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Community Health Centers Play a Critical Role in Caring for the Remaining Uninsured in the Affordable Care Act Era

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“There’s a general perception that everybody has insurance now...{but} 17 percent of our patients are still uninsured and undocumented.”

— New York CHC director

SUMMARY: Federally Qualified Health Centers¹—commonly referred to as Community Health Centers (CHCs)—serve as a safety net for people who did not gain health insurance under the Affordable Care Act (ACA), including those immigrants not eligible for Medicaid or health insurance exchange coverage. ACA-driven changes in health insurance coverage, funding, and related policy have created new challenges for these safety net organizations.

This policy brief reports the findings from analyses of the U.S. HRSA Uniform Data System and interviews conducted in 2014-16 with the leadership of 31 CHCs. The CHCs were located in communities with high concentrations of

immigrants and uninsured residents, in states that either expanded Medicaid (California and New York) or that chose not to expand it (Georgia and Texas). The study found that most CHCs now see more patients, including significant numbers without insurance. The ACA has brought new resources to CHCs but has also reinforced challenges, including the need for stable revenue streams, sufficient staffing support, and assistance in leveraging new reimbursement mechanisms. Policy recommendations to address these challenges include continuing core federal funding, insuring the remaining uninsured, addressing workforce challenges, and preparing CHCs for alternative payment mechanisms.

CHCs are primary care providers with a mission to serve low-income and underserved communities. Nationally, more than 6 million CHC patients (28 percent) were uninsured in 2014,² accounting for about one-third of all low-income uninsured persons nationally. Significant numbers of uninsured patients are served by CHCs in the four states examined in this analysis: California, New York, Georgia, and Texas. Of the two states that did not expand Medicaid (Georgia and Texas), almost half (46 percent) of those served by CHCs were uninsured (Exhibit 1). CHCs in the expansion states of New York and California also had significant numbers of uninsured patients (19 percent and 27 percent, respectively).

CHCs Have Served More Insured Patients Post-ACA

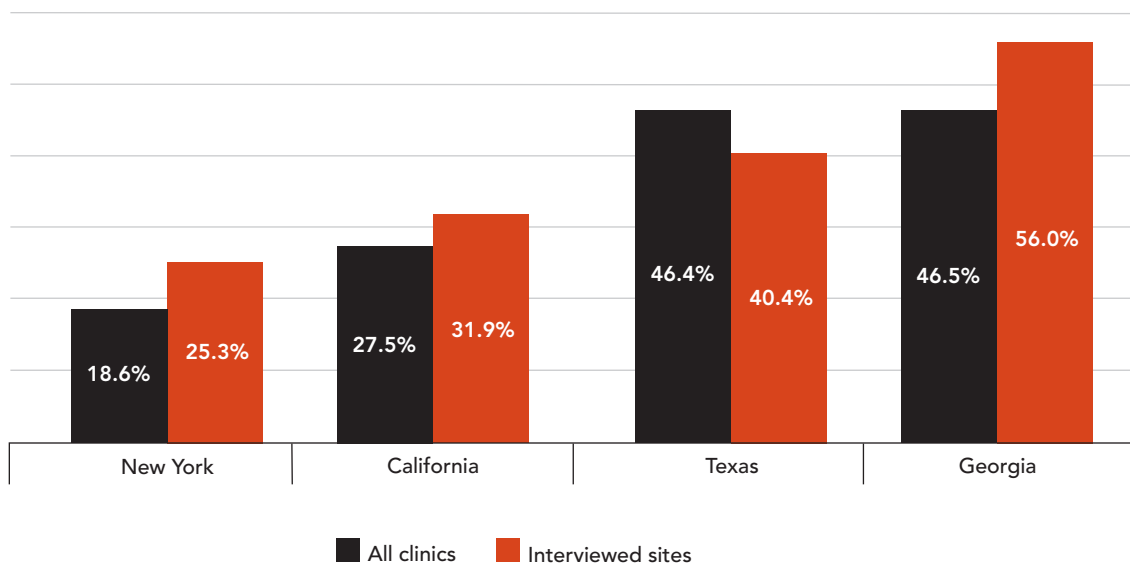
Prior to ACA, some predicted that newly insured persons would leave CHCs for private providers. Instead, the number of insured patients served has increased over time, both nationally and in this study’s sample of CHCs in immigrant communities. Nationally, the number of insured patients using CHCs rose from 12 million in 2010 to 16.5 million in 2014, an increase of 35 percent.³ In all four states studied, the total number of insured patients increased as well, with the greatest growth in California (from 1.67 million to 2.70 million, a 61 percent increase), followed by New York (1.05 to 1.44 million, 37 percent increase); Texas (440,000 to 630,000, 43



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Exhibit 1

Mean Percent of Federally Qualified Health Center Patients Who Were Uninsured, New York, California, Texas, and Georgia, 2014



Source: U.S. HRSA, Uniform Data System²

“It’s difficult to have these conversations with patients and try to tell them that they are too poor to benefit (from the ACA).”

