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The Fundamentals of Community Health Centers

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OVERVIEW — *This background paper examines the dominant model of federal grant funding for primary care in the health care safety net: the community health center. It describes the history of the health center program and highlights key policy issues influencing health centers, such as Medicaid payment policies and medically underserved area designations. The paper also examines the recent presidential initiative to expand health centers, including a review of the process used to identify new grantees, an assessment of remaining gaps in capacity, an exploration of continuing challenges, and a discussion of unresolved policy questions.*

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The Fundamentals of Community Health Centers

About 45 million Americans were uninsured at some point in 2003 and millions more lacked access to care, even if they had public or private health insurance. For the millions without health insurance, getting care means seeking out providers who are either personally committed or legally required to provide services regardless of a patient's ability to pay. Those with only catastrophic coverage or with Medicaid coverage sometimes find it challenging to identify a provider who will accept their insurance.

The health care professionals who are willing to provide care to the uninsured and underserved form a loosely knit, frayed, and often torn group that is called the health care safety net. It consists of a mix of people and institutions that includes hospital emergency departments, public hospitals, community health centers, free clinics, and private physicians' offices, among others. Its financing is equally varied and reflects a range of funding sources, such as federal, state, and local expenditures through Medicaid, including the disproportionate share hospital (DSH) program; federal community health center grants; and philanthropic contributions. Although they represent only one component of the health care safety net, health centers are often seen as a pivotal player in this complex web of providers and financing mechanisms.

WHAT IS A COMMUNITY HEALTH CENTER?

The history of federal involvement with today's community health centers is integrally tied to the Johnson administration's War on Poverty and the civil rights movement. Initially named neighborhood health centers, these clinics were created in 1965 as part of the Office of Economic Opportunity (OEO) to provide health and social services access points in poor and medically underserved communities and to promote community empowerment. Consistent with the community empowerment philosophy, federal funds for neighborhood health centers flowed directly to nonprofit, community-level organizations, bypassing state governments. The original centers were designed and administered with significant community involvement to ensure they remained responsive to community needs. Funding was approved in 1965 for the first two neighborhood health center demonstration projects, which opened in a public housing project in Boston in 1965 and in Mound Bayou, Mississippi, in 1967. Although the Medicaid and Medicare programs were created around the same time, these new health insurance programs were not integrated with the neighborhood health centers until at least a decade later.¹

In the early 1970s, prior to the dissolution of OEO, the health centers program was moved to the Department of Health, Education, and Welfare (HEW). At this stage, a precursor migrant health program that had been established by the Kennedy administration became part of the neighborhood health centers program. HEW has since become the U.S. Department of Health and Human Services (DHHS). Within DHHS, the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) currently administers the program. In 1975, Congress authorized neighborhood health centers as “community and migrant health centers”;² subsequent authorizations added primary health care programs for residents of public housing and the homeless. The Health Centers Consolidation Act of 1996 combined these separate authorities (community, migrant, homeless, and public housing) under §330 of the Public Health Service Act (PHSA) to create the consolidated health centers program.³ Health center grantees are often called 330 grantees because of this statutory authorization. Most recently, the Health Care Safety Net Amendments of 2002 reauthorized the consolidated health centers program through fiscal year (FY) 2006.

Federal Grant Requirements

Although the legislative authority for the health center program has evolved somewhat over the last 30 years, in the most fundamental ways the program remains true to its founding philosophy. To receive §330 grant funds, a clinic must meet certain statutory requirements. It must:

- Be located in a federally designated medically underserved area (MUA) or serve a federally designated medically underserved population (MUP).
- Have nonprofit, public, or tax exempt status.
- Provide comprehensive primary health care services, referrals, and other services needed to facilitate access to care, such as case management, translation, and transportation.
- Have a governing board, the majority of whose members are patients of the health center.
- Provide services to all in the service area regardless of ability to pay and offer a sliding fee schedule that adjusts according to family income.⁴

The requirement that a majority of board members be health center patients makes these clinics unique among safety net providers and is designed to ensure that the centers remain responsive to community needs. It generally prevents health centers from being part of a larger enterprise, such as a hospital, local government,⁵ or religious order. Health centers that exclusively serve migrants or homeless patients do not have to meet the majority consumer board requirement, nor do health centers in frontier areas.⁶

Although the health centers’ statutory consolidation created a single legislative authority for health center grants, the 330 grant program is

The requirement that a majority of board members be health center patients makes these clinics unique among safety net providers.

subdivided into separate grant competitions for community, migrant, public housing, and homeless health centers, thereby allowing communities to tailor applications to their particular needs. HRSA has also funded some school-based health centers, even though the agency does not have an explicit authority to fund school-based programs.

The 2002 health center reauthorization required that grants be awarded for FY 2002 and beyond in such a way that maintains the proportion of the total appropriation awarded to migrant, homeless, and public housing applicants as in FY 2001.⁷ In general, about 80 percent of funding is awarded to community health centers with the remaining 20 percent divided across migrant, public housing, homeless, and school-based centers.

The 330 grant program has grown significantly, both in number of grantees and funding level, since health centers were first funded in 1965. In 2003, 890 federally funded health center grantees provided care at 3,600 comprehensive health care delivery sites to over 12.4 million patients.⁸ For fiscal years 2003 and 2004, federal grant funding for the consolidated health centers program totaled \$1.47 billion and \$1.57 billion, respectively. It is important to note, however, that health center budgets consist of a variety of funding sources; federal grant funds constitute only one-quarter of overall health center revenues.

Because the intent of health center grants is to fund direct services, HRSA has always limited the amount of grant dollars that could be used for capital-related purposes. From 1978 to 1996, the health center statute allowed health centers to use grant funds for construction, renovation, and acquisition and to purchase equipment. In 1996, however, Congress revised the statute to prohibit the use of grant funds for construction; the statute still allows the use of grant funds for acquiring and leasing buildings, minor renovation, and equipment purchase or leasing.

HRSA currently allows grantees to use up to \$150,000 from their first year's budget on activities associated with equipment or capital alteration. HRSA also offers a loan guarantee program to grantees and funds a nonprofit organization to assist health centers in accessing capital resources. Although no published data exists to quantify the impact of these statutory and administrative limitations, anecdotal accounts suggest that health centers struggle to access capital funding to address aging or outgrown structures and equipment, as well as the costs of moving to electronic health records, among other things.

Federal Payment Policy

Though 330 grant funding is important to health centers, federal reimbursement policy under the Medicaid program is perhaps even more critical to centers' continued viability. In 1989, Congress created the Federally Qualified Health Center (FQHC) program in response to concerns that health centers were using 330 grant funds, intended to support care for

the uninsured, to subsidize low Medicaid payment rates. The FQHC program established a preferential payment policy for health centers by requiring “cost-based” reimbursement for both Medicaid and Medicare. The methodology that resulted paid health centers on the basis of their actual costs for providing care, not by a rate negotiated with the state Medicaid agency or set by Medicare. Congress has subsequently made changes to this cost-based reimbursement policy, which will be discussed later in this paper.

Eligibility for FQHC designation is limited to three types of primary care clinics: (a) those that receive a grant under §330 of the PHS Act (commonly called “health centers”), (b) those determined by the Secretary of Health and Human Services to meet all the requirements for receiving such a grant but do not actually receive grant funding (commonly called “look-alikes”), or (c) those outpatient facilities that are operated by a tribe or tribal organization or by an urban Indian organization.⁹

The Centers for Medicare and Medicaid Services (CMS) is responsible for administering FQHC payment policy. However, HRSA determines FQHC eligibility for 330-funded health centers and look-alikes, and the Indian Health Service determines eligibility for tribal and urban Indian programs. About 80 percent of FQHCs are 330-funded health centers, 10 percent are look-alikes, and 10 percent are tribal or urban Indian facilities. As of August 2004, over 900 health center grantees, 93 look-alikes, 79 outpatient tribal health organizations, and 19 urban Indian health facilities were qualified FQHCs.

