The Role of Health Centers in the Health Care Delivery System

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Federally Qualified Health Centers (FQHCs) are community-based, nonprofit or public organizations that provide services to people who lack access to other health care, including those without insurance, residents of rural and underserved areas, and some Medicaid patients. These health care services are available to all people, regardless of their ability to pay. FQHCs include community health centers, migrant health centers, health care for the homeless health centers and public housing primary care centers. Most FQHCs receive federal grant funding under Section 330 of the Public Health Service Act, while others—referred to as Look-Alikes—meet all requirements to receive a grant but do not actually receive such funding.

Achieving Look-Alike status often is a stepping stone to becoming a fully designated FQHC. To qualify as an FQHC, a center must provide comprehensive primary health care services to all, be located in or serve a high-need community and be governed by a community-majority board. Centers also offer support services such as health education, translation and transportation. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, enacted in March 2010 and referred to together as the Affordable Care Act, further expand the reach of health centers in the nation’s health care system. In this document, the term “health centers” refers to the two main categories of Federally Qualified Health Centers—Section 330 grantees and Look-Alikes.¹

**Those Served by Community Health Centers, 2009**

- **Uninsured**: 38%
- **Medicaid/CHIP**: 37%
- **Privately Insured**: 15%
- **Medicare**: 7%
- **Other Public**: 3%

Other Types of Health Centers

Rural Health Clinics (RHC): Rural health clinics provide primary health care services in medically underserved areas, but differ from health centers in several ways. Because of provider scarcity in rural areas, RHCs tend to employ mid-level providers such as nurse practitioners or physician assistants. Primary care practices that can document their main purpose is to provide primary care services in a rural area may qualify to be an RHC.

School-Based Health Centers (SBHC): These centers set up as clinics in schools, making primary health care services more available to school-age children. Programs at individual centers are based on community need and resources; however, no two SBHCs are identical.

Other: Some federally funded clinics exist to serve Native Americans and veterans. Some clinics are operated solely with state money, others are run by volunteers, and some are operated by area hospitals as a service to the community.

Location of Health Centers

Health centers are located in areas where private health providers lack financial incentives to operate, including sparsely populated rural locations with fewer patients or highly populated urban centers where there are high rates of publicly insured or uninsured patients. To ensure that patients receive care and that health centers do not expand into markets adequately served by private providers, health centers must serve a federally designated medically underserved area or population.

State Example: Mobile Health Services in Fort Lupton, Colo.

Limited or no public transportation and local shortages of medical providers contribute to rural residents’ inability to access primary health care. In 1985, Salud Family Health Centers, a migrant health center in Fort Lupton, Colo., addressed this access barrier by establishing a mobile health clinic to bring health care services to rural resident across northern Colorado. More than 25 years later, the mobile clinic continues to provide health and dental screening services to more than 6,000 patients a year and regularly serves adults and children living in rural, low-income housing.

How Communities Reduce Their Patients’ Barriers to Care

A person’s inability to access health care often involves a complex set of factors, extending beyond insurance or income status. Non-English speakers, for example, may be uncomfortable with clinical staff who speak only English; non-drivers may not have transportation to an out-of-neighborhood health care provider; or a person may not have the necessary knowledge or skills to manage complex, multi-stage treatments. Complementary services—often referred to as enabling services—offered by health centers reduce these obstacles to health care and often attract patients. Nationally, health centers spend $870 million—nearly 8 percent of their total accrued cost—on complementary services to meet a diverse range of patient needs.

Health Center Revenue Sources

Health centers serve a unique patient population, which often presents funding challenges. In 2009, the incomes of approximately 71 percent of health center patients were at or below federal poverty guidelines ($22,350 for a family of four in 2011), 38 percent were uninsured, and 37 percent were enrolled in Medicaid or the Children’s Health Insurance Program (CHIP). Although uninsured patients are the largest group served by health centers, out-of-pocket patient payments account for only about 6 percent of total revenue. Due to this revenue gap, centers rely heavily upon grants to subsidize care to the uninsured. Medicaid payments make up 37 percent of an average health center’s funding, and federal government grants account for approximately 22 percent. Funding from state and local gov-
ernments is about 10 percent, nationwide. Other support is provided by Medicare, private foundation grants, private insurance and other public programs. Due to this mix of funding sources, health centers are likely to be affected by changes not only to state Medicaid programs, but also in federal and state funding.