– Georgia CHC director

percent increase); and Georgia (157,000 to 198,000, 26 percent increase) (Exhibit 2).

The data shown in Exhibit 2 suggest that the demand for safety net services remains high in both expansion and nonexpansion states. Most CHCs saw an increase in the number of insured patients, both because they retained previous patients who became insured and because they attracted new insured patients. Interview respondents shared examples in which newly insured, long-time patients chose to continue seeking care at their organizations because of long-standing relationships and rapport. One respondent reported that some newly insured patients had tried out different providers and had returned to the CHC because of the perceived better quality of care.

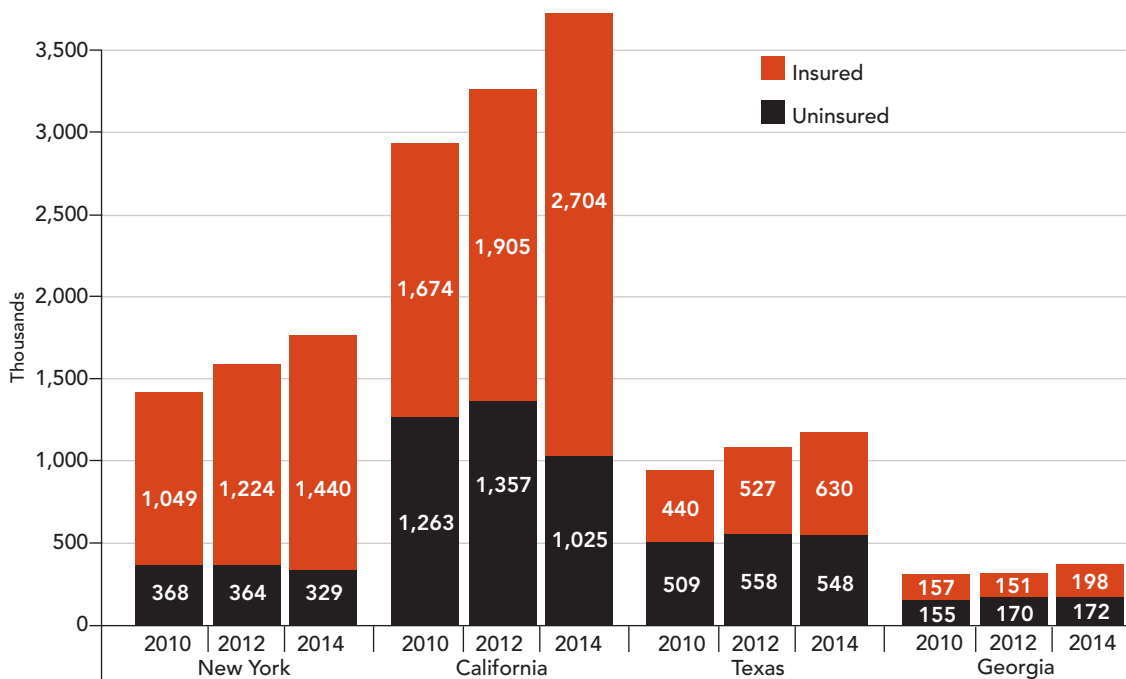
CHCs Continue to Serve Large Numbers of Patients Who Remain Uninsured

The numbers of uninsured CHC patients are substantial across all four states in our study. In the nonexpansion states of Georgia and Texas, the total number of uninsured CHC patients increased from 2010 to 2014, while New York experienced a modest decline. Only California showed a significant decline in the number of uninsured served by CHCs, but more than 1 million patients remained uninsured (Exhibit 2).

In Georgia and Texas, interview respondents pointed out that many of their current citizen or documented immigrant patients had incomes that were too high for them to qualify for Medicaid, but not high enough that they could qualify for federal marketplace subsidies because their states did not expand Medicaid.⁴ Likewise, some of those newly insured through the exchanges had high-deductible policies, which meant that they continued to use the subsidized primary care services of CHCs.