The Rural Health Clinic (RHC) is another type of clinic that receives cost-based reimbursement from Medicaid and Medicare but is not an FQHC. This designation was created by Congress in 1977¹⁰ to facilitate payment to clinics staffed substantially by nurse practitioners and physicians assistants and located in federally designated rural areas with limited access to primary care services. RHCs differ from FQHCs in significant ways. For example, RHCs can be for-profit; can be part of a Medicare participating hospital, skilled nursing facility, or home health agency; and are *not* mandated to provide care to everyone regardless of their ability to pay. RHCs do serve some Medicaid and uninsured patients, but the majority of their patients are covered by Medicare or private insurance.¹¹ The rules governing cost-based reimbursement for RHCs also differ from those governing FQHCs, and a clinic cannot be dually designated as both an RHC and FQHC.

The federal terminology (see sidebar) for describing primary care sites can be confusing and may not be operative at the community level. Community leaders

Terminology

Community Health Center or Health Center:

An outpatient clinic that receives grant funds from the federal government through §330 of the Public Health Service Act (PHSA).

Look-alike: An outpatient clinic that meets all requirements to receive §330 grant funds but does not actually receive a grant.

Rural Health Clinic: An outpatient clinic that may be for profit, is located in a rural HPSA or MUA, and uses nurse practitioners and physician assistants to provide the majority of care.

Tribal or Urban Indian FQHC: An outpatient clinic or program operated by a tribe or tribal organization or by an urban Indian organization.

may refer to their hospital-based outpatient facility—which does not receive 330 funds and is not designated as either an FQHC or RHC—as a “health center.” For the purposes of this paper, however, the term health center is reserved for clinics that receive 330 grant funds. References to FQHCs and other types of clinics will be appropriately qualified.

WHERE ARE HEALTH CENTERS LOCATED?

Health centers are located in all 50 states, the District of Columbia, and the territories and commonwealths. In 2003, there were 890 health center grantees who provided services through 3,600 comprehensive health care delivery sites. The statute requires that grants be awarded in a way that ensures rural populations receive no less than 40 percent or no more than 60 percent of total grants awarded.¹² Applicants for grant funds self-declare their rural status, and in 2003 about 50 percent of the 890 grantees were in rural areas. Because site-level data is not available, it is unclear how many of the 3,600 health center sites are rural versus urban.

By definition, health centers must be located in federally designated MUAs or serve federally designated MUPs. A community or facility must be proactive and seek out the designation by contacting the state primary care office, which submits an application to HRSA. Applicants must define a rational service area, which is typically a county, a group of contiguous counties within 30 minutes’ travel time of each other, a portion of a county depending on market and transportation patterns, or a neighborhood in a metropolitan area defined by its homogeneous socioeconomic and demographic characteristics.¹³

The criteria for designating a community as medically underserved are designed to capture community need from a variety of perspectives including: existing primary care capacity, health status, economic vulnerability, and demand for care. These dimensions of need are quantified in the Index of Medical Underservice (IMU), which is calculated from four data variables:

- Ratio of primary medical care physicians per 1,000 population
- Infant mortality rate
- Percentage of the population with incomes below the poverty level
- Percentage of the population age 65 or over

The four variables are weighted with the most emphasis placed on the primary care provider-to-population ratio. The other variables receive decreasing weights, in the order listed above. These weighted variables are converted into a IMU score from 1 to 100. An IMU score of 62 or lower qualifies the applicant as an MUA/MUP. HRSA does allow some flexibility in the designation process, however. Governors may request designation of a part of their state as an MUA/MUP if it does not meet the 62 IMU score threshold but can still demonstrate significant barriers to care.

WHOM DO HEALTH CENTERS SERVE?

In general, health centers serve a low-income, predominantly female, relatively young population. Ninety-three percent of patients are under age 65. However, the percentage of older working-age adults (45 through 64) seeking care at health centers has been growing in recent years (Figure 1). The health center population is also racially, ethnically, and linguistically diverse; almost two-thirds of health center patients are members of racial or ethnic minority groups, and 30 percent of patients are best served in languages other than English (Figure 2).

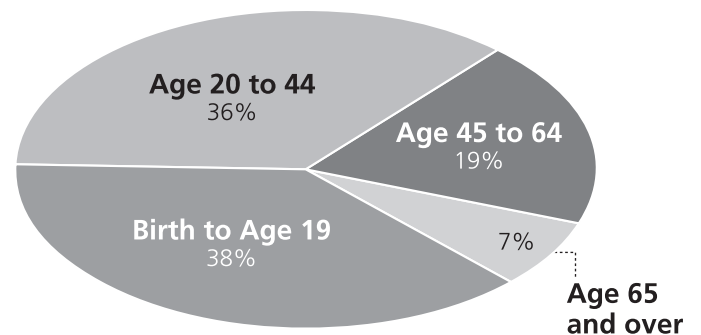
Health centers also serve a mostly low-income population. In 2003, 69 percent of health center patients lived at or below 100 percent of the federal poverty level and 90 percent lived at or below 200 percent of the federal poverty level.¹⁴ Health center patients are also much less likely than the general population to have an insurance source and, when insured, they rely heavily on public insurance programs like Medicaid. In 2003, health centers served about 5 million uninsured patients, just over 10 percent of the estimated 45 million uninsured people nationwide.

Aggregate information on health center patients, staff size and composition, utilization, financing, and other characteristics is available through the Uniform Data System (UDS) on a calendar year basis. All health centers are required to submit such data electronically each year to HRSA's contractor who maintains the UDS. Data is available at the grantee level, not at the level of a grantee's individual delivery sites, limiting its utility to some extent. Look-alikes and tribal FQHCs do not currently participate in the UDS, and as a result much less information is available about their patient populations and practices.

WHAT SERVICES DO HEALTH CENTERS PROVIDE?

The ambulatory care services offered by health centers reflect the diverse needs of the population they serve. The combination of a young and predominantly female patient population (59 percent) creates a high demand for obstetric/gynecologic, family practice, and pediatric services. Because of the combination of low incomes, linguistic barriers, and often poor health status, health center patients require access to comprehensive primary care as well as enabling services. Health centers are unique among primary care providers for the array of enabling services they offer, including case management, translation, transportation, outreach, eligibility assistance, and health education.

FIGURE 1
Health Center Patients by Age Group, 2003



Source: Uniform Data System (2003), table 3A from "Calendar Year 2003 Data: National Rollup Report."

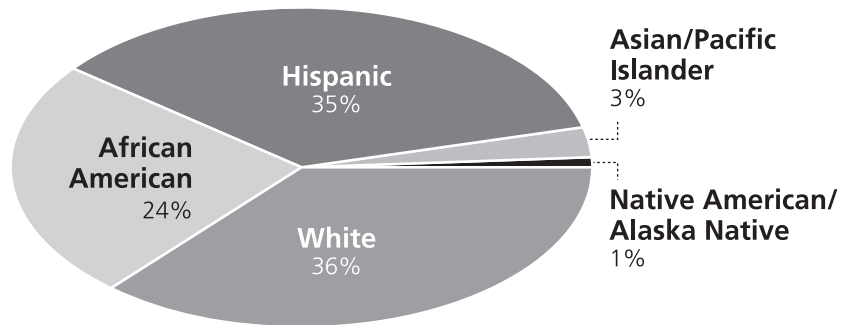
Although patients served by health centers tend to be young, their incidence of chronic conditions, like diabetes and hypertension, is disproportionate in comparison to the general population. As a result, health centers commit significant resources to managing these chronic conditions.

In many areas, health centers are the sole providers of dental, mental health, and substance abuse services for medically underserved individuals and families. Close to 75 percent of health center grantees provide preventive dental services at one of their sites. Seventy percent provide mental health treatment and counseling, and 50 percent provide substance abuse treatment and counseling on-site. In cases where health centers do not offer services on-site or where demand exceeds on-site capacity, referrals are made to other providers and the health center pays for those services some of the time.