Medicaid, CHIP and Medicare and Health Centers

Compared to the U.S. population, health center patients are nearly three times as likely to be enrolled in Medicaid.\(^5\) Since Medicaid provides the largest source of financing, representing 37 percent of health center revenues, changes in state Medicaid programs can significantly affect health center operations and financing.

![Patient Distribution by Coverage Source, 2009](chart.png)


**Prospective Payment System (PPS)**

Health centers are paid per patient visit by the Medicaid program, rather than by billing for each individual service as is typically done by many other clinics and providers. This system is based on the average of each health center’s reasonable costs per patient visit; thus, each health center has its own payment rate. The rate is adjusted annually for inflation and for any change in scope of services provided. In 2009, the system was adopted for CHIP services.

Most states use the prospective payment system, but also have the option of using an alternative payment mechanism. The alternative payment rate must not be
lower than that under the PPS, the Centers for Medicare and Medicaid Services must approve the payment system, and health centers must agree to the method.

**Managed Care Supplemental Payments**

As an incentive for health centers to participate in managed care plans, states must make supplemental payments to health centers that provide care to Medicaid beneficiaries who are enrolled in such plans. These payments must cover the difference between the rates paid by managed care plans and the health center’s prospective payment rate.

**Medicare Payments Based on Reasonable Costs**

Health center services also are available to Medicare beneficiaries. Medicare pays a health center an all-inclusive per-patient visit amount, based on reasonable costs as determined by the center’s Medicare cost report. The Affordable Care Act instructed the U.S. Department of Health and Human Services to develop a prospective payment system for health center services. This new payment plan will establish payment rates that take into account the type, intensity and duration of services, including preventive services, and can include appropriate geographic adjusters.

In addition, Medicare pays a supplemental managed care payment to health centers, similar to the supplemental Medicaid payment. The Centers for Medicare and Medicaid Services will pay health centers the difference between a Medicare Advantage health care plan payment and the reasonable cost payment the health center otherwise would receive under Medicare fee-for-service.

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**Health Center Revenue, 2009**

- **Medicaid**: 37%
- **Medicare**: 6%
- **Self-Pay by Uninsured**: 6%
- **Grants, Contracts, Other**: 41%
- **Other Public Insurance**: 3%

How Health Centers Create Efficiencies

The National Association of Community Health Centers estimates that, by 2015, health centers will treat two of every three people who are living in poverty. Because most health center patients are uninsured or have public insurance, centers must provide effective, low-cost care for maximum efficiency.

Prevention and management: Health centers provide preventive care services such as immunizations, mammograms, prenatal care, and screening for prostate and other cancers. These preventive care services are considered to be cost-effective because they are inexpensive to administer and prevent problems or detect them early.

Decreasing emergency department use: Health centers also may prevent or decrease patients’
use of expensive emergency medical services. Research shows uninsured people who live in communities where there is a health center are less likely to have made an emergency room visit. 

The health center focus on prevention and disease management can help avoid emergency department visits as well as hospitalizations for conditions that can be managed by the patient (such as asthma). A recent study showed that medical expenses of patients who used health centers as their medical home were 44 percent lower than those of comparable patients seen elsewhere, resulting in savings to the nation’s health care system of between $9.9 billion and $17.6 billion annually.

Special programs: The Health Center Federal Tort Claims Act Program (FTCA) also has generated significant savings for health centers. FTCA shifts the malpractice risk from individual doctors and facilities to the federal government. Since the law was enacted in 2007, health centers have saved an estimated $88 million on malpractice insurance premiums.

