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Peter Shin
George Washington University

Jessica Sharac
George Washington University

Sara J. Rosenbaum
George Washington University

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Community Health Centers: A 2012 Profile and Spotlight on Implications of State Medicaid Expansion Decisions

Peter Shin, Jessica Sharac, Sara Rosenbaum, and Julia Paradise

Executive Summary

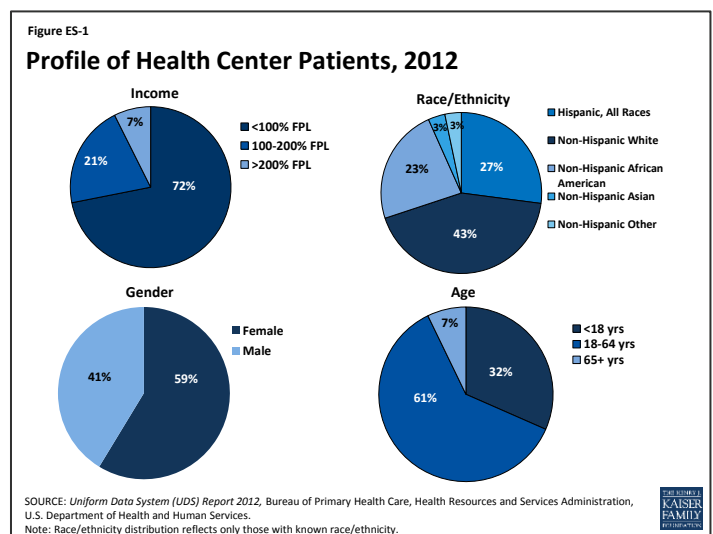
In 2012, nearly 1,200 federally funded community health centers were providing access to care for a predominantly low-income population in medically underserved areas across the country. As health insurance coverage expands under the Affordable Care Act (ACA) and the demand for primary care increases, the role of health centers is likely to increase, and the ACA's large investment in the health center program provides new resources to help meet growing needs. This brief provides a pre-ACA snapshot of health centers that can help in understanding the impact of state decisions about the ACA Medicaid expansion on health centers as health reform unfolds in the coming years.

PRE-ACA PROFILE

- Health centers' safety-net role.** In 2012, 1,198 health centers operating in close to 9,000 sites provided over 83 million visits to about 21 million patients, primarily for medical care, but also for dental, behavioral health, and enabling services. More than 70% of health center patients have incomes below the federal poverty level (ES-Figure 1). Most are working-age adults (61%) or children (32%), and 7% are age 65 or older. More than half are people of color.

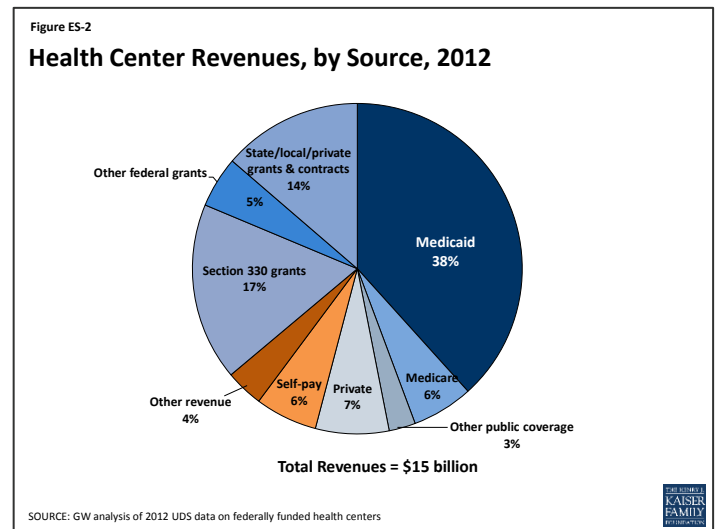
- Health center patients.** More than one-third (36%) of health center patients are uninsured and 40% are covered by Medicaid. Under the ACA, the number of health center patients is expected to grow substantially. The uninsured rate among health center patients is expected to fall, but still to remain high relative to the uninsured rate overall, and health centers will probably serve a larger share of those who remain uninsured and lack other sources of care.

- Scope of services.** Health centers provide primary care spanning physical, dental, and behavioral health care, as well as enabling services, such as translation and transportation, that help patients access care. Between 200 and 2012, the availability and use of both dental and mental health care in health centers expanded, reflecting both increased federal resources and widespread need for such care.



HEALTH CENTERS AND MEDICAID

- **Medicaid support.** The health center program began as a federal demonstration. Since 1974, when the program was permanently established as part of the Public Health Service Act, health centers have received regular annual federal appropriations. The ACA augmented these appropriations with a special five-year, \$11 billion Health Center Trust Fund. Both funding streams are major sources of financing for health centers (Figure ES-2). However, Medicaid now accounts for close to 40% of health center revenues, reflecting the large share of health center patients covered by Medicaid, as well as Medicaid's prospectively set cost-based payment rates for health centers, which are also used by CHIP, Medicare, and Qualified Health Plans offered in the new Marketplaces.