Number of Insured and Uninsured Patients (in Thousands) Served at Federally Qualified Health Centers, New York, California, Texas, and Georgia, 2010, 2012, 2014

Exhibit 2



Source: U.S. HRSA, Uniform Data System²

CHCs Continue to Serve Many Uninsured Immigrants

Across all four states studied, CHCs reported that a common reason that patients were ineligible for insurance was their legal status. Over half of all immigrants nationally are not citizens and face barriers to coverage because of their legal status.⁵ Respondents in all four study states served individuals who were undocumented. In addition, in Georgia and Texas, some documented immigrants—such as recently arrived Lawful Permanent Residents and immigrants with Deferred Action for Childhood Arrivals (DACA)—also remained ineligible for insurance. Using the proportion of patients “best served in a language

other than English” as a rough proxy for all immigrant patients,⁶ we found that immigrants were an increasingly larger share of patients served by CHCs. Between 2010 to 2014, the population of these patients grew from 4.7 million to 5.3 million persons nationally, a 12 percent increase. CHCs in our study states have estimated proportions of immigrants in their patient populations that are similar or higher to the proportions of immigrants in those states’ low-income populations⁷ (Exhibit 3).

Short-Term Boost in Federal Grants Provided CHCs with Needed Support

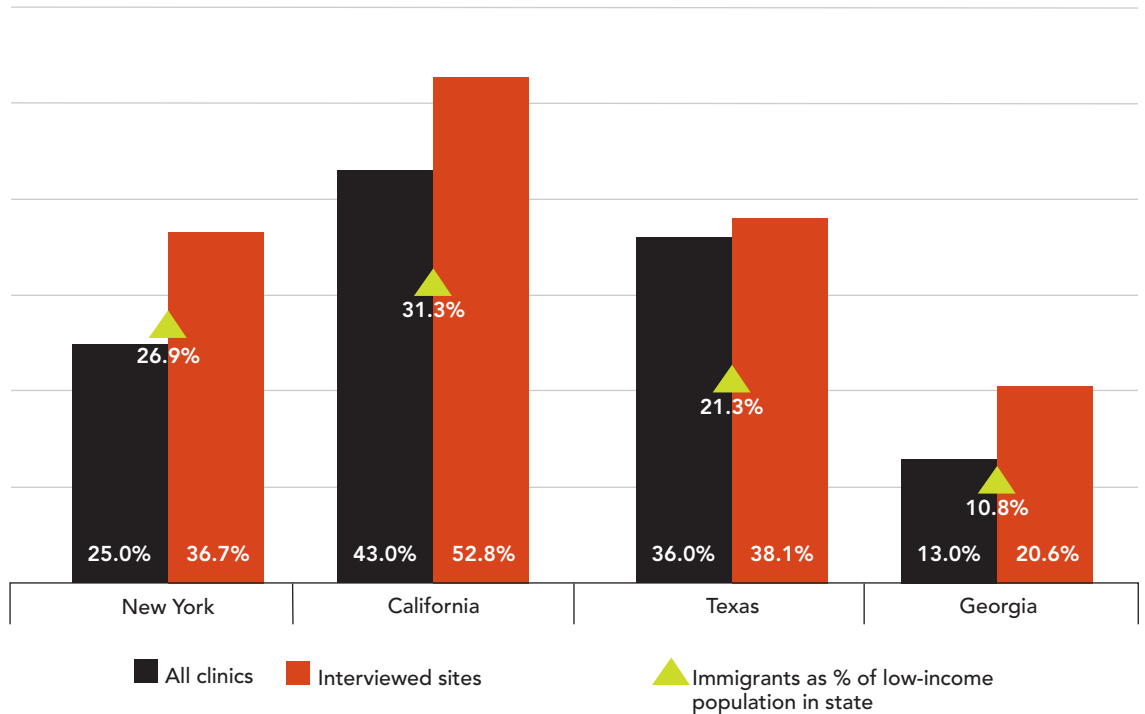
Both prior to the ACA and currently, the federal core grant⁷ for FQHCs from HRSA has been a primary source of funding to offset the costs of care for uninsured patients who pay on a sliding fee scale. A few CHCs have also received additional federal funding—such as family planning and Ryan White funds—that helps pay for the uninsured.