About one-third of health centers have a licensed pharmacy staffed by a pharmacist either in-house or through a contractual arrangement with a local pharmacy. Sixty percent of health centers rely solely on their physicians to dispense prescription drugs. Federal and manufacturer-sponsored programs exist to help health centers make affordable prescription drugs available to their patients. Health centers, look-alikes, tribal FQHCs, and RHCs, among other provider types, can receive significant discounts on outpatient prescription drugs through the federal 340B discount drug program. Drug manufacturers are statutorily required to participate in the 340B program in order to have their drugs reimbursed by Medicaid. HRSA administers the 340B program and contracts with a "prime vendor" or preferred wholesaler who works with the drug manufacturers to negotiate significant discounts and assists entities participating in the 340B program in receiving their orders. In general, 340B drug prices have been found to be about 50 percent of the average wholesale price (AWP).¹⁵

Just over half of health center grantees take advantage of the drug discounts available through the 340B program. It is not entirely clear why more health centers do not participate in the program. There appears to be confusion about the extent to which health centers are allowed to rely on contractual arrangements with local pharmacies versus creating in-house pharmacies, a more expensive undertaking. HRSA maintains that contracted pharmacies have always been allowed, but health centers did not seem to know this was an option until the last few years. There appears to be growing acceptance of the contractual approach,

FIGURE 2
Health Center Patients by Race and Ethnicity, 2003



Source: UDS, table 3B from "Calendar Year 2003 Data."

which explains the recent uptake in the 340B program among health center grantees. HRSA encourages participation in the 340B program by providing technical assistance to grantees as well as competitively funding grants to establish pharmacy networks across several grantees.

The services offered by an individual health center will likely be customized to the needs of the population it serves. Specialized programs, such as Health Care for the Homeless grantees, will tailor their service offerings to the unique needs of their patients. For example, this type of grantee might utilize mobile vans as a base for service delivery, whereas a community health center is more likely to rely on a traditional structure for their clinic.

WHAT TYPES OF PROVIDERS DELIVER CARE IN HEALTH CENTERS?

Health centers are staffed by a combination of clinical, enabling, and administrative personnel. They are typically managed by a chief executive officer, a chief financial officer, and a clinical director. Depending on the size of the patient population, the clinical staff consists of a mixture of primary care physicians, nurse practitioners, physician assistants, nurses, substance abuse and mental health specialists, dentists, hygienists, and other health professionals.

Health centers face numerous challenges in recruiting and retaining staff. Health centers are located in areas that often do not attract health care professionals; they serve needy, vulnerable patients; and generally they do not have the financial resources to offer competitive salaries. In response, the federal government has developed several programs to help health centers and other providers in underserved communities to meet their workforce needs.

National Health Service Corps Program

The National Health Service Corps (NHSC) provides scholarships and loan repayments to health professionals in exchange for a commitment to practice full-time in a Health Professional Shortage Area (HPSA). The HPSA designation is similar to an MUA or MUP designation, but a HPSA is based solely on a service area's physician-to-population ratio (see text box). NHSC scholarship recipients receive tuition and fees, books, supplies, equipment, and a monthly stipend for up to four years. They must serve one year for every year of financial support received, with a two-year service minimum. Scholarships are awarded to students enrolled in medical schools, nurse practitioner programs, nurse-midwifery programs, physician assistant programs, and dental schools.

The loan repayment program targets already trained health professionals. It is open to the same providers as the scholarship program as well as to dental hygienists, clinical or counseling psychologists, clinical social workers, licensed professional counselors, marriage and family therapists,

Health centers face numerous challenges in recruiting and retaining staff.

HPSA Designation Requirements

To be designated a primary care Health Professional Shortage Area (HPSA), the area must be a rational service area and have a population-to-full-time equivalent primary care physician ratio of at least 3,500:1. Areas with a ratio between 3,500 and 3,000:1 may still be designated as a HPSA if they can demonstrate unusually high need for primary care services or insufficient capacity through existing primary care providers. As with the MUA/MUP designation, communities must be proactive in seeking out a HPSA designation. In 2002, Congress authorized automatic facility HPSA status for all FQHCs and for RHCs that provide access to care regardless of ability to pay. This automatic HPSA designation makes these clinics eligible to recruit from the NHSC program.

and psychiatric nurse specialists. For a two-year minimum service commitment, the NHSC will pay up to \$50,000 of the provider's qualifying educational loans, plus a 39 percent tax assistance payment.¹⁶ In 2003, 731 of the approximately 11,000 full-time equivalent clinical staff in health centers were NHSC assignees.¹⁷

J-1 Visa Waiver Program

Recruiting foreign medical graduates is another way underserved communities (especially rural ones) meet their health care workforce needs. Many foreign medical graduates come to the United States on a J-1 visa to pursue graduate medical education. Upon completion of their residency programs, they are required to return to their country of legal residence for at least two years to share the knowledge and experience they have gained. In some cases, the two-year return home requirement may be waived if an interested government agency (IGA) requests a waiver for the physician.

The J-1 visa-holding physician must have a contract to serve as a full-time, primary care provider for three years in a HPSA or MUA/MUP in order to have the return home requirement waived. A waiver request must be sent by the IGA to the Department of State, who reviews it and forwards it to the Department of Homeland Security (DHS) for final approval. If approved, the J-1 visa converts to an H1B visa. The Conrad 30 Program is a similar program in which state offices of primary care serve as the IGA and may request up to 30 waivers each year per state for J-1 visa physicians to work in HPSAs and MUA/MUPs in their state.

No data are available to quantify the extent to which health centers rely on former NHSC providers or J-1 visas to meet their workforce needs. HRSA recently surveyed health center directors about workforce issues, including gathering information on NHSC and J-1 providers, and expects to release the results in the fall of 2004.

Malpractice Coverage Through the Federal Tort Claims Act

The federal government also supports health centers' ability to secure health care professionals through special malpractice coverage. Until 1992, health centers had to purchase private malpractice insurance to protect themselves from malpractice judgments. That year, Congress brought employees of qualifying health centers under the protective liability coverage provided to federal agencies and employees through the Federal Tort Claims Act (FTCA). In essence, malpractice liability is shifted from the individual health center to the federal government, with the costs paid out of the federal health center program's annual appropriation.

In order to receive FTCA coverage, health centers must apply to HRSA to be designated a "deemed" organization. The deeming process covers credentialing of health center providers, the health center's risk management systems, and the center's past claims history. Once a center is deemed, any officer, governing board member, or employee of the health center is covered by the FTCA.¹⁸ In 2003, 77 percent of health center grantees were deemed under the FTCA.

Each year Congress earmarks a portion of its appropriation for health centers for HRSA's Health Center Judgment Fund to cover the cost of judgments and settlements against health centers. FTCA coverage, unlike private insurance policies that limit the insurer's liability, does not have a monetary limitation for judgments. As of the end of FY 2003, 1,279 claims had been filed against this fund and 224 of them had been paid. Total claims obligations under the program from its beginning in 1993 to the end of FY 2003 were approximately \$79 million, whereas total appropriated deposits were \$95.7 million. Because there is only a slight margin between the aggregate claims payout level and the Judgment Fund balance, a single large settlement could easily bankrupt the Fund.

Claims and payment obligations have risen significantly since the fund's inception and have raised concerns about future funding requirements of the program. Despite these concerns, FTCA coverage has proven cost-effective in providing health centers with malpractice coverage. Had FTCA coverage not been in place, health centers would have spent an estimated \$1.05 billion on malpractice insurance premiums from 1993 to 2003.¹⁹