- **Health centers in Medicaid expansion vs. non-expansion states before the ACA.** Even before the ACA, health center patients in the Medicaid expansion states were significantly more likely to be covered by Medicaid and less likely to be uninsured compared to those in non-expansion states, reflecting broader Medicaid eligibility for adults in the expansion states prior to health reform. Health centers in expansion states also already had higher revenues per patient and derived a larger share of their total revenues from Medicaid. Overall, they were in a stronger revenue position leading up to 2014 to expand their patient capacity and scope of services, and their states' Medicaid decisions enhanced their position.
- **Health center opportunities and challenges under the ACA.** The share of health center patients who are uninsured is expected to decline significantly because of expanded coverage under the ACA. However, especially in non-expansion states, health centers will continue to treat high numbers and shares of uninsured people. In addition, health centers will potentially face uncompensated care costs even for patients who *are* insured. Potential sources of uncompensated care costs are under-insurance, including out-of-pocket costs that low-income patients may be unable to pay, as well as services not covered by their health insurance; and QHP provider networks that limit health center participation.

LOOKING AHEAD

Because health centers' ability to grow is so strongly influenced by government policy, measures of health center dynamics and community impacts are informative gauges of the effectiveness of the ACA coverage expansions and safety-net expansions in improving access to care and population health in at-risk communities. Thus efforts to monitor the experiences of health centers in Medicaid expansion and non-expansion states can play a key role in evaluating the impact of health reform.

Introduction

Community health centers are an integral component of the health care safety-net in the U.S., providing access to care for over 21 million mostly low-income patients in medically underserved areas across the country. The Affordable Care Act (ACA) made a major investment in the health center program to help broaden access to care as coverage expands, establishing a five-year, \$11 billion trust fund to support health center growth and new construction over five years, and providing \$1.5 billion to expand the National Health Service Corps (NHSC), from which health centers recruit many of their clinical staff.

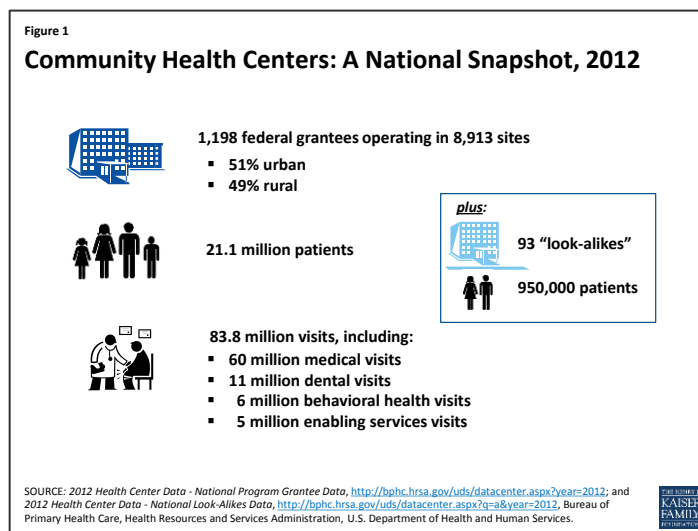
This brief is the latest in an annual series of updates on community health centers produced by the Kaiser Commission on Medicaid and the Uninsured in partnership with the George Washington University's Geiger Gibson Program in Community Health Policy. It provides a current overview of community health centers, the patients they serve, the services they furnish, and the sources of their revenues. It also presents an overview of the nation's "look-alike" health centers, which meet all the requirements of the community health centers program but do not receive federal grants under Section 330 of the Public Health Service Act. Finally, this report assesses the implications of state decisions regarding the Affordable Care Act's (ACA) expansion of Medicaid to nonelderly adults with income up to 138% of the federal poverty level (FPL) for health center growth.

An Overview of Health Centers

HEALTH CENTERS' SAFETY-NET ROLE

The community health centers program was established in 1965 by the Office of Economic Opportunity as a small demonstration program. Under Section 330 of the Public Health Service Act, which authorized the health centers program and is now a permanent authority under the ACA, health centers must satisfy five key requirements to receive federal grant funding. They must be located in or serve medically underserved communities and populations. Their doors must be open all patients, regardless of their ability to pay. They must furnish comprehensive primary health care, defined in both federal statute and regulations. They must prospectively adjust their charges in accordance with patients' ability to pay (i.e., sliding scale fees). And they must be governed by community boards, at least 51% of whose members are health center patients.

Over the nearly five decades since the program was established, both the number of health centers and health center patient volume have grown substantially. In 2012, 1,198 federally funded health centers located in all 50 states, the District of Columbia (DC), and six U.S. Territories, and distributed about evenly between urban and rural areas, served 21.1 million patients in 8,913 different service delivery sites (Figure 1). Over 90 look-alike health centers served almost another 1 million patients. Recently published data indicate that, in 2013, health centers served an additional 600,000 patients.¹

