enrollment. Last year, several states cut eligibility,¹³ and many other states enacted changes that led to enrollment declines.

- **Minnesota** reduced automatic eligibility from 24 to 12 months, causing an estimated 4,412 beneficiaries to lose coverage, and instituted other changes that lead to 3,600 additional beneficiaries to lose coverage.¹⁴
- **Rhode Island** began charging monthly premiums of between \$43-58 to Medicaid families over 150% of the federal poverty limit, triggering a loss of coverage for 18% of families within the first three months. The state further increased premiums the following year, causing an additional 670 families to lose coverage and another 1,100 to be temporarily disenrolled for non-payment.¹⁵
- A TennCare waiver implemented in July 2002 required 600,000 beneficiaries to re-apply, with an estimated 150,000 losing coverage. Most recently, **Tennessee** has begun cutting between 226,000 and 323,000 beneficiaries from its Medicaid rolls.
- **Nebraska** initiated many changes in its Medicaid program in 2003, reducing eligibility periods and income levels (by reducing the earnings disregard), causing a loss of coverage for an estimated 12,600 children and 12,750 parents. Last year, Nebraska ended presumptive eligibility for children, and as a result enrolled nearly 340 fewer kids each month. An additional 3,400 beneficiaries lost coverage when 19 and 20 year olds were made ineligible.
- **North Carolina** dropped coverage for an estimated 51,000 beneficiaries when the state ended transitional Medicaid in 2004.
- In 2003, **Massachusetts** eliminated 36,000 long-term unemployed workers from the Medicaid rolls, and caused another 4,000 to lose coverage when they increased premiums for certain eligible populations. The following year, the state further increased premiums and capped enrollment among other changes, causing 4,400 more people to lose coverage.¹⁶

The impact of these cuts has been immediate and dramatic at health centers in each of these states, and in many others. Each of the states mentioned above reported a decline in the total number of Medicaid beneficiaries served by health centers relative to all patients between 2002 and 2003 or 2003 and 2004. As Table 2 below shows, more than 50% of health centers in 9 states experienced a drop in Medicaid patients, while between 30 and 50% of health centers in

another 21 states lost Medicaid patients. Losses in health center Medicaid beneficiaries do not translate into fewer patients, but rather higher rates of uninsured patients seen at health centers.

Table 2
States with Declines in Number of Health Center Patients with Medicaid, by
Percent of Grantees Experiencing Declines, 2003-2004

<30% of Health Center Grantees	30-50% of Health Center Grantees	Over 50% of Health Center Grantees
Hawaii	Alaska	Alabama
Iowa	Arizona	Delaware
Illinois	Arkansas	Minnesota
Indiana	California	Mississippi
Kansas	Connecticut	New Mexico
Kentucky	Colorado	North Carolina
Louisiana	Florida	Ohio
Maine	Georgia	Oklahoma
Maryland	Massachusetts	Tennessee
Missouri	Michigan	
Montana	Nebraska	
New Jersey	New York	
New Hampshire	Oregon	
Rhode Island	Pennsylvania	
Virginia	South Carolina	
Washington	South Dakota	
Wisconsin	Texas	
	Utah	
	Vermont	
	West Virginia	
	Wyoming	

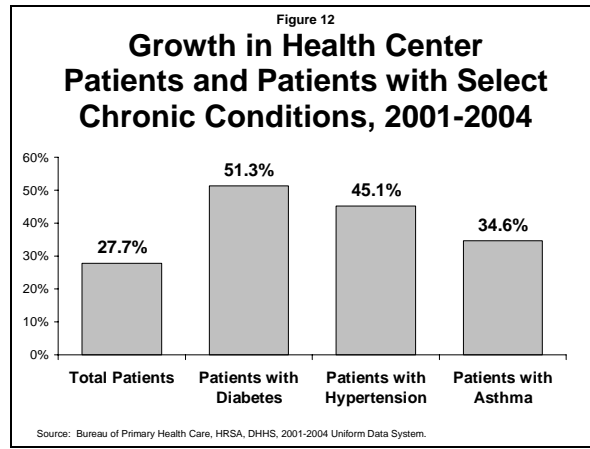
Source: Bureau of Primary Health Care, HRSA, DHHS, 2003-2004 Uniform Data System.