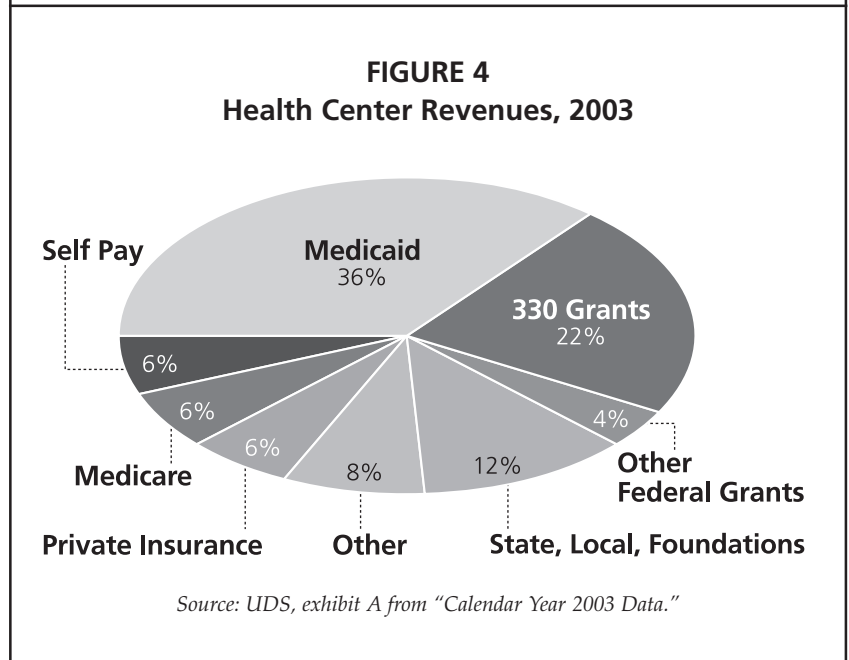
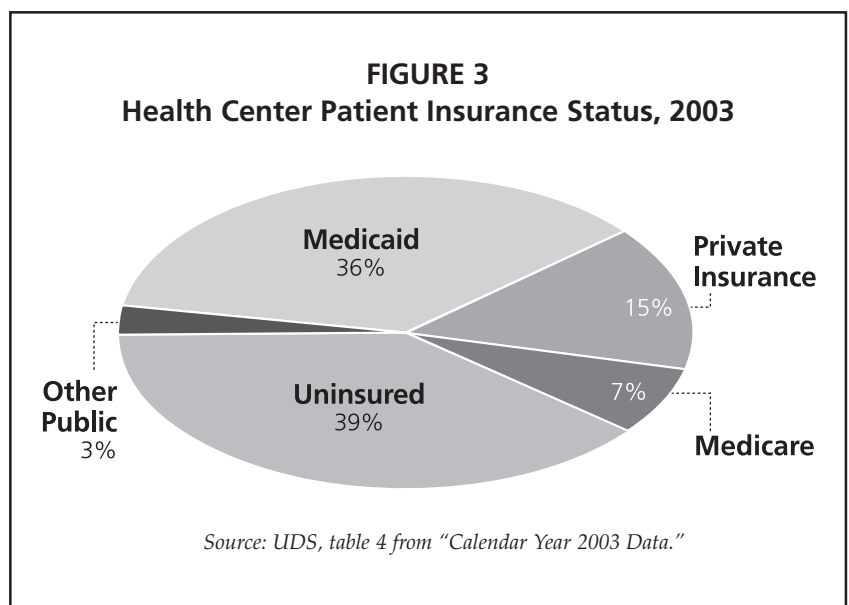
HOW ARE HEALTH CENTERS FINANCED?

Medicaid is the largest source of revenue for health centers, followed by federal grants. Health centers serve about 10 percent of all Medicaid enrollees nationally and, like all other Medicaid providers, were affected by Medicaid's shift to a managed care delivery system in the 1990s. Although the trend created apprehension among health centers and results have been mixed, overall, health centers have adapted to the change. In

2003, 45 percent of health center Medicaid patients were enrolled in managed care plans, about on par with overall Medicaid managed care enrollment of 50 percent (Figures 3 and 4).²⁰

With the advent of Medicaid managed care, health centers were most concerned about losing their Medicaid patient base and the Medicaid cost-based reimbursement that helped them serve the uninsured. Health centers generally lost money in their early experiences of contracting and assuming risk for Medicaid managed care patients, and they struggled to meet many requirements such as providing 24-hour coverage. Much of the centers' losses occurred in states with "1115 waivers" that chose to legally waive cost-based reimbursement for FQHCs under managed care. Recognizing that health centers needed Medicaid payment protections under managed care to stay financially viable and able to serve the uninsured, Congress in 1997 mandated that state Medicaid agencies make a "wrap-around" payment to FQHCs to cover the difference between their costs for providing care and the rates they were receiving from managed care organizations (MCOs).²¹ In many states, these payments were not made in a timely fashion, and health centers resorted to litigation to secure them.

Instead of merely contracting with MCOs, some health centers reacted to the shift to Medicaid managed care by forming their own Medicaid managed care plans.²² This move preserved their patient base and allowed them greater control over the funding stream. Initially, commercial plans dominated the Medicaid managed care market, but many have since exited for various reasons and plans that focus on Medicaid beneficiaries have gained prominence. Much of the success of Medicaid-focused plans has been attributed to their prior experience with and understanding of the complexities of serving the Medicaid population. The number of Medicaid-focused plans has remained relatively steady since 1996,



but membership has expanded²³: Currently, 18 community health center–affiliated health plans serve 1.3 million enrollees.²⁴

A number of health centers also participate in networks with other health centers or other safety net providers to jointly negotiate contracts with MCOs, centralize some services, and pool resources. HRSA has stimulated these efforts by providing some grant funds through the Integrated Services Development Initiative (ISDI), which began in 1994. Network grantees focus on integrating a chosen area—like financial, pharmacy, or information systems—across members.

The Mechanics of Medicaid Cost-Based Reimbursement

Since 1990, the hallmark of being an FQHC has been cost-based reimbursement for services provided to Medicaid patients. This preferential payment policy helps ensure adequate reimbursement for care provided to Medicare and Medicaid beneficiaries, thus allowing federal and other grant funds to be used to provide care to the uninsured. But cost-based reimbursement systems have their critics. For state Medicaid agencies, cost-based reimbursement rates for FQHCs are higher than the rates they pay other providers and it raises accountability and efficiency concerns; some believe it creates a disincentive to control costs. Consequently, cost-based reimbursement for FQHCs has been threatened in the past; in 1997 Congress passed a law that began to phase it out.²⁵ Advocates protested the phase-out and in response Congress created a prospective payment system (PPS) for Medicaid payments to FQHCs, which became effective in 2001.

Medicaid cost-based payments for FQHCs were based on the clinics' overall costs, not the costs of providing care to Medicaid patients alone. Under the cost-based system, FQHCs totaled their annual allowable costs, such as personnel, mortgage, utilities, transportation, and supplies, and divided that by their total encounters with patients to get a cost-per-encounter rate. States reviewed the cost reports to determine which costs were allowable; Medicaid programs had to follow Medicare statute and regulations in determining allowable costs and reasonableness of costs. States could set their own limits for reasonableness of costs, including setting ceilings on costs per service or a limit on a certain type of cost.²⁶ In a given year, an FQHC was paid based on the previous year's per encounter rate and underwent a reconciliation process at the end of the year—once cost reports had been audited—to reimburse it for any underpayment or overpayment by the state. Because the calculation was based on total costs, it did not reflect any difference in utilization by or resource intensiveness of Medicaid patients relative to other types of patients.

The current PPS is a less generous Medicaid payment methodology than cost-based because it is tied to the average of each FQHC's allowable costs from FY 1999 and FY 2000. Medicaid agencies started using the PPS to pay for services provided on or after January 1, 2001. For services provided in FY 2002 and each subsequent year, each FQHC's per-encounter

The current Medicaid Prospective Payment System for FQHCs is less generous than cost-based reimbursement.

rate is adjusted for inflation by the Medicare Economic Index (MEI) for primary care.²⁷ The MEI is considered a historically low measure of inflation and “an FQHC’s...ability to manage under the new PPS will depend on its initial payment rate, and changes it can make to keep its cost growth at or below the inflation index.”²⁸ In general, states prefer the PPS because it limits their payments to FQHCs and is a more predictable expense. It also eliminates the annual cost report auditing required by a cost-based system, which is resource-intensive. As with cost-based reimbursement before, under the new PPS states must pay FQHCs a wrap-around payment for the difference between their per-encounter rate and the payment they receive from MCOs.