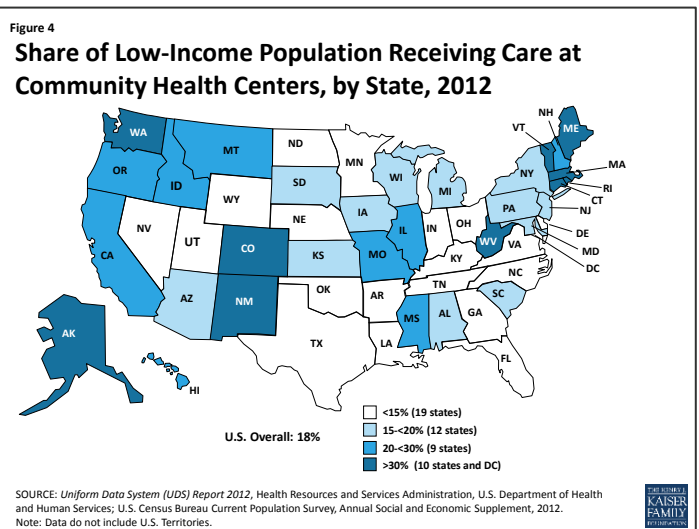
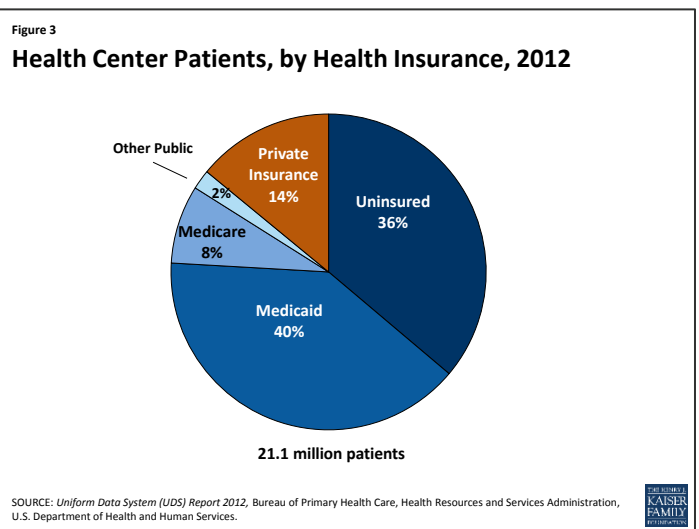
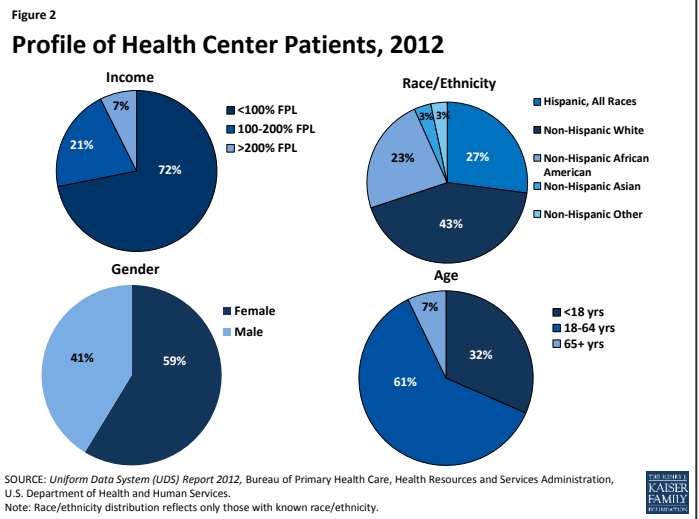


Two main factors have fueled health center growth. The first is the investment of federal grant funding to build and support health centers. The second is increasing revenues from the Medicaid program as a result of both expansions of Medicaid coverage for low-income pregnant women, children, and parents over time, and Medicaid’s prospective, cost-based “federally qualified health center” (FQHC) payment methodology, which also applies to payments under Medicare, CHIP, and payments for covered services by qualified health plans (QHPs) operating in the new health insurance Marketplaces. The FQHC rate enhances health centers’ capacity by covering much of the cost of care furnished to insured patients, which means that health centers do not have to use their grant funds to offset deeply discounted insurance payment rates, and can instead finance care for uninsured patients while expanding both the scope of services they provide and the community locations in which they operate.

HEALTH CENTER PATIENTS

Reflecting the statutory mission of the health center program, almost three-quarters of health center patients have family incomes at or below 100% FPL (Figure 2). About six in ten patients are female. Working-age adults make up the largest share of health center patients – about 60% – while children account for roughly one-third and about 7% are seniors. More than half (57%) of health center patients who report their race and ethnicity are people of color.

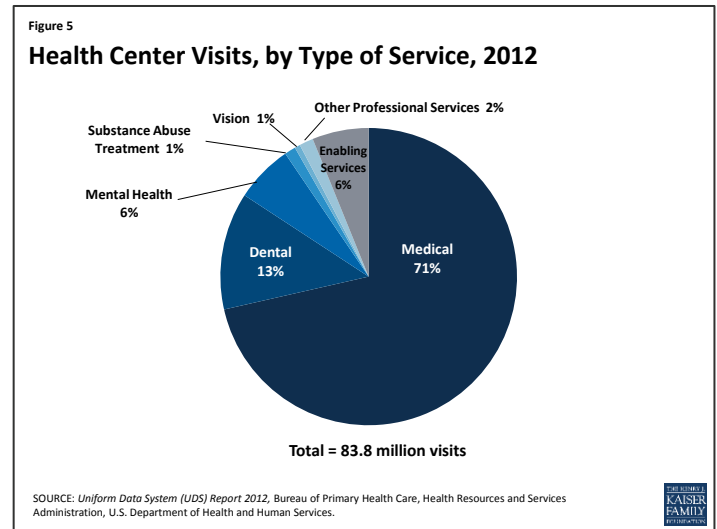
Consistent with their low income, health center patients are disproportionately likely to be uninsured; they are also disproportionately likely to be covered by Medicaid. In 2012, when the uninsured rate for the nonelderly population overall stood at about 18%,² 36% of (all) health center patients were uninsured (Figure 3). Similarly, 40% of health center patients were covered by Medicaid, compared to 21% of the U.S. population overall. Fourteen percent of health center patients had private health insurance and 8% were covered by Medicare.