Chronic Conditions

Health centers are important providers of care for individuals with chronic illness, such as diabetes, hypertension, and asthma. In fact, recent research has documented that the proportion of visits for people with chronic illness grew between 1994 and 2001,¹⁷ likely because older adults ages 45-64 make up the fastest growing age group at health centers.

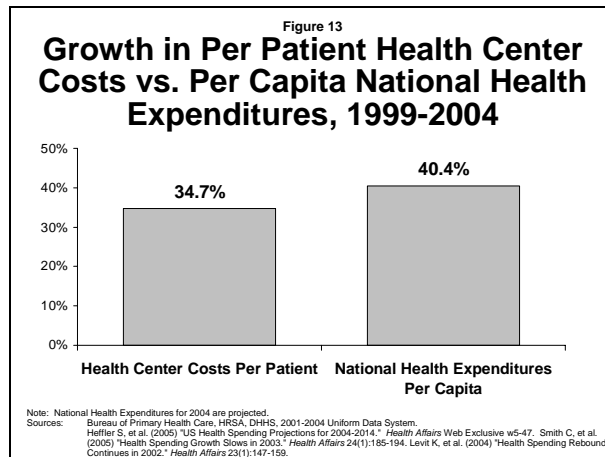
Nationally, 26% of all health center medical encounters are for chronic diseases, including asthma, diabetes, hypertension, HIV/AIDS, and mental health and substance abuse conditions. A significant and growing number of health center patients have chronic illness. Health centers treated over 775,000 patients with diabetes (6.7% of all medical patients), over 230,000 patients with heart disease (2.0% of all medical patients), nearly 1,260,000 patients with hypertension (10.8% of all medical patients), and nearly 420,000 patients with asthma (3.6% of all medical patients) last year. Health centers also served over 400,000 patients with depression, making up 3.1% of all patients. Figure 12 below demonstrates that the number of patients with diabetes, hypertension, and asthma grew faster than total patients between 2001 and 2004. Moreover, the percent of patients with diabetes and hypertension has increased slightly over the

last few years. These related patients visits make up a significant proportion of total patient visits and are costly to treat.



Cost of Care

The cost of care at health centers is comparable to or even less than private, office-based physicians, even as they provide high quality care¹⁸ to a growing number of patients. Between 2003 and 2004 alone, costs per patient rose 5.3% while patients rose 5.9%. However, between 1999 and 2004, costs per patient grew slower than national health expenditures per capita over the same period, as displayed by Figure 13 below. Thus, health centers have kept costs down where they can.

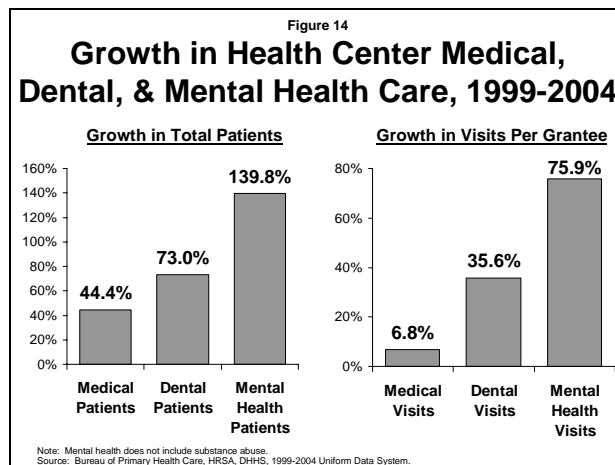


The rising cost of care at health centers generally stems from three factors: rising costs of delivering health care, an increasing and disproportionately medically vulnerable patient population, and an increase in the number and type of services that health centers offer. Soaring health care costs can be observed in every health care sector, and health centers are not sheltered from this reality. Per capita spending for insured adults will grow 7.4% annually from 2002 to 2013, while personal income will only grow by 4.6% each year. This dynamic is directly related to growing numbers of uninsured as they are being increasingly priced out of affordable health

care coverage.¹⁹ But the cost of care is a central issue for health centers, where patients are more at risk than the general population, and require a more intensive level of care.²⁰ While a typical 15 minute office visit may be appropriate for the average American, health center patients may require more face time with clinicians, as well as time with case managers, health educators, and health insurance enrollment specialists.