“There was a tremendous amount of publicity and buzz around the rollout of the ACA.... So a combination of the information out there and the fact that there was a huge expansion allowed us to see more of the uninsured and the undocumented who were seeking services.”

– California CHC director

Exhibit 3

Mean Percent of Federally Qualified Health Center Patients Best Served In a Language Other Than English, and Immigrants as a Percent of Low-Income Population, New York, California, Texas, and Georgia, 2014



Source: U.S. HRSA, Uniform Data System² and U.S. Census American Community Survey⁵

“{We} look at that balance of making sure that we’re providing services for the population we serve in the right capacity and the right amount...but also making sure we’re financially sustainable.”

– Texas CHC director

However, one of the most significant impacts of the ACA for CHCs was the influx of new targeted federal grants. Across all four states, but especially in nonexpansion states, these grants provided a needed infusion of resources for conducting outreach and meeting the ongoing needs of patients.

CHCs reported that service and infrastructure expansion grants increased capacity for new clinical services, such as pharmacy, behavioral health, and dental health. At some CHCs, these grants provided the opportunity to establish or expand services that were likely to increase revenue, such as pediatrics or obstetrics and gynecology, since children and pregnant women were more likely to have coverage under Medicaid. Grants were also used to recruit nonclinical staff in charge of supporting and growing community outreach, patient education, and care coordination.

Despite new and ongoing sources of funding, CHCs face significant financial challenges. Few CHCs have contingency plans for the reduction in enhanced funding scheduled to occur in 2017, as there is no ready source of replacement funds nor any simple way to reduce expenditures without impairing the ability to serve existing patients. Further, it is unclear what the financial impact may be on CHCs if Medicaid changes from a cost-based reimbursement to a capitation or health outcome-based reimbursement. Respondents reported that their organizations are not prepared for a shift from current payment systems that are based largely on patient visits to value-based payment systems that focus more on patient outcomes.⁸

ACA Funding Enabled CHCs to Expand Outreach and Enroll Uninsured Patients in Health Insurance Programs

CHCs increased their numbers of insured patients through outreach and enrollment activities aimed at both their existing uninsured patients and new patients. Some CHCs reported that they previously had not dedicated significant resources to outreach and enrollment, but that they used ACA funding to participate in community events to enroll significant numbers of new and existing patients in health insurance, at the same time increasing their visibility in the community. Many CHCs reported that the passage of the ACA resulted in increased public awareness about available health insurance. Even in states that did not expand Medicaid, CHCs successfully enrolled many children and adults who were previously eligible for Medicaid or CHIP (Children's Health Insurance Program) but were not enrolled.

CHCs Continue to Face Infrastructure and Financial Capacity Limits

Many CHCs reported that limitations in infrastructure, including clinical space and equipment, posed an obstacle to expanding services. Some of the smaller CHCs reported that the limited availability of capital funding grants and the competition for them created a barrier to expanding physical capacity. A significant challenge for CHCs was that expansion of services required new funding, but generating new funding often required increased revenue-generating services. And growth had its own costs, such as the need for increased administrative capacity to enroll more patients in insurance and to implement organizational policies (e.g., the use of electronic health records for monitoring quality and outcome indicators). Each CHC pursued financial strategies tailored to its organizational needs. These included engaging in strategic planning, developing systems for long-term planning, conducting financial modeling using the CHC's own data, growing financial reserves, and improving billing and reimbursement processes.

CHCs Must Carefully Balance Their Payer Mix and Services

While HRSA core grants are essential to CHCs, most seek Medicaid, Medicare, and private insurance patients, as well as public and private grants. Many CHCs mentioned that adult primary care receives the least amount of federal funding and is also the most difficult service area in which to obtain additional foundation grants. To maximize the number of uninsured patients they can afford to serve, many CHCs share resources among those clinic sites that have more insured patients and services and those that have higher levels of uncompensated care. Services that were revenue generators in some states were revenue losers in others; for example, Medicaid coverage for dental services is different in each state. As a result, the optimal balance of payer mix and services was specific to organizations as well as sites.

CHCs Faced Workforce Recruitment and Retention Challenges

CHCs across all four states reported that challenges to recruiting and retaining staff led to more financial and capacity challenges. One of the most common difficulties was the ability to provide competitive salaries for hiring and retaining clinical staff,⁹ who were being recruited by private sector providers increasing staffing due to an influx of insured patients. Because of the low-income and often immigrant patient populations of CHCs, respondents noted that they had the additional challenge of identifying employees who were culturally competent and embraced the CHC's mission. Workforce shortages often prevented or delayed the expansion of services, even when there was adequate space and patient demand. Some sites reported using per diem providers to fill in gaps or sharing providers with a local hospital or another CHC.