Health centers play a major role nationally in providing care for low-income populations and an even larger role in many states. In 22 states and DC, health centers serve at least one in five people with incomes below 200% FPL; in ten of these states and DC, health centers provide care to more than 30% of the population with income at this level (Figure 4).

HEALTH CENTER VOLUME, SERVICES, AND STAFFING

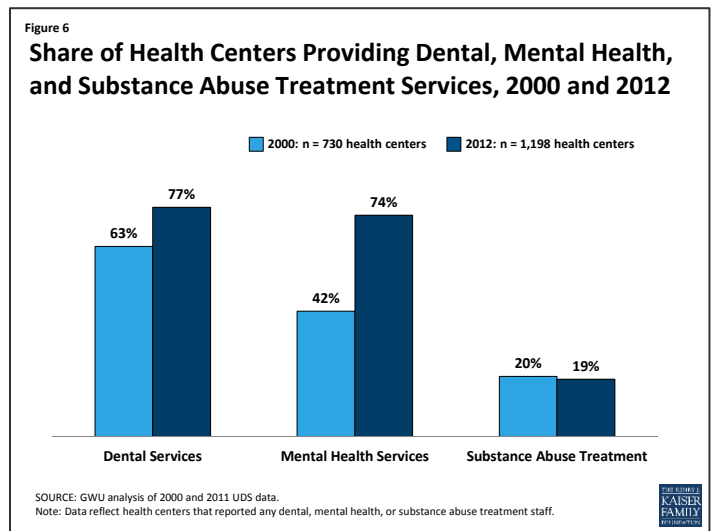
In 2012, patients made 83.8 million visits to health centers (Figure 5). The vast majority of visits (71%) were for primary medical care. Visits for dental care (13%) accounted for the next largest share of the total, highlighting health centers' important role of as a source of oral health care in underserved communities. Another 8% of all visits were for mental health or substance abuse treatment services. In addition to clinical services, health centers offer enabling services, such as case management, transportation, and interpretation services, which help address language, cultural, and other barriers facing low-income individuals and communities. Enabling services accounted for 6% of all health center visits in 2012.



Between 2000 and 2012, the number of health centers rose from 730 to 1,198, and both the number of patients served by health centers and the number of visits provided more than doubled (Table 1).

	Total health centers	Total patients (millions)	Total visits (millions)
2000	730	9.6	38.3
2002	843	11.3	44.8
2004	914	13.1	52.3
2006	1,002	15.0	59.2
2008	1,080	17.1	66.9
2010	1,124	19.5	77.1
2012	1,198	21.1	83.8

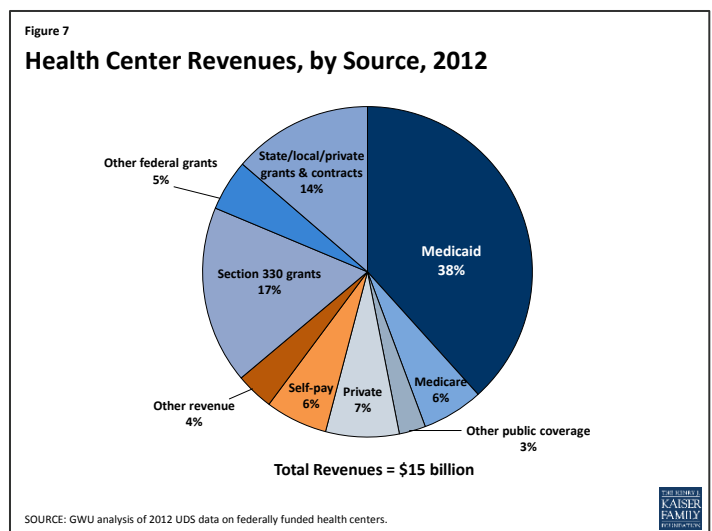
In addition, the scope of services available at many health centers expanded over this 12-year period (as measured by the share of health centers reporting specified types of clinical staff). In particular, more than three-quarters (77%) of health centers now provide dental services, compared to under two-thirds (63%) in 2000 (Figure 6). The share offering mental health services grew even more dramatically – by about 75% – from 42% of health centers in 2000 to 74% in 2012. The fraction of health centers providing substance abuse treatment remained flat at about one-fifth over the period. Still, because of major growth in the number and patient capacity of health centers during this time, many more people using health centers now have access to these services.