Health centers also are eligible for the federal discount drug pricing program under Section 340B of the Public Health Service Act. By participating in this program, health centers save an estimated 20 percent to 50 percent on the cost of pharmaceuticals. Those savings are passed on to their patients.

Economic Value to the Community

Health centers can be an important economic force in a community by offering employment and training opportunities and purchasing local services. Investments in health centers generated approximately $20 billion in economic benefits for low-income communities around the nation in 2009. This number is expected to increase to $53.9 billion by 2015. The Colorado Community Health Network, for example, found that health centers generated approximately $374 million in Colorado economic activity in 2007. This figure includes business and community-supported activities.
property taxes and salaries paid not only to health center employees, but also to other community members whose jobs were created as result of the health center needs (e.g., medical equipment vendors, restaurants and store employees).\textsuperscript{14}

Communities also benefit from investment of federal and state funds. Health centers attract federal grants, loans and other financial assistance to the communities where they are located. In 2011, health centers in every state, the District of Colombia and several territories received a total of approximately $2 billion in federal grants; in 2010, health centers received more than $600 million in American Recovery and Reinvestment Act grants from the federal government.\textsuperscript{15}

The National Association of Community Health Centers estimates that, for every $1 million of federal funding for health center operations, $1.73 million is generated in new economic activity.\textsuperscript{16} These investments result in savings for the nation’s health system overall because annual medical expenses for health center patients are 41 percent lower than those for patients seen elsewhere, resulting in total savings of between $9.9 billion and $17.6 billion every year.\textsuperscript{17}

\begin{tcolorbox}
\textbf{Coordination with Other Safety-Net Providers}

Collaboration and coordination among critical access hospitals, rural health clinics, veterans’ health administration providers, Indian Health Services providers and health centers are important in areas that have difficulty attracting health care providers or achieving adequate and efficient service delivery.\textsuperscript{18} Safety-net providers—particularly those in close proximity to each other that serve similar communities—can improve and enhance each other’s roles in the health care system and stabilize or expand needed services by collaborating. Legislators can play a role in fostering such collaboration among providers.
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Many options are available for consideration by policymakers for interacting with health centers in their state. Some are listed below.

**Change state funding to support health centers**

Many states support health centers through general fund appropriations or tobacco tax settlements. Thirty-three states and the District of Columbia allocated a total of $354 million in direct state funding to health centers in 2011. This funding often covers the cost of providing care for uninsured patients, additional services or hours, capital improvements, workforce development and health information technology.

**Support Medicaid and CHIP coverage and benefits**

Medicaid and the Children’s Health Insurance Program are important to health centers’ financial viability. Changes to the state’s eligibility levels and benefits for these programs can significantly affect health centers. Supporting the enhanced Medicaid reimbursement for health centers helps them maintain enabling services and provide free or subsidized care to the uninsured.

**Support workforce programs**

Loan repayment and other incentive strategies that address clinical workforce shortages support primary care providers who practice in areas that experience provider shortages.

**Review facility licensure laws**

States can exempt health centers from certain laws or regulations to make it easier for them to operate in underserved areas. To address patient access issues and workforce shortage needs, New Mexico, for example, has given certain health center pharmacies more flexibility in supervision, hours of operation and dispensing guidelines.19
Review health professional licensing

States can review their scope of practice laws and create policies that allow all primary care providers to practice to the full extent of their training. (See NCSL scope of practice database at http://www.ncsl.org/default.aspx?tabid=22376 for more information.)

Encourage or require health plan contract language to favor health centers

States purchase a significant share of health care through Medicaid, the Children’s Health Insurance Program, state employee benefit plans and other programs. States can help health centers by encouraging or requiring contracted health plans to include health centers in their networks. Minnesota, for example, requires all plans that serve Medicaid beneficiaries to include FQHCs and other safety net providers in plan networks.

Encourage reimbursement for oral, behavioral and other services

A number of states do not pay for behavioral health and primary care services given on the same day, which presents a barrier to integrating services. States can encourage integrated practices by reviewing payment methods and ensuring that providers are not penalized for merging operations and offering truly comprehensive health care at a single center.