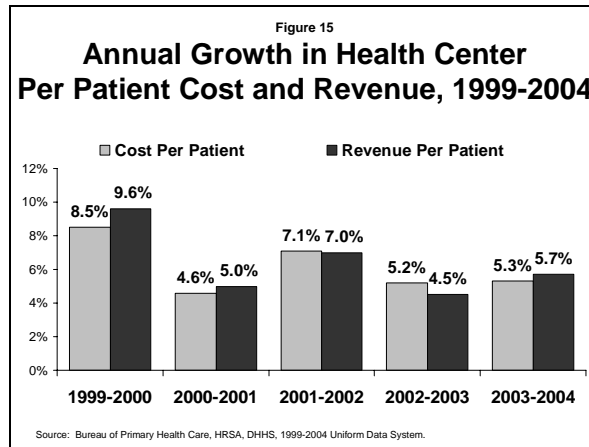
More and more health centers are offering services that go above and beyond traditional primary care. For example, last year, 71.1% of federally funded health centers provided preventive dental care and 66.4% provided restorative dental care onsite – up from 69.6% and 58.3% respectively during 1999. Because new health centers are now required to provide these services onsite, these rates will continue to rise significantly. More health centers are also providing mental health treatment and counseling onsite, growing to 72.2% of all health centers from 53.8% in 1999. Without health centers, medically underserved patients would most likely be unable to access or afford such services from other providers. More importantly, by offering a full range of health care services in one location, health centers make it easier for at risk and working populations to access them.

More telling than the percentage of health centers that provide these services is the growing number of patients who rely on them and are seeking them out, as Figure 14 below demonstrates. While the number of patients using medical services rose 44.4% between 1999 and 2004, the number using dental services and mental health grew by 73.0% and 139.8%, respectively. Although medical visits make up the bulk of all health center visits, the number of medical visits per health center grantee grew 6.8% since 1999, while the number of dental visits per grantee grew 35.6% and mental health visits per grantee grew 75.9%.

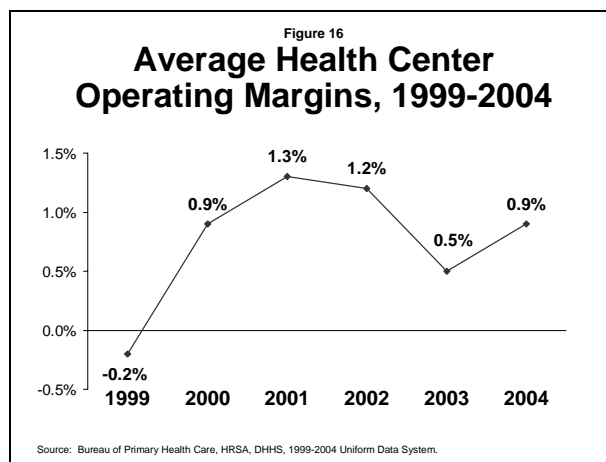


Health Center Costs and Revenue

While health center cost per patient generally rise about as much as revenue per patient each year, cost per patient grew faster for two of the last three years (Figure 15).