Between the beginning of 2009 and June 2012, health centers added more than 25,000 new full-time positions – the number has risen to 43,000 according to the most recent estimate – evidence of their importance as a source of local employment and economic growth in many low-income and underserved communities.³ In 2012, more than 148,000 full-time equivalent (FTE) staff, including 10,000 physicians and more than 7,500 nurse practitioners, worked in health centers; health centers had 124 FTEs, on average.⁴

HEALTH CENTER REVENUES

Health center revenues in 2012 totaled \$15 billion. The single largest source of revenue was Medicaid, which accounted for 38%. Health center grants from the Bureau of Primary Health Care (BPHC), made up the second-largest share, accounting for 17%, and other federal grants provided 5%. Private insurance, Medicare, and out-of-pocket payments provided 7%, 6%, and 6% of health center revenues, respectively. State, local, and private grants and contracts provided 14% and other sources made up the remaining 4% of total health center revenues (Figure 7).



An Overview of “Look-Alike” Health Centers

The federal government recently issued data on look-alike health centers for the first time, reporting on the year 2012. The data reflect 93 look-alike health centers located in 30 states and DC; one-third of all look-alikes are located in California. In 2012, look-alike health centers served over 950,000 patients across 263 delivery sites.

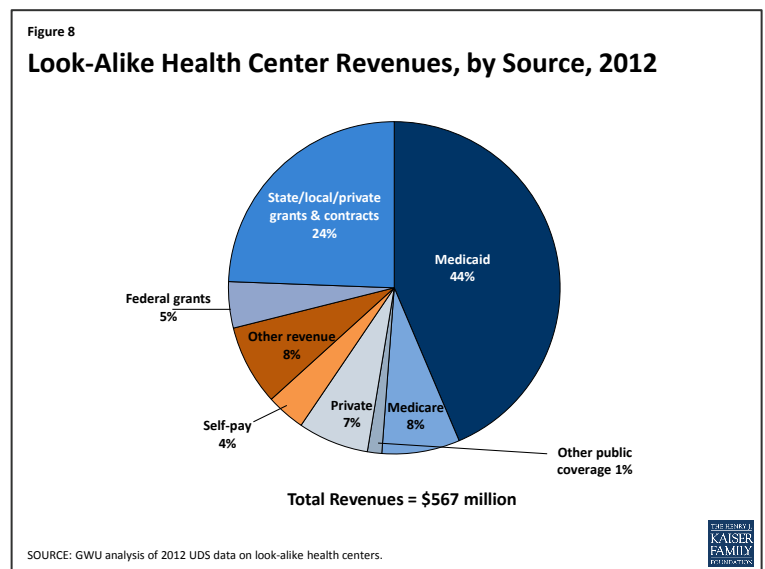
Between their smaller numbers and fewer sites relative to federally funded health centers, look-alikes serve far fewer patients. In 2012, their average caseload was about 10,000 patients per center, compared to about

18,000 in federally funded health centers, and they provided a total of 3.4 million visits, compared to the 83.8 million provided by federally funded health centers.⁵ As is the case with federally funded health centers, over 70% of patients in look-alike health centers are poor. About one-third (32%) of patients in look-alike health centers are uninsured and 44% are covered by Medicaid (Table 2).⁶

Table 2: Characteristics of Federally Funded and Look-Alike Health Centers and Patients, 2012		
	Federally funded	Look-alike
Health center characteristics		
Total health centers	1,198	93
Total sites	8,913	263
Total patients	21.1 million	951,242
Total visits	83.8 million	3.4 million
Average patients/health center	17,674	10,228
Total revenues	\$15 billion	\$567 million
Patient characteristics		
<100%FPL	72%	73%
Uninsured	36%	32%

Medical visits appear to make up a larger share of visits in look-alike health centers than in federally funded health centers— 80% compared to 71%. The apparent difference could, at least in part, reflect more limited capacity among look-alike health centers to provide certain other types of care. For example, dental visits made up 7% of all visits in look-alike health centers in 2012, compared to 13% of all visits in federally funded centers (data not shown).

In 2012, look-alike health center revenues totaled \$567 million – just 7% of the level of total revenues for federally funded health centers. Because look-alike health centers do not receive Section 330 grants, they must rely more heavily on other sources of revenue. Medicaid accounts for almost 44% of their revenues, compared to 38% in federally funded centers; and state, local, and private grants and contracts account for 24% of their revenues, compared to 14% of total revenues in federally funded centers (Figure 8).



Health Centers and Implications of ACA Medicaid Decisions

Under the ACA, regardless of state decisions regarding the Medicaid expansion, federal grant dollars will continue to flow directly to health centers through the regular annual Congressional appropriations process. In addition, federal allocations from the ACA Health Center Trust Fund will continue. However, as discussed

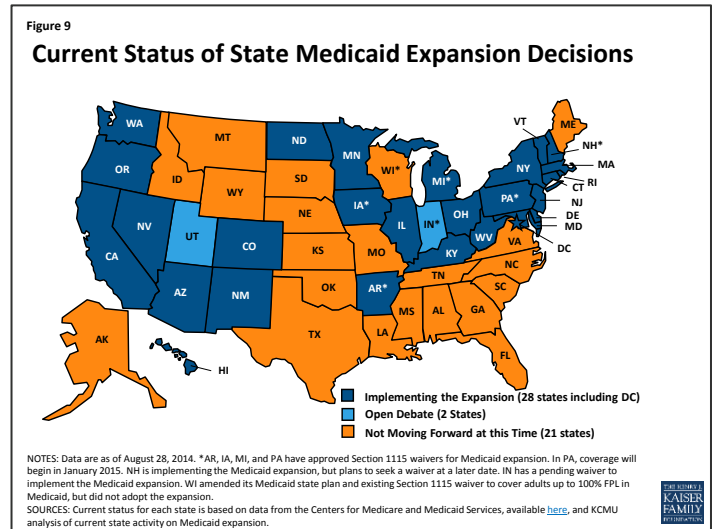
below, state Medicaid expansion decisions have an independent impact on health centers, with respect to the health insurance coverage of their patients and, by extension, health center financing and capacity for growth.