Notwithstanding these benefits of the PPS, states must strike a balance between saving money in the short term through lower Medicaid payments with a PPS and spending money in the long term if a health center becomes insolvent and therefore cannot care for Medicaid or uninsured patients, causing patients to revert to emergency room-based care. Some states have therefore chosen to take advantage of a provision in the Medicaid statute that allows them to reimburse FQHCs more generously than the PPS by implementing an alternative payment methodology. The alternative must pay at least what the FQHC would receive under the PPS and must be agreed to by the FQHC. Based on a 2003 survey, 15 states have maintained cost-based reimbursement as their alternative payment methodology. A few others are implementing a PPS using more recent costs than those from FY 1999 and 2000 or are using more generous inflators.²⁹ Both Maryland and Florida are implementing the PPS and are using the MEI as the inflator, rather than an alternative payment methodology. Maryland’s Medicaid program pays FQHCs between \$90.71 and \$191.24 for medical visits and \$78.90 to \$171.53 for dental visits under the standard PPS formula.³⁰ By comparison, Florida’s Medicaid program pays FQHCs between \$78.70 to \$125.86 per visit, including dental payment.³¹

It is unclear whether the shift to a PPS has had a negative impact on the general financial viability of health centers. In the aggregate, Medicaid revenues to health centers have been increasing each year, before the PPS implementation and after. To date, most analysis of the PPS has focused on determining where it is being implemented and how. Some clarity may come from a report requested by Congress in the same law that authorized the PPS. Congress charged the U.S. General Accounting Office [(GAO) renamed the Government Accountability Office in July 2004] with studying the need and method for re-basing or refining costs for determining Medicaid payment to FQHCs; the GAO is in the preliminary phase of conducting this study.

Grant Funds

Despite aggregate funding increases to the health centers grant program over the last decade, dollars per uninsured patient have remained flat. In

1995, health centers received \$249 per uninsured patient compared to about \$268 per uninsured patient in 2003.³² These grant dollars are critical to health centers to enable them to provide care to the uninsured as well as pay for enabling services, but they are not enough to cover those costs entirely. In 2003, the total cost per patient averaged about \$479. In real 2003 dollars, the annual rate of growth of federal appropriations for health centers was 7.3 percent between FY 2002 and FY 2003, but the estimated growth in the number of uninsured health center patients over that same period was 11.4 percent.³³

To make up for this gap in funding, health center administrators leverage their dollars from grant, Medicaid, and other sources to cover the costs of care to the uninsured. The George W. Bush administration has increased overall appropriations for the health centers program (Table 1), but for FY 2004 about three-quarters of it has been targeted to funding new health centers, additional delivery sites at existing centers, and expanding capacity to serve more patients, with only one-quarter dedicated to increasing the amount existing centers receive.

Many health centers also rely on state, local, and private grants and donations to supplement Medicaid reimbursements and federal grant funds that, in general, are not keeping up with health care cost inflation. Many states have cut grant funds to health centers during the last few years of state budget crises. According to a survey conducted by the National Association of Community Health Centers, 17 of 31 states that provided direct funding to health centers in 2003 cut that funding by more than \$40 million,³⁴ or about 7 percent of total state and local grant funding to health centers. Larger state funding cuts were anticipated but did not materialize, in large part because of the \$20 billion in federal fiscal relief states received from the Jobs and Growth Tax Relief Reconciliation Act of 2003. However, the cuts implemented were not insignificant and tightened health center margins, which can easily shift from black to red.

Private Health Insurance

In general, health centers do not generate a significant amount of revenue from privately insured patients. In 2003, 15 percent of health center patients were privately insured, but only 6 percent of health center revenues came from private insurance. These privately insured patients could be lower utilizers of care, but it is more likely, considering the low income level of the majority of health center patients, that the private insurance policies they had were high-deductible plans that offered limited benefits and paid low rates.³⁵ By comparison, 36 percent of health center patients were covered by Medicaid and 36 percent of health center revenues come from Medicaid. If many Medicaid-covered patients were to shift to private insurance coverage, it could negatively impact health centers' ability to serve the uninsured.

TABLE 1
Health Center Federal Appropriations
(in billions of dollars),
Fiscal Years 1994–2004

FY	\$ Billions
1994	0.734
1995	0.756
1996	0.753
1997	0.797
1998	0.820
1999	0.920
2000	1.01
2001	1.16
2002	1.34
2003	1.47
2004	1.57
2005	1.79 *

*President's Budget Request.

Source: Bureau of Primary Health Care, Health Resources and Services Administration, DHHS.

Medicare

Medicare is a relatively small revenue source for health centers. Like Medicaid, it has special payment provisions for FQHCs. Medicare services are paid on an all-inclusive, per-encounter rate but are capped by an upper payment limit set by CMS. Each FQHC has its own encounter rate derived from its prior year total allowable costs (dental, pharmacy, and optometry costs are excluded), divided by total encounters. Beneficiaries pay a coinsurance of 20 percent of the per-encounter charge and Medicare pays 80 percent. For the 80 percent it reimburses the center, Medicare will not pay above \$106.58 for urban FQHCs and \$91.64 for rural FQHCs. Health centers must absorb any costs above these levels. CMS's fiscal intermediary for FQHCs estimates that 60 percent of FQHCs have hit this upper payment limit. Medicare does not reimburse FQHCs for some preventive services that FQHCs typically provide because they are excluded by Medicare law; examples include preventive dental services and health education classes. However, for eligible FQHC services, no Medicare Part B deductible applies.³⁶

The Bottom Line

With the many changes in the health care environment affecting health centers over the last decade—the shift from cost-based reimbursement to a PPS, the increasing prevalence of managed care delivery systems in Medicaid, increasing numbers of uninsured patients, flat per-uninsured patient grant funding, and state budget shortfalls—it would seem that health centers would be under significant financial stress, and some are. According to HRSA's analysis, approximately 4 percent of health centers have financial, organizational, or managerial problems that seriously threaten their stability and viability. About half of those have sound internal management and operational systems but are facing external market changes (for example, an increase in uninsured patients due to a local economic downturn) that are negatively impacting their viability.³⁷ Achieving financial stability and growth in the midst of such a complex and rapidly changing health care market requires astute health center leadership and expertise beyond merely balancing costs with revenues. Factors such as productivity, operations, information technology, and access to capital, among others, all contribute significantly to the overall balance sheet.

HOW DO HEALTH CENTERS ENSURE HIGH-QUALITY CARE?

Health centers were patient-centered and focused on improving the quality of care long before these terms became industry buzz words. Despite the financial pressures they face, multiple studies document health centers' efficacy in reducing the delivery of low birth weight babies, reducing hospitalizations for patients with chronic conditions, and providing

preventive women's health services. For example, a comparison of health center and national data showed that 10.3 percent of African American women served by health centers deliver low birth weight babies, compared to 13.1 percent of African American women nationally. The rate for rural African American women served by health centers and delivering low birth weight babies was even lower: 8.5 percent, compared to 13.0 percent for all rural African American women.³⁸

Another study compared hospitalization and emergency visits for a set of chronic and acute conditions across 50,000 Medicaid beneficiaries, some of whom received the majority of their care from FQHCs and others who received their care from office-based providers or other outpatient settings in the same areas. It found that beneficiaries "who received most of their primary care from FQHCs were significantly less likely to be hospitalized and less likely to seek ER care for ACSC [ambulatory care sensitive conditions] than a comparison group."³⁹

Performance Review and Accreditation

The most basic way HRSA assures health center quality is by reviewing grantee performance before renewing their grant funding (usually every 3 to 5 years). Until recently, the agency conducted a Primary Care Effectiveness Review (PCER) that was mostly compliance-oriented. The PCER was phased out in December 2003 and has been replaced by the Performance Review Protocol. The new process aims to be more performance than compliance-oriented and will be conducted by teams of mostly federal reviewers from HRSA's ten field offices. For example, the new process will include a review of data capacity and systems and their use. A standard list of performance measures for health centers is unavailable because the new process is in its early stages.

About one-third of health center grantees have been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).⁴⁰ HRSA began working with the JCAHO in 1996 to combine the PCER with JCAHO's accreditation survey for ambulatory care organizations. With the introduction of the new review protocol, HRSA is reviewing its relationship with the JCAHO and considering how and when to review JCAHO-accredited health centers in the future.