“We provide care regardless of someone's ability to pay. The elimination of {enhanced federal funding} would impact {our}...being able to afford the appropriate and qualified staff to provide the quality of services that we want to provide, that we believe the community deserves.”

– Georgia CHC director

“If you want to do it right, you have to have the proper staffing for it.”

– California CHC director

CHCs faced challenges in hiring sufficient administrative staff for effective billing and reimbursement, documenting and tracking service quality and patient outcome indicators, and grant writing. New IT systems increased the data available but also created new specialized staffing needs. Several CHCs reported that responding to grant opportunities required staff to collect data and prepare reports on top of their daily workload. Increased patient loads also required administrative staff to take on more intake duties, care coordination, and case management. On the other hand, ACA funds for marketplace navigators and outreach staff relieved some financial pressure on many organizations. In some cases, it freed up discretionary funds that had been used for outreach and enrollment to be used for other high-priority services.

Policy Implications and Solutions

CHCs continue to be key providers of primary care to the remaining uninsured in the ACA era. Fostering a robust CHC delivery system requires continued public policy effort, including the following:

Maintain and enhance CHC core funding.

The ACA temporarily provided enhanced funding for CHCs to help them expand services, under the assumption that having more insured patients would make a long-term boost unnecessary. The enhanced funding, which accounts for 70 percent of direct federal funding to CHCs,⁷ is set to end after Fiscal Year 2017. But the large numbers of uninsured patients still served by CHCs makes a permanent boost in the federal core grant necessary to avoid cuts to services available to the remaining uninsured.

Expand Medicaid in all states. The expansion of Medicaid is critical to the financial stability of CHCs. More insured patients translate into more stable revenue

streams, allowing CHCs to provide and expand needed services rather than devoting resources to fundraising. Respondents in nonexpansion states reported that any Medicaid expansion, whether through a waiver or state plan amendment, is the most important policy change needed by their organizations.

Extend insurance coverage for currently ineligible immigrants. Even in expansion states, coverage should be extended to those who are currently ineligible due to their legal status. State and local policies to expand coverage are needed, such as for undocumented children (e.g., New York State’s Child Health Plus and California’s Health4AllKids) or for the remaining uninsured who are not eligible for other coverage (such as Healthy San Francisco, My Health L.A., and the new ActionHealthNYC).¹⁰

Increase workforce availability. Challenges in recruiting and retaining clinicians and the lack of reimbursement of many nonclinical services limit the service capacity of CHCs. Respondents reported that changes in the scope of practice laws could significantly increase their capacity. In Georgia, respondents noted that current law made it difficult for small CHC sites to provide full services when a supervising physician is temporarily not available, even though a nurse practitioner (NP) could provide needed care.¹¹ In addition, reimbursement for services such as care coordination and language interpretation will increase CHC revenues and service capacity. Finally, covering volunteer providers under the Federal Tort Claims Act (FTCA) for malpractice coverage will make it easier for CHCs to expand capacity.¹²

Prepare CHCs to move away from traditional volume-based reimbursement.

Most CHCs are not adequately prepared for a value-based reimbursement system and fear being penalized for serving a sicker and more disadvantaged patient mix. However, most payers are moving toward alternative payment models that require accountability for patient outcomes. Some CHCs are preparing for these changes by using patient data to monitor increasing numbers of health outcomes, improving care coordination, creating team-based models of care, partnering with private providers, and establishing formal collaborative agreements among themselves. CHCs require further time, resources, and new expertise to successfully transition to new payment models.⁸

Methodology

We collected in-depth information from 31 CHCs representing four states, focusing on two regions within each state. The states were two Medicaid expansion states with the largest immigrant populations (CA and NY) and two nonexpansion states, one with the largest number of immigrants (TX) and one with a large number of immigrants and a policy climate hostile to both the ACA and undocumented immigrants (GA). For each state we selected the largest city and one other region with significant concentrations of noncitizen residents. Finally, we selected CHCs within each region that served a patient population of whom at least 10 percent were best served in a language other than English. The final sample included CHCs in the following locations: Los Angeles (n=6) and Fresno (n=3), California; New York City (n=5) and the Hudson Valley region (n=3), New York; Atlanta (n=4) and South and East (n=4), Georgia; and Houston (n=5) and South Texas (n=1). Community Health Center data were drawn from U.S. HRSA Uniform Data System 2010, 2012, and 2014 and the American Community Survey 2014. For additional details about the methodology, please see http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/Methods_FQHCPB_10-26-16.pdf.