As outlined earlier, in 2012, roughly 60% of all health center patients were working-age adults, a large majority had incomes at or below 100% FPL, and more than one-third were uninsured. This profile closely matches the target population for the ACA expansion of Medicaid – nonelderly adults with income up to 138% FPL. Thus, state decisions regarding the Medicaid expansion could have a large impact on access to coverage for uninsured health center patients. In DC and the 26 states that had, at the time of this analysis, expanded Medicaid, many poor uninsured health center patients may gain Medicaid coverage (Figure 9). (In late August,

Pennsylvania announced that it will expand Medicaid coverage under an approved Section 1115 waiver beginning January 1, 2015.) At the same time, according to a recent analysis, an estimated 1.1 million uninsured health center patients who could qualify for Medicaid if their states implemented the expansion will remain uninsured.⁷ These patients fall into a coverage gap, because the Medicaid eligibility thresholds for adults are very low in these states and premium subsidies for plans in the new Marketplaces are available only for people with income at or above 100% FPL – for those between 100% and 138% FPL, even subsidized premiums may not be affordable.⁸

Notably, state decisions not to expand Medicaid do not affect all populations equally. More than half of all poor nonelderly uninsured adults who fall into the coverage gap are people of color (who are already at much higher risk of being uninsured than Whites). Also, because Blacks are disproportionately likely to reside in the South, where most states are not currently expanding Medicaid, 40% of uninsured nonelderly Blacks in the income band targeted by the Medicaid expansion will fall into the coverage gap.⁹

Regardless of states' Medicaid expansion decisions, increased outreach and enrollment efforts associated with the ACA are increasing participation in Medicaid among children and some parents who were eligible for the program under pre-ACA rules but had not previously enrolled. Thus, health centers in both non-expansion and expansion states can be expected to receive some increased Medicaid revenues just by virtue of more robust participation in the pre-ACA Medicaid program – revenues that help them expand their capacity to serve more patients, add services and/or sites, and improve their operations in other ways. However, by definition, health centers in non-expansion states will not have access to the additional increased patient revenues associated with expanded Medicaid coverage. For this reason, state decisions not to expand Medicaid adversely affect not only coverage of poor uninsured adults, but also the capacity of health centers to serve them. The analysis mentioned earlier estimated that the 544 health centers in the states not then expanding Medicaid will forgo \$569 million in Medicaid revenues in 2014, associated with the roughly 1 million uninsured health center patients in those states who could have gained coverage under the expansion.¹⁰



A comparison between health centers in Medicaid expansion and non-expansion states in 2012 (Table 3) reveals some important differences between health centers in the two groups of states leading up to 2014, discussed below:

Table 3: A comparison of health centers in Medicaid expansion and non-expansion states: patients, staffing, and revenues, 2012		
	Health centers in non-expansion states (n=544)	Health centers in expansion states (n=625)
Total patients***	13,968	20,946
Location***		
Rural	56%	39%
Urban	44%	61%
Health insurance profile of patients		
Uninsured***	44%	35%
Medicaid***	29%	39%
Medicare***	10%	9%
Private insurance	17%	16%
Revenues		
Total***	\$8.6 m	\$16.1 m
Total revenue per patient***	\$687	\$795
Medicaid share of revenues***	25%	34%
Medicaid revenue per Medicaid patient***	\$552	\$681
Medicare share of revenues	7%	6%
Other public insurance share of revenues***	1%	3%
Private insurance share of revenues	8%	8%
Self-pay share of revenues***	9%	6%
Section 330 grants as share of revenues***	33%	22%
Total grants as share of revenues***	52%	45%
Staffing (per 10,000 patients)		
Physicians***	4.2	5.1
Mid-level professionals**	5.1	4.5
Dental FTEs	6.0	6.0
Mental health FTEs	3.1	3.5
Substance abuse treatment FTEs***	0.4	1.4
Enabling services***	6.5	9.0
SOURCE: GWU analysis of 2012 UDS data on federally funded health centers. ***p<.01; ** p<.05; *p<.10 Notes: The non-expansion states include Pennsylvania, which recently announced that it will expand Medicaid under a Section 1115 waiver, beginning January 1, 2015. Data do not include health centers in U.S. Territories.		