Improving Clinical Care Processes

Although health centers' effectiveness as providers of care to vulnerable populations is well documented, the patients they serve have diverse needs and there remain disparities in health status between health center patients and the general population. In a continued effort to reduce and eliminate these disparities, HRSA's BPHC implemented a series of health disparity collaboratives, beginning in 1998 with an effort to improve diabetes health outcomes and diabetes clinical practice. The collaboratives

Multiple studies document health centers' efficacy in providing quality care.

are the result of a partnership between BPHC, the Institute for Healthcare Improvement, and the MacColl Institute for Healthcare Innovation. Their goal is to change the way health centers manage chronic diseases by improving their delivery system, encouraging more self management by patients, and utilizing clinical information systems for decision making.

Though national evaluations of the collaboratives are currently underway, none has yet been completed or published, but one regional study found that the interventions performed as a result of the diabetes collaborative did improve the number of patients receiving care according to the American Diabetes Association's clinical practice recommendations. The study reviewed charts and surveyed and interviewed providers and staff in 19 Midwestern health centers who participated in the collaborative in 1999. It found that HbA1c measurement (a blood test that measures the average blood sugar level during the past few months), eye examination referral, foot examination, nutrition counseling, and other care processes improved for diabetic patients as a result of the collaborative.⁴¹

Since April 2000, according to HRSA, average HbA1c values for patients in the diabetes registry have fallen from almost 8.8 to 8.1 as the registry grew from about 22,000 to 92,000 patients. Such reduction could be significant, as suggested by the United Kingdom Prospective Diabetes Study which found that a nearly 1.0 percent reduction in HbA1c results in a 17 percent reduction in mortality, a 15 percent reduction in stroke, and an 18 percent reduction in heart attacks.⁴²

HRSA helps defray the costs to health centers for the intensive first year of a collaborative. Beyond the first year, health centers may compete for grants of about \$40,000 to continue and expand collaborative efforts. Additional collaboratives targeting asthma, depression, cardiovascular disease, cancer, and HIV/AIDS have been added since the initial diabetes collaborative. Currently over 500 health centers are participating in health disparities collaboratives involving over 180,000 patients. HRSA is working on prototypes for four new collaboratives: prevention, redesigning the office practice, perinatal care, and diabetes prevention. HRSA and the Agency for Healthcare Research and Quality are collaborating on a multi-year, national evaluation of the collaboratives that is expected to be available in late 2005.⁴³

Despite documented success in providing care to underserved populations, centers face challenges in their ability to ensure access to specialty care and diagnostic tests for their uninsured populations. In order to receive grant funds, health centers must establish formal referral relationships for specialty care, diagnostic services, nonemergency hospitalizations, and other care not provided by the center. Despite these requirements, they face limitations in providing meaningful referrals for their uninsured patients. One survey of 20 health center executive directors and medical directors from ten states found that they could "obtain specialty referrals for their insured patients 'frequently' or 'very frequently' but only 59 percent could do so as often for uninsured patients."⁴⁴

It is worth noting that HRSA's preliminary analysis of the 2002 health center visit survey, a review of a representative sample of health center patient medical records, shows that only 7.5 percent of patient visits resulted in hospitalization or specialty referral.⁴⁵ However, for the minority of patients who do need to consult with a specialist or have access to a diagnostic imaging test, these barriers to care can have significant consequences.

Some health centers are partnering with other primary care providers to draw on their resources to provide specialty care to their uninsured patients. In some communities, health centers are working with free clinics to take advantage of their referral networks. Other health centers have become part of community consortia that apply to HRSA for a Healthy Communities Access Program (HCAP) grant. HCAP grants are designed to help communities better coordinate their health care system for the uninsured. For many health center grantees, that means establishing a network of specialty care providers willing to see uninsured patients as well as managing the number of uninsured patients sent to each provider to ensure their continued participation.

WHAT HAS BEEN THE IMPACT OF THE RECENT HEALTH CENTER EXPANSION INITIATIVE?

The health centers' long track record of providing cost-effective care to underserved populations led the Bush administration to expand health centers as a key component of its strategy to address the uninsured. In FY 2002, the administration launched the President's Health Centers Initiative with the goal of adding 1,200 new and expanded health center sites over five years and to "ultimately double the number of patients treated" at health centers.⁴⁶ Due to budget pressures, the goal of the initiative has shifted to increasing "the number of patients served annually from about 10.3 million in 2001 to 16 million by 2006."⁴⁷

To meet the expansion goal, HRSA's BPHC administers three grant competitions: new access points, expanded medical capacity, and service expansion.

- The **new access point** competition provides funding for an entirely new grantee or for an existing grantee to open a new site. Individual awards are capped at \$650,000 for FY 2004.
- The **expanded medical capacity** competition increases an existing health center's ability to serve more people at existing sites. Individual awards are capped at \$600,000 for FY 2004.
- The **service expansion** competition seeks to add new or expanded mental health, substance abuse, or oral health services and to fund continued participation in health disparities collaboratives. These individual awards are capped at \$250,000 for oral health expansions where it is a new service, \$150,000 for oral health expansions where it is an existing service, \$150,000 for new and existing mental health/substance abuse expansions, and \$40,000 for health disparities collaboratives.

The expanded medical capacity and service expansion competitions are limited to existing grantees, so the only way new organizations may receive funding is through the new access point competition. Typically, HRSA will run two to three application cycles for new access points and one cycle for expanded medical capacity and service expansion in a fiscal year.⁴⁸

All applications for each of the three competitions are evaluated by an Independent Review Committee (IRC) comprised of federal and nonfederal experts. The IRC makes recommendations on the merits of each application, but HRSA program officials ultimately make the grant award decisions. All grant awards for health centers must be made in such a way to ensure that rural populations receive no less than 40 percent or no more than 60 percent of grant funds and to ensure that awards to the migrant, public housing, and homeless programs are made in the same proportion of the total appropriation as in FY 2001.

In order to effectively assess community need and to ensure readiness to serve patients within 90 to 120 days of grant award, the application process is extensive and complicated. BPHC imposes certain screens and preferences in deciding which applications will be reviewed and which will receive funding. For example, new access point applicants are encouraged to submit a letter of interest describing the level of community need for additional primary care services and a brief description of the proposed project, and BPHC provides feedback to those submitting letters to help strengthen their final application. New access point applicants are also screened through a need for assistance worksheet to see if their level of need is high enough to merit formal application review. A funding preference is given to those applicants that serve sparsely populated rural or frontier areas, defined by BPHC as a geographic area with fewer than seven people per square mile.

Recognizing the need to build capacity to compete in this fairly resource-intensive application process, HRSA partners with and provides funding to Primary Care Associations (PCAs) throughout the country. Each state's PCA analyzes the state's unmet need for primary care services, works with communities to develop competitive applications to fill that need, and provides technical assistance to existing and expanding health centers. Despite this funding, it is unclear whether the efforts are adequate to jumpstart activities in resource-poor areas.

The Bush administration is on track toward achieving its expansion goal by the end of the five-year period (FY 2006). To date, with almost three of the five fiscal years of the initiative completed, HRSA has created 334 new access points (165 new grantees and 169 new satellite sites) and awarded 285 expanded medical capacity grants, for a total of 619 toward the goal of 1,200 new and expanded sites. Service expansion grants do not factor into these increases because they add or expand services like dental or mental health but do not add new sites or a new patient population. About 3 million new patients have been added during the first three years of the expansion, over half of the goal of adding 5 million new patients in five years.⁴⁹

The Bush administration is on track toward achieving its expansion goal by the end of the five-year period.

If sheer volume of applications is any indication, there is substantial desire and need in communities for health center funding. With the first three years of the expansion almost complete, about 600 of 1,600 applications have been awarded (new access point and expanded medical capacity), or 38 percent. The number of applications received and awarded in any given fiscal year is relative because HRSA has been taking some applications received in one fiscal year and awarding them in the next, if they scored well and there was not enough money to fund them in the initial application year. For example, 48 of the 63 new access point awards for FY 2004 thus far were funded from the batch of 468 applications received in FY 2003; the other 15 awards for FY 2004, therefore, were decided from 182 applications—only an 8 percent award rate (Table 2).