While health centers on average have been able to generate enough revenue to cover their costs, operating margins have remained low, as seen in Figure 16. Even as non-profit health care providers, health centers rely on these margins to ensure financial stability. Any surplus – which tends to be negligible in comparison to costs or revenue – can be used to care for more uninsured patients in the following year, or to cover the costs related to unexpected events, such as public health outbreaks or natural disasters and even disaster preparedness. Over the last few years, health centers’ operating margins on average have tended to hover around 1%, though margins were half this rate in 2003. In fact, around two in five federally-funded health centers reported operating deficits last year. This compares to 36% of hospitals experiencing negative operating margins in 2003.²¹ Almost 15% of centers had operating deficits exceeding 10% of their revenue. These health centers with zero or negative margins had higher growth in the number of low-income (7.2% vs. 6.8%) and uninsured patients (8.7% vs. 6.0%) than centers that reported positive margins. Moreover, they tend to collect less from Medicaid, Medicare, and other public insurance programs, as will be discussed later.



It is important to note that health center operating margins are often lower than other provider types. For example, hospital operating margins were 3.3% in 2003.²² At such low operating margins, a single unexpected event – a disease outbreak, or a hurricane, snowstorm, or power outage alone – could easily put a health center in deficit, thereby threatening its ability to

provide comprehensive care for its community. In fact, last year the average annual surplus equaled less than half a week's revenue.

Health Center Third Party and Other Collections

As depicted in Figure 17, the proportion of patients with Medicaid is similar to the proportion of health center revenue received by Medicaid. The same cannot be said for Medicare or private insurance, as described below.

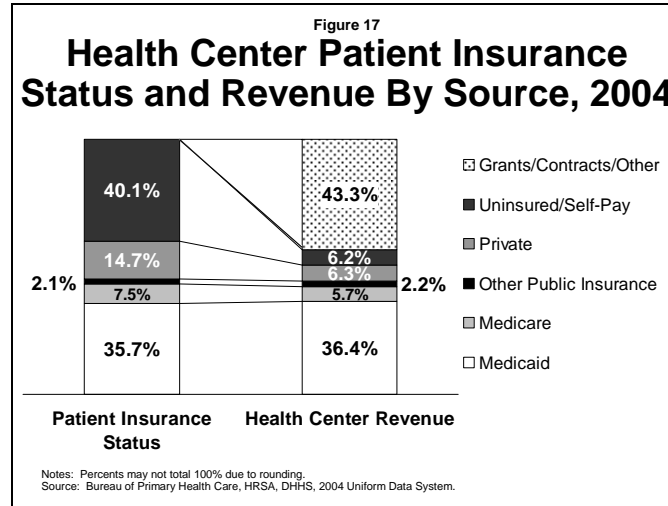
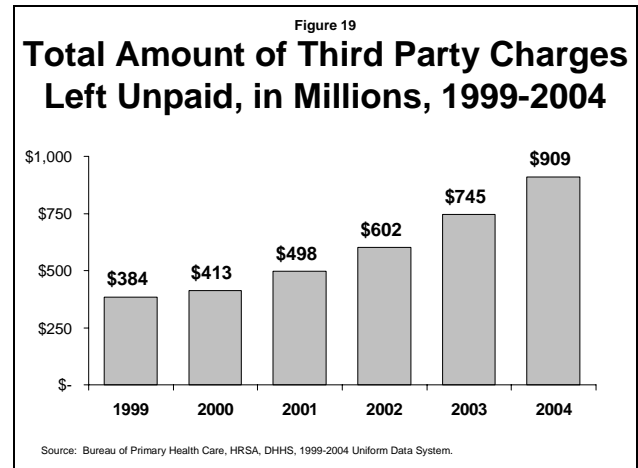
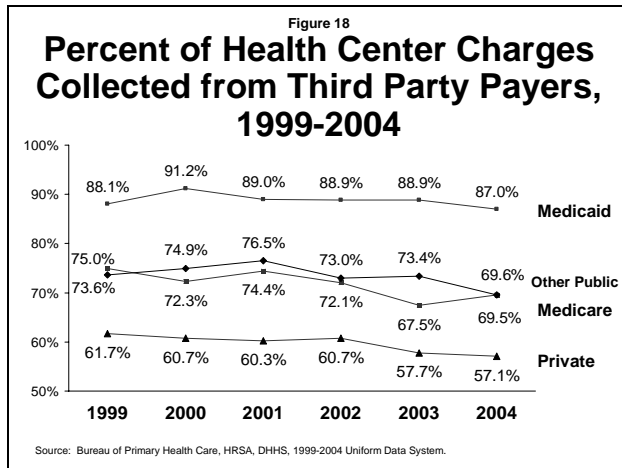