- **Coverage.** In 2012, before state actions on the Medicaid expansion, health center patients in the states moving ahead with the expansion at the time of this analysis were already significantly more likely to be covered by Medicaid (39% vs. 29%) and significantly less likely to be uninsured (35% vs. 44%). Privately insured patients accounted for similar proportions of health center patients in both group of states. The differences in Medicaid and uninsured rates among health center patients between the two groups of states largely reflect much broader Medicaid eligibility for adults in the expansion states even before 2014, compared to states that are not expanding Medicaid at this time. Indeed, as of January 2013, the median income eligibility threshold for working parents in the expansion states was 106%, compared to 48% FPL in the non-expansion states (this threshold has since dropped to 46% FPL.)¹¹

- **Revenues.** The pre-ACA revenue picture was also distinctly different between health centers in expansion and non-expansion states. In 2012, revenues in health centers in expansion states averaged more than \$16 million, compared to slightly more than \$8.6 million among health centers in non-expansion states, and revenues per patient were also significantly higher. Mirroring the differences in the coverage status of their patients, health centers in expansion states derived 34% of their revenue from Medicaid, compared to 25% in health centers in non-expansion states. Average Medicaid revenue per Medicaid patient was also significantly higher in expansion states, likely a reflection of greater clinical capacity among health centers in the expansion states, due in part to their better revenue situation. Heading into 2014, health centers in states not currently expanding Medicaid already were significantly more dependent than those in Medicaid expansion states on federal Section 330 grants (33% vs. 22% of total revenues) and grant funding overall (52% vs. 45%), as well as on self-pay patient revenue (9% vs. 6%).
- **Staffing.** In 2012, health centers in the Medicaid expansion states had significantly higher ratios of physicians to patients but significantly lower ratios of mid-level professionals (such as nurse practitioners and physician assistants) to patients, relative to health centers in the non-expansion states. In part, this difference may reflect the fact that health centers in the non-expansion states are more likely to be located in rural areas, where physician supply is more limited. Health centers in expansion states also had significantly more staff capacity to provide enabling services and substance abuse treatment. Notably, however, dental staff capacity did not differ between health centers in the two groups of states.

Financial Challenges Facing Health Centers

Separate from increased revenues from health center patients attributable to broader coverage, the ACA's major investment in health centers and increased funding for the NHSC are supporting substantial expansion of preventive and primary care capacity and access in underserved communities as coverage expands and the demand for health care increases, and they help to ensure and improve access to care for people who remain uninsured. However, both these federal funding sources are set to expire in 2015 and, going forward, health centers face a set of financial challenges.

While the share of health center patients who are uninsured is expected to decline significantly due to new coverage under the ACA – from 36% in 2012 to an estimated 23% in 2020¹² – health centers, even in Medicaid expansion states, are likely to continue to treat high numbers and shares of low-income patients without coverage. The experience of health centers in Massachusetts following a 2006 expansion of coverage to adults with incomes up to 300% FPL illustrates what may lie ahead for health centers under the ACA.¹³ Although the share of health center patients who lacked insurance declined sharply due to the coverage expansion, Massachusetts health centers continue to serve a population with a disproportionately high uninsured rate – about 20%, compared to 4% overall statewide.¹⁴ In states not expanding Medicaid, nonelderly adults with incomes between 100% and 138% FPL are generally eligible for subsidies to purchase QHPs. However, even with subsidies, many health center patients with income this low may be unable to afford the premiums for Marketplace plans and thus remain uninsured.

In addition to the costs of caring for those who remain uninsured, health centers may also face uncompensated care costs for patients who *are* insured, due to under-insurance and limited QHP provider networks:

- ***Under-insurance.*** Under the ACA, people with incomes up to 250% FPL who purchase Silver plans can qualify for cost-sharing reductions. Although the reductions are substantial, potential annual out-of-pocket exposure for covered services still amounts to nearly 20% of income for an individual at the poverty level and 10% of income for a poor family of three.¹⁵ Cost-sharing reductions do not apply in (more affordable) Bronze or catastrophic plans. If patients face cost-sharing that they cannot afford, their providers face uncompensated costs. How patient cost-sharing exposure will affect health center revenues is an open question. QHPs are required to pay health centers the FQHC rate for covered services, but because plans have broad discretion in how they distribute cost-sharing reductions, the amounts health centers actually receive could fall short.¹⁶ Depending on how the assistance is structured, insured health center patients could be effectively uninsured for health center care if they face high deductibles and copays or coinsurance for services like maternity and newborn care or management of chronic conditions. Health centers also incur uncompensated costs if they provide services to insured patients that their insurance does not cover, such as dental services for adults.
- ***Limited provider networks.*** If patients are enrolled in QHPs whose networks do not include their health centers, then their health centers receive no QHP payment for the visits they provide to them. Research on the Massachusetts experience referenced earlier highlighted the importance of network counseling as part of health plan enrollment assistance to protect established health center patients from inadvertently selecting a plan that does not include their health center.¹⁷ The ACA requires that QHP networks include a sufficient number and geographic distribution of “essential community providers” (ECPs), including health centers, but the implementing regulations give plans significant discretion regarding the ECPs with which they contract.¹⁸ HHS has set minimum requirements, but also indicated latitude for waivers.¹⁹ Official CMS correspondence indicates that a QHP that does not contract with any health center in its service area would be obligated to pay a health center the FQHC rate for covered services even though it is out-of-network,²⁰ but this policy has not been codified in regulations.