TABLE 2
Applications and Awards for Health Center Grant Competitions,
Fiscal Years 2002 – 2004

	Received	Awarded	% Awarded	Received	Awarded	% Awarded	Received	Awarded	% Awarded
New Access Point	309	171	55%	468	100	21%	182	63	35%
Expanded Medical Capacity	238	131	55%	182	88	48%	235	66	28%
Service Expansion	284	203	72%	412	71	17%	<i>pending</i>	<i>pending</i>	<i>pending</i>
	FY 2002			FY 2003			FY 2004 Year-to-Date		

Source: Bureau of Primary Health Care, Health Resources and Services Administration, DHHS.

Geographic Distribution of Expansion Funds

Several western states, namely Alaska, North and South Dakota, and Montana, received the biggest increases in BPHC grant dollars relative to their prior funding levels since the expansion effort was initiated (see Appendix). These states historically have had a small number of grantees, so these increases may indicate a move toward a more equitable distribution of funds. However, a detailed analysis of relative funding allocation across states in the context of estimated need (such as numbers of underserved and uninsured persons or percent of population living in an MUA) is not publicly available.

Some states with widely publicized rates of uninsurance, such as Oklahoma, California, and Arizona, were in the top third of states receiving the largest percentage increases in their grant awards, but other states with high percentages of uninsured people like Florida, Texas, and Louisiana,

were in the bottom third. Because the health centers' mission is to provide access to care for medically underserved populations—not just the uninsured—looking at changes in uninsured patients by state is an imperfect way of assessing impact, but data on changes in underserved populations by state are not available.

HRSA has conducted its own internal analysis which shows that states with the lowest health center penetration relative to their unserved populations before the expansion—Georgia, Texas, North Carolina, and North Dakota—have set the most ambitious expansion goals for health center penetration and are meeting their targets after the first two years.⁵⁰ Although these findings are heartening, further analyses of the placement and impact of the expansion grants appear warranted and merit broad dissemination.

Workforce Implications

The expansion to 1,200 new and expanded sites will require 36,000 additional personnel including 11,000 new clinicians.⁵¹ The Bush administration has requested budget increases in the range of 10 to 20 percent for the NHSC for each year of the health centers' expansion. Funding the NHSC scholarship program creates a timing problem because scholarship recipients will not be ready to serve for up to seven years. In light of this reality, the NHSC is targeting most of its funds to loan repayment for ready-to-serve providers, which will increase total NHSC clinicians in the field to about 4,000 in FY 2004.

This is an historic high for the program, but it will likely yield limited impact on health centers' workforce needs. Typically, half of NHSC providers serve in health centers, which equates to approximately 2,000 providers available for the 3,600 existing comprehensive health center sites, plus any new sites that are added during the FY 2004 grantmaking process.⁵² DHHS is also using its participation as an IGA for the J-1 visa waiver program to target physicians to health centers in HPSAs of greatest need, but their participation will amount to less than 25 applications for placement in FY 2004.⁵³

Even with these federal efforts, it appears that a significant workforce gap at health centers remains. According to preliminary results from a 2004 HRSA-sponsored survey of health center directors, about 70 percent of health centers can fill their clinician vacancies within 6 months and approximately 90 percent of health centers can fill them within a year.⁵⁴

WHAT FUTURE POLICY CHANGES ARE IN STORE FOR HEALTH CENTERS?

The 330 grant program is both popular and successful. Health centers have proven to be an effective investment of federal funds, have garnered sustained goodwill and advocacy in the communities they serve, and, as a result, generally have enjoyed broad, bipartisan support. The wide appeal and positive results of health centers have made many reluctant

to raise questions or concerns that could be perceived as criticisms of the 330 grant program. Internal scrutiny of the program by HRSA has certainly taken place, as evidenced by grantee performance monitoring and management initiatives aimed at improving program operations and health center effectiveness. Furthermore, the health center expansion is a top priority of the Bush administration, and progress in meeting the goals of its initiative has been closely monitored and widely shared. However, public discourse and legislative debate related to structural and substantive changes in the health center program have been very limited.

Although there are no loud calls for a substantial policy overhaul, the recent expansion of community health centers has brought attention to a number of policy concerns. Chief among these are questions related to whether 330 grant funds, and expansion funds in particular, are being targeted to communities with the greatest need. These concerns involve perceived deficiencies in the empiric measures of need, as well as reservations regarding the competitive process used to make grant awards.

Measures of Underservice

The first hurdle communities face in qualifying for health center grant funds is becoming designated as a medically underserved area (MUA) on the basis of the Index of Medical Underservice (IMU). Critics argue that this index is not an accurate reflection of need for a variety of reasons, including:

- **Insurance status is not addressed.** Although the existing measure addresses income level, it does not explicitly reflect health insurance status. Some argue that incorporating rates of uninsurance and Medicaid coverage levels into the IMU would help target funds to the neediest places. Others counter that such an approach could establish perverse incentives for state policy makers and question the feasibility of collecting community-level data on insurance status for MUA designation.
- **Provider ratios do not serve as a reliable access proxy.** Some argue that traditional physician-to-population ratios have little relationship to the accessibility of care. Provider willingness to serve the uninsured or Medicaid patients is likely to vary across communities, and these differences fail to emerge in the existing measure. Although this weakness may result in an overestimation of available capacity in some communities, other concerns involve possible underestimation of capacity. Some have suggested that nonphysician providers, an increasingly important source of primary care, should be included in these calculations. Others point out that reliable data sources for these provider types do not exist at the community level and that gathering such data would be expensive.
- **Infant mortality may not reliably predict health service needs for some populations.** Infant mortality reflects a wide variety of threats to community health, including environmental, nutritional, medical, and

The recent expansion of community health centers has brought attention to a number of policy concerns.

societal risks. Some argue that the broad nature of this measure makes it an imperfect predictor of the need for medical care. These critics often note that Hispanics have a lower infant mortality rate than Whites or African Americans but have the highest rate of uninsurance.

In response to these criticisms and other concerns, DHHS is considering a change to the MUA designation criteria that could involve merging the MUA/MUP and HPSA measures. The department attempted to combine the measures in the mid-1990s and published a proposed regulation, but there was so much criticism of it that a final regulation was never published. Because over 30 federal programs tie their eligibility or funding preference to HPSA and MUA/MUP designations, making any attempt to change the process politically sensitive, given the likelihood that some communities could lose their designations and their funding.

The new proposed regulation is likely to suggest some key changes such as recognizing the special needs of frontier areas, providing a broader set of proxies for health status beyond infant mortality, and counting the contributions of nonphysician providers. The draft regulation is currently undergoing review within DHHS, and a projected date of its publication has not been made public.

Competitive Award Process

Some argue that HRSA's application and review processes further compound the inadequacies of the empiric measures used to establish MUAs. Although few question the integrity of the process, many feel a competitive approach is not appropriate for directing funds to vulnerable, resource-poor communities. The competitive nature of the process ensures that award decisions are favored toward organizations able to put together an application, how well they can make their case regarding community need, and their readiness to utilize the grant award.

Managing a health center requires significant financing, workforce, operations, management, and governance savvy. As stewards of federal funds, HRSA wants to award grants to organizations that are capable of providing high-quality care in a complex health care marketplace and, understandably, has crafted a grant award process that rigorously tests the readiness of potential grantees.

Concerns have been raised that this approach is not effective in channeling funds to areas of greatest need, but instead to areas with stronger safety nets made up of more sophisticated organizations that have the resources to secure professional grantwriters and good data analyses.

According to a recent analysis of the safety net in 12 communities across the United States, communities with larger, stronger safety nets competed most successfully for HRSA grant funds. The study found that the application and review process rewards financially stable organizations with the infrastructure and leadership to prepare successful grant applications, not those most in need of funding.⁵⁵

Critics argue that the process should target the neediest areas by linking dollars more explicitly to objective measures of need. For example, some have suggested that the award process should take into account the relative generosity of a state's Medicaid program and prioritize areas with growing uninsured populations. Others respond that increasing awards to applicants in states with less generous Medicaid programs might create a disincentive for states to expand their Medicaid programs or to pursue alternative coverage expansion strategies.