Primary Care Associations

Primary care associations (PCAs) are private, nonprofit organizations that offer technical assistance and other services to health centers and other state and regional health care safety net providers. PCAs often work closely with state legislators to inform them of options to expand health care access to uninsured, underinsured and underserved populations. (Contact information for the PCA and brief snapshots of state actions to improve the primary care system in the states is available at NCSL’s Primary Care State Profile webpage at http://www.ncsl.org/?tabid=21310.)
Getting to Know the Center(s) in Your District

✓ Set up an appointment with any health center in your district and your state primary care association or the primary care office, usually located in the state health department.

✓ To find health center(s) in your district, use HRSA's Find a Health Center tool at http://findahealthcenter.hrsa.gov/Search_HCC.aspx.

✓ Ask the health center director the questions you may have, such as:
  • Who does the health center serve?
  • How many patients does it serve?
  • What is the average patient income?
  • How many patients are uninsured?
  • How many patients are children?
  • How is the center financed?
  • What is the per-patient cost for health care?
  • How long is the waiting list?
  • Where do patients receive specialty services?
  • Are behavioral health services provided?
  • Are dental services provided?
  • What hospitals do patients use?
  • What health needs remain in your district?
  • What challenges does the health center face?
  • What are the primary successes of the health center?

✓ Contact your state primary care office and ask them about provider shortages in your state.
An inadequate supply and uneven distribution of primary care providers currently exists in the United States. Before passage of the Affordable Care Act in 2010, it was estimated that, by 2015, the nation’s primary care physician shortage would reach 21,000. The new law potentially could bring an additional 32 million Americans into the pool of covered people, creating an increased demand for primary care providers and placing an even greater strain on the primary health care workforce.  

Although health centers are not immune to these shortages, the following federal programs may help them recruit and retain providers.

- The National Health Service Corps (NHSC) program offers loan repayment in exchange for practice in a Health Professional Shortage Area (HPSA). Program participants are placed at health centers and must serve for a specific number of years. (For more information, visit http://nhsc.hrsa.gov.)

- Additional loan repayment and scholarship programs are designed as federal-state partnerships; program requirements are similar to those of the NHSC program.

- The Health Center Federal Tort Claims Act (FTCA) program created another important incentive for health center professional recruitment. This program enables Section 330-funded health centers to obtain no-cost malpractice insurance, thus creating savings for both the health center and the practitioner.

States that are experiencing shortages that cannot be fully addressed by federal programs have created and appropriated funds to recruit and retain health professionals in underserved areas. Examples of state actions to increase the primary care workforce are highlighted below.
Loan Forgiveness Programs

As a result of the financial burden medical school places on many graduates, states have implemented student loan forgiveness programs to ease high loan payments for certain health professionals who agree to work in underserved areas. In Colorado, for example, the state works closely with a local foundation to create a robust loan repayment program for primary care providers who practice in underserved areas. The Texas Legislature created a loan repayment program as part of its $1.8 billion plan to increase Medicaid rates and availability of services.

Scope of Practice

The procedures and treatments health professionals are allowed to perform or provide—known as their scope of practice—are regulated through licensure requirements. The scopes of practice for a range of medical practitioners vary considerably among states. In Alabama, for example, nurse practitioners can work only under a physician's supervision; in Oregon, however, they can be in private practice. Legislatures are beginning to examine these regulations and change the roles of primary care providers.

Community Health Workers

This generic term for nonclinical public health workers describes those who share the cultural experience of people in their community and serve as facilitators, educators and advocates. They not only help people obtain care, but also educate them about how to prevent and manage chronic diseases. State regulation of community health workers varies. Requiring training and certification standards can help enhance recognition of health worker roles and provide greater opportunities for reimbursement through state Medicaid programs and third-party insurers. The Ohio legislature, for example, established a formal credentialing program for community health workers in 2003.
Payment System Reform

Under the traditional fee-for-service payment system, primary care providers earn significantly less than many specialists. States have addressed this inequity by reviewing their payment systems. In 2008, Minnesota passed legislation to redesign the health care payment system. Some key characteristics of the reform include developing a statewide system of quality-based incentive payments for public and private providers, ranking providers on relative cost and making that information available to the public, and providing financial rewards for primary care providers who function as a medical home.