The financing gaps that health centers face, arising from serving uninsured and under-insured patients and from provider network limitations, underscore the role that direct federal grant funding plays in stabilizing health centers and promoting access to primary care in the communities they serve. Moreover, the experience of Massachusetts health centers demonstrates that this funding is important even in Medicaid expansion states, for the remaining uninsured population. The \$11 billion health center growth fund included in the ACA is slated to sunset at the end of FY 2015. A key question is whether, separate from ongoing annual health center appropriations, this fund will be extended by Congress to support additional health center growth and service capacity, and to offset costs associated with unpaid cost-sharing and non-covered services. The President’s FY 2015 budget calls for continuation of the Health Center Trust Fund in addition to the annual operational grants to health centers made through the discretionary appropriations process. Whether Congress will extend the Trust Fund remains to be seen. Another question is whether the allocation of Health Center Trust Fund dollars should take states’ Medicaid expansion decisions into account and, if so, how.

Looking Ahead

The ACA’s investments in coverage, as well as its direct investments in primary health care, stand to improve the accessibility and quality of health care for the 60 million people estimated to lack adequate access to primary care.²¹ As these reforms take hold, health centers in states and communities that more fully benefit

from the coverage expansions can be expected to grow, and the scope and quality of their care can be expected to increase. In the same vein, health centers in the nearly two dozen states that, to date, have elected not to proceed with the Medicaid expansion, will likely have less service capacity and less ability to make capital investments and attract personnel, and their services will likely reach fewer people.

Because health centers' ability to grow – in number, scope, and reach – is so strongly influenced by government policy, measures of health center dynamics and community impacts are informative gauges of the impact of the ACA's coverage expansions and safety-net investments on access to care and population health in at-risk communities. Thus, efforts to monitor the experiences of health centers in expansion and non-expansion states can play a key role in evaluating health reform. Some important questions to assess include:

- How does the health insurance profile of health center patients compare in Medicaid expansion and non-expansion states?
- As the coverage expansions take hold, how do health center organization, structure, and staffing change, especially in the Medicaid expansion states? Do staffing, recruitment, and retention experiences differ between health centers in expansion and non-expansion states?
- Do health centers in expansion versus non-expansion states differ with respect to their participation in population health-oriented activities (e.g., nutrition and exercise programs, community health promotion)?
- Do measures of health care quality differ between health centers in the two groups of states?
- Is there any connection between Medicaid expansion and health center implementation of quality improvement strategies (e.g., advanced HIT, health homes) and/or affiliation with larger health care systems in their communities, such as accountable care organizations?

Health centers have a long history of strong performance even as they confront both financial and human capital challenges. The different environments that health centers in Medicaid expansion and non-expansion states face in the next several years will help to shape the next chapter in their history. What is learned from close analysis of health centers' experiences can help to elucidate the mechanisms of the ACA's impact and the broad implications of state decisions about the Medicaid expansion – most importantly, their impact on access to care for uninsured and low-income individuals and families.

Funding support for this paper was provided to The George Washington University by the RCHN Community Health Foundation.

Endnotes

- ¹ *2013 Health Center Impact*, Bureau of Primary Health Care, Health Resources and Services Administration, US Department of Health and Human Services, <http://bphc.hrsa.gov/healthcenterdatastatistics/>
- ² *The Uninsured: A Primer* (Supplemental Tables, Table 1). Kaiser Commission on Medicaid and the Uninsured (2013), <http://kff.org/report-section/the-uninsured-a-primer-2013-tables-and-data-notes/>
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- ¹⁵ The 2014 federal poverty level (FPL) is \$19,790 for an individual and \$31,670 for a family of three. See *2014 Poverty Guidelines*, <http://aspe.hhs.gov/poverty/14poverty.cfm>.
- ¹⁶ Certain clinical preventive services must be furnished free of charge under the ACA: immunizations recommended by the Advisory Committee on Immunization Practices, clinical preventive screening services with an A or B classification from the U.S. Preventive Services Task Force, certain children’s preventive services, and designated women’s preventive services, including all FDA-approved contraceptive methods.
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- ¹⁸ 45 C.F.R. §156.235(a)
- ¹⁹ HHS/CCIIO 2015 Letter to Issuers in the Federally-facilitated Marketplaces, <http://2c4xez132caw2w3cpri1l98fssf.wpengine.netdna-cdn.com/wp-content/uploads/2014/03/2015-final-issuer-letter-3-14-2014.pdf> (Accessed online August 13, 2014)

²⁰ Letter to Daniel Hawkins from Timothy Hill, Deputy Director, HHS/CCIIO, dated June 8, 2012. (“ . . . [C]onsistent with the . . . Affordable Care Act, a QHP issuer must pay an FQHC the relevant Medicaid PPS rate for the items and services the FQHC provides to a QHP enrollee, if the QHP issuer and the FQHC have not contracted on a mutually agreeable rate. . . . That means that if a QHP issuer does not have a contract with an FQHC, the QHP issuer must pay the FQHC the Medicaid PPS rate for the items and services furnished to the QHP enrollee.” (p. 2)

²¹ *Primary Care Access: An Essential Building Block of Health Reform* (2009), National Association of Community Health Centers, <http://www.nachc.com/client/documents/pressreleases/PrimaryCareAccessRPT.pdf>