Relationship Between 330 Grants, Medicaid, and Public Insurance Coverage Policies

Policy decisions regarding health centers are closely linked to dynamics within the Medicaid program and other efforts influencing insurance coverage levels. Health center financial viability is a delicate balance of Medicaid reimbursements, federal grant funds, and state and local grant funds. Some health centers are struggling to balance a mission and mandate to provide care to anyone who walks through their door regardless of ability to pay with the reality of tight fiscal environments at the national, state, and local levels.

Many state legislatures are approving Medicaid benefit and eligibility cuts in an effort to balance their budgets. Others are considering major Medicaid demonstration waivers that would fundamentally reform their Medicaid programs by capping enrollment, creating waiting lists, and reducing benefits, among other cost-containment strategies. Although reimbursement rates for health centers are currently protected through the PPS and total Medicaid revenues to health centers have been steadily increasing each year, the financial stability of health centers could be jeopardized if a significant number of health center patients were to lose their Medicaid eligibility.

Recent trends suggest that health centers are experiencing growth in the number of uninsured patients served as federal grant amounts per uninsured patient remain flat. Some states and localities are reducing grant funding to health centers, forcing them to reduce enabling services like outreach and enrollment that might otherwise draw additional revenues from Medicaid and SCHIP (State Children's Health Insurance Program). Health centers are also facing significant increases in health care premiums and workers' compensation costs for their own employees.

As a result of these fiscal challenges, many argue that the pre-expansion health centers, "the base," deserve more attention and resources to ensure their continued viability. Policymakers have acknowledged the needs of existing health centers. In FY 2004, Congress directed HRSA to set aside \$25 million for base adjustments to existing grantees. With the remainder of the appropriation, HRSA has budgeted \$37 million for new starts and new access points, \$26 million for expanded medical capacity, and \$7 million for service expansions. There is debate over whether \$25 million is adequate to cover the rising number of uninsured patients and increasing

Health center financial viability is a delicate balance of Medicaid reimbursements, federal grant funds, and state and local grant funds.

costs of providing care that pre-expansion health centers are experiencing. Some believe the Bush administration may achieve the goals of the expansion in the short-term but that ultimately access and service may deteriorate without more attention to the viability of existing grantees. More objective analyses are needed on this issue.

Alternative Models for Safety Net Services

Concerns have also been raised that current federal support for primary care services, as embodied in the health center program, does not adequately address the contribution of provider groups that do not conform to the health center model. Primary care clinics run by religious organizations, hospital outpatient departments, and local governments generally are not eligible for 330 funding due to the governance requirements of the grant. Because the existing primary care safety net in some communities is composed entirely of these noneligible providers, many communities face a dilemma in securing federal funds. They can opt to forgo such funding or establish a 330-funded clinic that may duplicate, and potentially undermine, existing capacity.

In May 2004, the Senate Republican Task Force on Health Care Costs and the Uninsured released a number of proposals to control health care costs and decrease the uninsured population. These proposals included a provision to allow religious-sponsored health systems to qualify for 330 funding by exempting them from the statutory governance and ownership requirements. Critics of this approach maintain that the community-based governing board is a central element of the health center program and that the exemption would subvert this defining characteristic.

Others believe the exemption should be expanded to include other types of noneligible organizations. Some observers question the priorities of noneligible provider groups. While health centers seek to provide a true medical home and an ongoing relationship with a clinician, other types of safety net providers, like some hospital outpatient departments, may be more focused on training a rotating roster of medical students or providing inpatient care than creating a medical home and arranging enabling services. However, the validity and generalizability of this concern has not been well documented.

Some have suggested that a funding stream separate from the 330 program should be established to support alternative primary care models. Though the health centers' national trade association has said it would not oppose such an action, these proposals have caused concern among some health center advocates who worry that such an approach would eventually compromise funding for the traditional health center model. These critics also maintain that high levels of federal funding already flow to many of these safety net institutions through the Medicaid disproportionate share hospital (DSH) program.

CONCLUSION

A careful examination of the history and current status of community health centers reveals both inspiring success stories and opportunities for future improvement. Both the projected conclusion of the expansion initiative and the reauthorization of the health center program are slated for FY 2006—in some respects distant on the legislative calendar, in other respects fast approaching. The reliance on the health care safety net by tens of millions of Americans demands a continuing policy focus on the health center grant program. The impact of increasing investments in health centers on access to care and the relationship between health centers and other safety net programs merit ongoing attention and evaluation.

ENDNOTES

1. Bonnie Lefkowitz and Jennifer Todd, "An Overview: Health Centers at the Crossroads," *Journal of Ambulatory Care Management*, 22, no. 4 (1999): 1–4; and Rhona S. Fisher, "Access to Primary Care in Underserved Areas: Expanding Medicaid, Medicare, and Public Health Services Through the FQHC Program," National Health Policy Forum, Issue Brief 613, January 13, 1993.
2. Health Revenue Sharing and Health Services Act, Public Law 94-63.
3. Health Centers Consolidation Act of 1996, Public Law 104-299.
4. §330, Public Health Service Act.
5. The consolidated health centers statute does allow for grants to public entities but limits them to no more than 5 percent of the health center appropriation in any fiscal year.
6. Frontier areas are defined in different ways by different parties. HRSA defines them as fewer than seven people per square mile.
7. §330(r)(2)(ii), Public Health Service Act.
8. Uniform Data System (UDS), "Calendar Year 2003 Data: National Rollup Report," table 4, Bureau of Primary Health Care, U.S. Department of Health and Human Services, 2004; available at www.bphc.hrsa.gov/uds/data.htm.
9. §1861 (aa)(4), Social Security Act.
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APPENDIX
Comparison of State Level Health Center Grantee Data for
Calendar Years 2001–2003

STATE	Grant Money (% Change)	Total Change in Grant Money (\$)	Uninsured Users (% Change)	Total Encounters (% Change)
Alaska	340	17,983,377	165	209
North Dakota	139	1,342,795	13	21
Montana	107	5,560,372	31	33
South Dakota	80	3,283,647	19	44
Delaware	68	1,402,867	97	53
Oklahoma	62	3,962,169	10	50
Vermont	61	1,106,719	48	78
Nebraska	58	1,426,084	76	18
Illinois	57	20,625,802	47	42
California	55	45,033,256	32	36
West Virginia	54	8,193,128	48	15
South Carolina	49	12,254,060	43	38
Connecticut	49	5,263,390	-5	18
Arizona	48	8,978,324	21	29
Utah	47	2,937,028	28	27
Rhode Island	43	2,703,442	1	16
Oregon	41	6,244,017	18	40
Iowa	41	3,635,328	1	20
Kansas	40	1,774,973	6	19
New Mexico	40	7,894,063	13	5
Hawaii	39	2,421,679	25	28
Massachusetts	36	9,164,117	43	17
Virginia	35	6,002,668	14	11
New York	35	22,298,290	9	24
Michigan	35	9,004,704	28	21

Appendix- continued

APPENDIX (continued)
Comparison of State Level Health Center Grantee Data

STATE	Grant Money (% Change)	Total Change in Grant Money (\$)	Uninsured Users (% Change)	Total Encounters (% Change)
Colorado	34	10,862,868	3	30
Kentucky	33	4,892,223	8	17
Wyoming	31	526,356	29	25
Maryland	31	4,142,050	14	32
North Carolina	31	7,898,656	30	22
Indiana	31	2,937,116	25	7
Georgia	31	6,984,011	14	15
New Jersey	31	5,607,821	19	17
Missouri	29	7,870,009	9	13
Idaho	27	2,263,038	21	10
Arkansas	26	3,804,604	5	8
Minnesota	25	2,901,668	19	43
Pennsylvania	23	8,137,922	1	17
New Hampshire	23	796,667	33	24
Tennessee	22	4,457,334	20	15
Alabama	22	5,867,392	31	19
Washington	18	5,581,848	21	22
Florida	17	10,246,657	24	21
Texas	16	9,911,829	22	29
Louisiana	13	1,722,392	2	7
Ohio	12	3,803,375	1	5
Maine	8	475,155	-10	8
Wisconsin	8	991,192	23	1
Mississippi	7	2,110,448	6	11
District of Columbia	*	*	*	*
Nevada	*	*	*	*

*No 2003 UDS data available to calculate change.

Source: Compiled from UDS, State Rollup Reports from "Calendar Year 2003 Data."