Figure 18 below displays the percent of charges health centers collect from third party payers since 1999. Clearly, Medicaid is the best and most reliable payer, covering 87% of charges in 2004. Enhanced Medicaid payments to health centers through a Prospective Payment System (PPS) as the law requires has helped ensure that health centers' grant revenues are dedicated to care for the uninsured. Private insurance is the least reliable payer, indicating the exceedingly limited coverage and likely high cost-sharing levels that characterize the types of private insurance coverage held by low-income individuals generally. While nationally the percent of patients with private insurance stands at around 15%, many health centers have far higher proportions of such patients. While Medicare insures 7.5% of health center patients, the percent of charges that Medicare pays has been decreasing over the last few years as a result of a payment cap that affects an ever-increasing number of health centers. More than 85% of all health centers are reimbursed at the Medicare payment cap, which fails to keep up with the cost growth of health care spending. In the aggregate, health centers are still faced with a substantial amount of charges left unpaid, amounting to over \$900 million in 2004, up 137% since 1999 (Figure 19).



Of major significance is the relationship between third party collections and operating deficits. As Table 3 below demonstrates, those with negative or zero margins on average collect less from Medicaid, Medicare, and other public insurance programs. Whereas health centers with positive margins collect on average 94.4% of Medicaid costs, 75.6% of Medicare costs, and 74.8% of other public insurance costs, health centers with negative or zero margins collect only 77.5%, 62.1%, and 62.5% of costs, respectively. For both categories of health centers, private insurance remains the worst payer, paying each category about equally. Given that Medicaid is the largest source of revenue for health centers nationally, adequate payments are related to health centers' financial health.

Table 3
Percent of Third Party Charges Collected By Health Centers with Positive and Negative Operating Margins, 2004

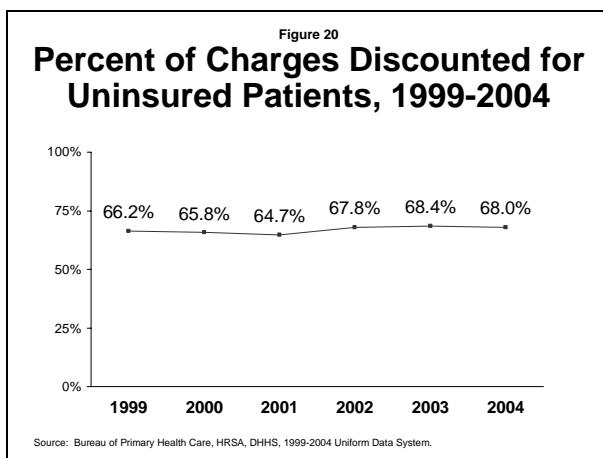
	Medicaid Collections	Medicare Collections	Other Public Collections	Private Collections
Positive Margins	94.4%	75.6%	74.8%	57.6%
Negative and Zero Margins	77.5%	62.1%	62.5%	56.4%
Health Center Average	87.0%	69.6%	69.5%	57.1%

Source: Bureau of Primary Health Care, HRSA, DHHS, 2004 Uniform Data System.

The percent of charges collected by health centers also varies by state. Last year, nine states (**Arizona, Connecticut, Illinois, Indiana, Nevada, New Jersey, New Hampshire, New York, and Wisconsin**) and the District of Columbia collected less than 60% of Medicare charges, with two of these states collecting less than 50%. Regarding private insurance, nine states (**Connecticut, Indiana, Louisiana, Maryland, Nevada, New Jersey, New York, Oklahoma, and Texas**) and the District of Columbia collect under 50% of charges. Reasons for failure to pay more include lack of coverage for certain services, high deductible and co-payment levels, and delayed payments, all of which threaten a health center's financial health and ability to serve patients.