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Endnotes

- 1 Our analysis is limited to CHCs regulated by the U.S. Health Resources and Services Administration (HRSA), which includes the vast majority but not all FQHCs.
- 2 Data from 2015 show the number of uninsured CHC patients remaining relatively constant at 5.9 million, or one-third of all low-income uninsured persons in the U.S., but the proportion of all CHC patients uninsured declined to 24.4% as a result of more insured patients at CHCs. (2015 Health Center Data, HRSA: <http://bphc.brssa.gov/uds/datacenter.aspx>)
- 3 In 2015, the numbers continued to increase, rising to 18.4 million insured nationally. The number of insured CHC patients in California was 3.15 million; New York, 1.59 million; Texas, 706,000; and Georgia, 233,000. See reference 2.
- 4 For example, in Texas, adults with dependent children must have incomes below 15% of the Federal Poverty Level (FPL) to qualify for Medicaid, and adults without dependents are not eligible at all. See <https://www.medicaid.gov/medicaid-chip-program-information/by-state/texas.html>. Federal subsidies on the exchange are available only to those with incomes of 100-400% of the FPL, leaving an estimated 684,000 uninsured Texans in the "gap" between Medicaid eligibility levels and eligibility levels for subsidized private coverage in the exchange. See <http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

“...{With} the ups and downs of whether you're going to get more funding here or there—it's been hard to plan. Half of the volatility {comes} from our federal funding side, not our everyday patient population.”

– Georgia CHC director

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5 See the Migration Policy Institute for demographic information on the immigrant and noncitizen population: <http://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states>

6 See U.S. Census, *American Community Survey*. From IPUMS-USA, University of Minnesota, <https://usa.ipums.org/usa/cite.shtml>. About three-quarters of low-income noncitizens and half of naturalized immigrant citizen adults speak English less than “very well,” making “best served in a language other than English” (the only clinic data available) a reasonable proxy but probably an underestimate of the immigrant population at clinics. Few who are U.S.-born are in this category.

7 See: Heisler EJ. 2015. Congressional Research Service. *The Community Health Center Fund: In Brief*. http://digital.library.unt.edu/ark:/67531/m12dc503374/m111/high_res_d/R43911_2015Feb12.pdf. Some health centers also receive funding that targets uninsured special populations, such as the homeless and migrant workers. See <http://hpbpc.brsa.gov/qualityimprovement/strategicpartnerships/specialpopulations/index.html>

8 See: Rosenbaum S, Shin P, Sharac J. 2016. Community Health Centers and the Evolution of Medicaid Payment Reform. *To the Point* (Commonwealth Fund), and companion report: <http://www.commonwealthfund.org/publications/blog/2016/oct/community-health-centers-medicaid-payment-reform>.

9 Similar findings of staffing challenges are reported from a national survey of CHCs. See: National Association of Community Health Centers. 2016. *Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers*. http://natchc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf

10 For statewide coverage for children in New York, see <http://www.wnylc.com/health/entry/53/>. For a local example, see: Marrow HB. 2012. Deserving to a Point: Unauthorized Immigrants in San Francisco's Universal Access Health Care Model. *Soc Sci Med* 74(6):846-54. doi:10.1016/j.socscimed.2011.08.001; and <http://www.latimes.com/local/lanow/la-me-ln-remaining-uninsured-los-angeles-20141006-story.html>.

11 For more details, see: Stephens B. 2015. Perspectives on Advanced Practice Registered Nursing in Georgia. *Georgia Watch*. <http://www.georgiawatch.org/wp-content/uploads/2015/01/APRN01072015WEB.pdf>. For a more general discussion of this issue, see: Ku L, Frogner BK, Steinmetz E, Pittman P. 2015. Community Health Centers Employ Diverse Staffing Patterns, Which Can Provide Productivity Lessons for Medical Practices. *Health Aff* (Millwood). 34(1):95-103.

12 See Family Health Care Accessibility Act of 2015, S.2151, 114th Cong. (2015). <https://www.congress.gov/bills/114/congress/senate-bill/2151>