Residency Training

Health centers are beginning to use primary care residency training programs to recruit recent medical school graduates to underserved areas and rural clinics. The National Association of Community Health Centers reports that a physician trained in a health center is more than twice as likely than a non-CHC-trained physician to work in an underserved area. The Affordable Care Act also offers funding opportunities to expand primary care residency programs and other state health care workforce development initiatives. Partnerships with medical schools and other academic institutions also help develop health center-led community-based research opportunities.
Health Reform and Health Centers

Health centers played an important role in various health reforms during the last decade. Starting in 2001, President George W. Bush expanded the health centers program, nearly doubling the number of health centers across the nation. The Affordable Care Act further expanded the reach of health centers in the nation’s health care system.

Affordable Care Act Provisions for Health Centers

The expansion of insurance coverage and Medicaid will allow more people access to the primary and preventive care health centers provide. Key provisions in the Affordable Care Act that relate to health centers include the following.

**Increased funding:** Beginning in 2011, the Affordable Care Act appropriates $11 billion to health centers over five years. Of this amount, $9.5 billion will allow health centers to expand and enhance medical, oral and behavioral health services; $1.5 billion is for capital expenditures. If implemented as enacted, this will nearly double the capacity of health centers to care for patients, and it is estimated that nearly 20 million new patients will visit health centers by 2019.

A subsequent cut of $604 million in the 2011 federal budget, however, means fewer service expansions and new health centers than anticipated will be funded with the new money.

**Teaching health centers:** The Affordable Care Act authorizes development of residency programs at health centers.
The Electronic Health Record (EHR) Incentive Program, created under the 2009 American Recovery and Reinvestment Act, offers monetary incentives to providers to acquire and use approved health information technology systems. To qualify for this incentive program, eligible providers must demonstrate “meaningful use” of EHR technology. Eligible providers at health centers have a patient population of at least 30 percent who are receiving Medicaid or CHIP, are uninsured, or otherwise qualify as a “needy individual.” Physician’s assistants (PAs) at health centers also are considered as eligible providers for the meaningful use and EHR program.

The program, managed by the Centers for Medicare and Medicaid Services in partnership with the Office of the National Coordinator, will provide the incentive payments. Although states are responsible for administering the Medicaid program, the federal government provides 100 percent federal financial participation (FFP) reimbursement for the incentive payments. In addition, because program administration requires resources and funding, states are eligible to receive an enhanced 90 percent FFP for administrative costs.22
Health centers may be a valuable partner to state policymakers who aim to contain their state’s health costs and, at the same time, expand quality medical coverage to the state’s underserved patients. With the mission to serve and care for the high-need communities in which they are located, these centers can leverage state and federal resources to address some of the most complex health system problems—access to care for the nation’s uninsured and underserved people, the primary care provider shortage, disparities in care for people living in rural communities and for ethnic minorities, and creation of medical homes for poor people. Legislators play an important role in helping these centers meet their community’s needs and operate more efficiently. Legislators can be leaders for the network of centers that serve their district and bring useful expertise to their future operations and growth.
1. A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under section 330 of the Public Health Service Act (PHSA), clinics that have been certified as meeting such requirements (called FQHC Look-Alikes) or outpatient facilities that are operated by tribal organization or urban Indian organizations. FQHC services are defined by Medicare statute as rural health clinic services (such as care provided by physicians, physician assistants, nurse practitioners, nurse midwives, visiting nurses, clinical psychologist or social workers and related services and supplies), diabetes outpatient self-management training services, medical nutrition therapy services and preventive primary health services required under section 330 of the Public Health Service Act (PHSA).


10. Look-Alike FQHCs are not eligible for FTCA coverage.