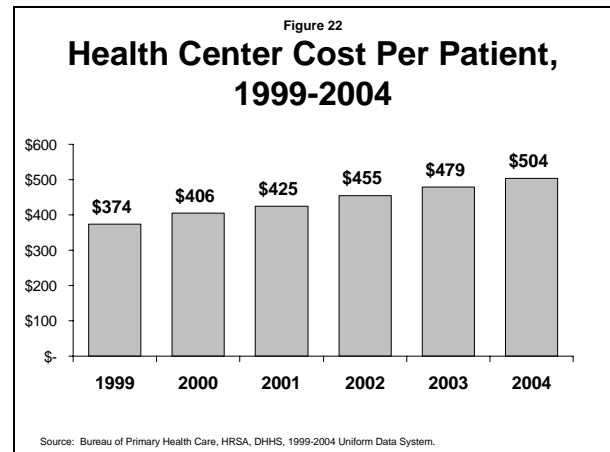
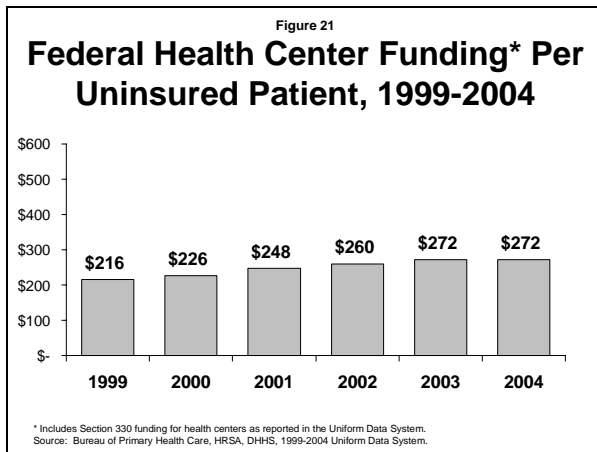
Last year, seven states (**Arizona, Illinois, Massachusetts, Minnesota, New Jersey, North Dakota, and Wisconsin**) collected less than 75% of Medicaid charges, with one state collecting less than 60%. Potential reasons for below average collections are similar to those listed for Medicare and private insurance, and may also include the fact that providers are not able to bill Medicaid for multiple visits on the same day. In addition, some state PPS rates may not adequately cover Medicaid services delivered to health center patients. The General Accountability Office (GAO) recently concluded that PPS rates in at least one-third of all states may not include all Medicaid-covered health services, and that many states have not created a process for rebasing PPS based on a change in a center’s scope of services, nor even specified what constitutes a change. That many states are using alternative methodologies in as a substitute for PPS has not ensured that their payments to FQHCs are at least equal to the amount they would have received under PPS. These three issues reflect a lack of adherence to the PPS law. Moreover, the GAO determined that neither the Medicare Economic Index (MEI), which is currently used to adjust PPS rates for inflation, nor any other existing inflation index, accurately reflect FQHC services and therefore does not constitute as an “appropriate” index. For instance, the GAO found that total costs per patient visit increased approximately 5 to 6% annually between 2001 and 2003, whereas the MEI increased only about 2 to 3% over these years.²³

Even as they struggle under the burden of unpaid charges, health centers provided almost \$1.6 billion in uncompensated care (both sliding fee discounts and bad debt) in 2004, *double* the amount provided in 1999. Figure 20 below illustrates that nearly 70% of all charges to uninsured patients are discounted on a sliding scale. This is related to the high percentage of low-income uninsured patients who rely on health centers for their care. Given the growing numbers relative to all patients of these patients, the percent of charges discounted for uninsured patients may continue to rise. These discounts exceed 80% of charges at 199 health centers (21.8% of all centers).



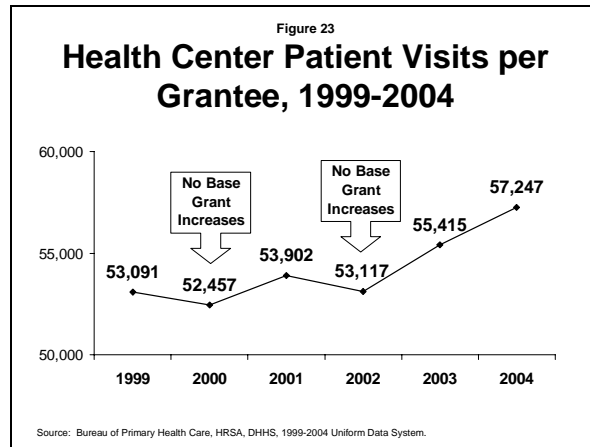
Adequate payments from third-party insurers are critically important to the financial stability of health centers. For instance, enhanced Medicaid reimbursement has allowed health centers to dramatically increase the number of uninsured people they serve because they have been able to maximize federal grants for uncompensated care. However, as vital as federal grants for the uninsured are, between 1990 and 2002 the number of uninsured health center

patients more than doubled while federal health center grants grew by only 65% in real dollar terms.²⁴ Figures 21 and 22 demonstrate that federal health center funding per uninsured patient has not kept up with the cost per patient. In fact, the gap has widened over the last few years. State and other funding for health centers plays a vital role in filling this gap. Yet, 17 states slashed direct funding for health centers in state fiscal year 2004, and seven states did so during the current fiscal year. The losses in these states amounted to \$40 million in 2004 and \$14 million in 2005.



Adverse Impacts of Health Center Closings

Medicaid erosion and further erosion of other revenue sources threaten the ability of health centers to meet the health care needs of their communities. This could eventually lead to financial insolvency, despite the fact that thousands of communities depend on them. Should a health center be forced to close, an entire community would be adversely affected by the termination of valuable public health services, such as immunizations, and the prospect of rising health care costs as a consequence. Already the percentage of Americans with a usual place to go for care and the percentage who assess their health as excellent or very good are on the decline.²⁵ Thus, cuts in Medicaid that negatively impact centers are, in fact, pennywise and pound foolish, and access to primary care is important for the entire health care system. Even a small drop in revenue affects health centers' ability to serve more patients. As the figure below depicts, since the expansion initiative health centers have increased the number of visits per grantee. Yet during the two years that existing health centers did not receive base increases in their federal operating grants, average patient visit capacity declined.



Health centers have proven to be an effective solution to the multiple and often complex barriers to health care, and as such often stand as the only accessible and available primary provider in a community. Private, office-based physicians generally do not locate in low-income areas where health care services are severely lacking. Moreover, only half of physicians are willing to accept all new Medicaid patients, and one-fifth are not accepting any.²⁶ The lack of doctors or providers willing or able to care for vulnerable or medically underserved populations remains a critical access problem in the U.S. Access to health care is a critical component of public health. Indeed, mortality levels are linked to the availability of primary care physicians.²⁷ Beyond and distinct from the number of available physicians, other barriers to care still exist, especially for those needing transportation, case management, translation, and other specialized services to facilitate health care use. Such services are especially important for certain populations, such as the homeless, agricultural farmworkers, and rural residents. Health centers were designed to overcome the inaccessibility of care resulting from all such factors.

Another major impact of diminished health center services is worsening disparities. Having a place to go for regular primary care is crucial for patient health outcomes and helps to counter the impact poverty has on public health.²⁸ Racial and ethnic health disparities in health status do not exist among health center patients even after controlling for socio-demographic factors.²⁹ Moreover, health centers are associated with reducing disparities at the state level. A recent landmark report found that as health centers serve more low-income individuals in a state, the state's black/white and Hispanic/white health disparity narrows (i.e., declines) in such key areas as infant mortality, prenatal care, tuberculosis case rates, and age-adjusted death rates. Furthermore, Medicaid alone has little direct impact on health disparities.³⁰ Closing a health center may well exacerbate health care disparities among the community formerly served, regardless of insurance status.

Financial instability that would force a health center to close would likely also lead to higher use of local hospital emergency departments (EDs). This would further undermine the community safety net as rising ED utilization among the uninsured would have a ripple effect on the financial stability of local hospitals. Several studies show that low-income, minority, uninsured, and Medicaid patients – the very patients health centers serve – have higher incidences of preventable hospitalizations,³¹ yet health center patients are less likely to be hospitalized or use the ED.³² In fact, uninsured people living within close proximity to a health

center are less likely to have an unmet medical need, to have postponed or delayed seeking needed care, and to have had an ED visit and a hospitalization compared to other uninsured.³³ Thus, health centers play a vital role in reducing the unnecessary or inappropriate use of community EDs.

Methodology Notes

Much of the underlying data analyzed in this report is taken from the federally-funded health centers' annual Uniform Data System (UDS) reports to the federal government. UDS reports are not the same as audited financial statements, and there may be some differences between the two. However, the UDS reports are filed annually by all individual health centers with the federal government, each covering a calendar-year period and containing uniform and comparable data on health center operations, and thus represent the best available information on operations we have from all health centers on a consistent nationwide basis. In the past, the closing of a health center or health center site has been a rare event. Yet it is important to recognize the compounding factors that currently threaten health centers' ability to meet the needs of underserved communities. These same factors also affect other safety net providers.

Conclusion

As the intersection between poverty and health care, health centers are the litmus test – the “canary in a coal mine” – that signal the health of the nation's safety net. Health centers are only just surviving financially, and continue to experience rising numbers of uninsured, low-income, and chronically ill patients while revenue is unstable and volatile. These financial pressures are occurring against a backdrop of more serious trends in the health care marketplace – skyrocketing health care costs, fewer choices for consumers, and rising numbers of uninsured and underinsured people – affecting Americans of all income levels.

Nevertheless, Congress and national leaders are considering proposals that could dramatically restructure Medicaid, amid a cross current of Medicaid changes sweeping the states in an effort to balance budgets. A diminished Medicaid would have a devastating impact on the financial health of all safety net providers and the health of their patients. Already health centers and patients have been affected by Medicaid cuts implemented in some states. Changing health centers' payer mix would threaten their role as high quality and cost effective providers. While no payer covers 100% of charges, Medicaid is still most reliable payer and has helped propel health center growth in recent years. When states change Medicaid to increase cost sharing and reduce benefits, they change the program to look and pay more like private health insurance – the worst third-party payer. Cuts in Medicaid benefits and enrollment, coupled with a loss of Medicaid's cost-related payment rates for remaining beneficiaries, could mean a direct hit of almost 20 percent on a typical health center's budget. No amount of short-term funding infusion could help a health center overcome this long-term structural abandonment of its financing base.

Medicaid erosion, coupled with further attrition of other revenue sources, poses the most direct threat to the ability of health centers to meet the health care needs of their communities.

The prospect of financial insolvency among health centers carries enormous consequences for public health. Should a health center be forced to close, an entire community would be affected, as its former patients flood emergency rooms because other sources of low-cost and high-quality primary care may not be available. Not only would the community's health be worsened, but the overall cost of care in the community would likely increase as a result. Even as Congress and the Administration plan to increase funding to support new health centers, sustaining diverse and dependable revenue streams for all health centers is essential if the program is to survive and continue its role in helping to meet the nation's most pressing health care needs.

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¹¹ Gilmer and Kronick, 2005.

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¹⁶ Ku and Nimalendran, 2003.

¹⁷ O'Malley, et al., 2005.

¹⁸ Falik, et al., 2001. Starfield, et al., 1994. Stuart and Steinwachs, 1993.

¹⁹ Gilmer and Kronick, 2005.

²⁰ Fiscella, K. & Williams, D. R. (2004). Health disparities based on socioeconomic inequities: implications for urban health care. *Academic Medicine*, 79, 1139-1147.

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