THE COMMONWEALTH FUND

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POLICY BRIEF

COMMUNITY HEALTH CENTERS IN A CHANGING U.S. HEALTH CARE SYSTEM

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For more than 30 years, community health centers (CHCs) have played a crucial role in serving some of the nation's most vulnerable populations. Driven by a mission to serve all, regardless of ability to pay, CHCs deliver services to poor and medically underserved patients through a network that includes migrant health centers, homeless health centers, and other community-based centers.

Today, CHCs face an array of problems that threaten their ability to provide accessible, high-quality care to their patients. Like other safety net providers, CHCs have been affected by the growth of managed care, the expansion of the for-profit health care sector, and other profound changes in the nation's health care system. At the same time, longstanding problems such as lack of health insurance and high rates of preventable mortality and morbidity among minority and disadvantaged populations remain to be solved.

The following analysis describes the importance of CHCs as a source of care for low-income and uninsured populations, discusses the impact of market changes on safety net providers, and offers strategies to ensure that they survive.

A SAFETY NET FOR THE POOR AND UNINSURED

CHCs serve as the entry point to the health care system for millions of Medicaid beneficiaries, the uninsured, and people residing in medically underserved areas. Many of these people are members of minority groups and suffer disproportionately from health problems and disease. Of the 10 million people served by CHCs in 1996, 41 percent were uninsured and another 33 percent were on Medicaid; just over two-thirds were members of a racial or ethnic minority group. Sixty-five percent of CHC patients live below the federal poverty level, while another 20 percent live from 100 to 200 percent of the poverty level.[1]

In 1996, CHCs also provided care for approximately 450,000 homeless people and 500,000 seasonal and migrant workers. Approximately 40 percent of patients are children, 90 percent of whom live at less than 200 percent of poverty.[2]

Community Health Center Patients, 1996

Characteristic	Percentage
Ethnicity	
White	35%
Hispanic	31%
African American	27%
Asian/Other	7%
Age/Gender	
Children	42%
Women of Childbearing Ages	32%
Other	26%
Economic Status	
Below poverty	65%
100%–200% poverty	20%
>200% poverty	15%
Payor Source	
Uninsured	41%
Medicaid	33%
Private	14%
Medicare	4%
Other public	4%

Source: Dievler and Giovannini, 1998.

Funding for community health centers is derived from grants from the Bureau of Primary Health Care (BPHC) and state and local governments, Medicaid and Medicare programs, private insurance, and patient fees. In the past, federal grants were the largest source of support for CHCs. More recently, however, Medicaid reimbursement has accounted for the greatest share of funding: as of the end of 1998, 34 percent of CHCs' revenues were generated from Medicaid-insured patients, while only 26 percent were grant-based.[3]

Early studies showed that CHCs provide cost-effective care, while also improving access to care, reducing emergency room use, and increasing preventive care.[4] Research also demonstrates that, overall, ambulatory care utilization rates have risen

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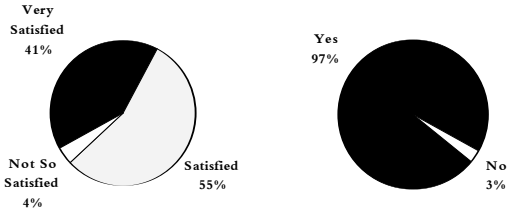
in medically underserved areas where CHCs have been introduced. Furthermore, utilization rates are higher among health center visitors than patients of private physicians or hospital outpatients.[5]

A recent analysis by BPHC found that female health center patients are more likely to obtain mammography and Pap smear tests than patients of other facilities. Sixty-three percent of women who use CHCs regularly receive a mammogram, compared with 45 percent of women in the general population. Similarly, 88 percent of female CHC patients have had a recent Pap smear, versus 75 percent of all women. A review of CHC records reveals that health center patients who are diabetic are twice as likely to have their glycohemoglobin level tested on schedule. In addition, CHC Medicaid patients are 22 percent less likely than non-CHC patients to be hospitalized for conditions that could have been treated on an outpatient basis had they received timely primary care.[6]

The 1994 Fund-sponsored *National Survey of Patient Experiences in Community and Migrant Health Centers,* which included 1,784 patients in 46 community and migrant health centers, found that patient satisfaction with quality of care is high. The study also determined that health centers and their patients are well integrated with the rest of the health care system. Seventy-four percent of patients who had been referred to a specialist saw that specialist. Of these patients, 85 percent reported that the results of the specialist visit were sent back to the health center.

According to the survey, about half of CHC patients receive preventive or prenatal care. In addition, patients say they are more satisfied with CHCs than other care providers—largely because health centers are perceived as more responsive to their concerns and tend to offer more culturally appropriate care.[7] Finally, 43 percent of the study respondents chose their health center because of its convenient location.

Patient Satisfaction with Community Health Centers



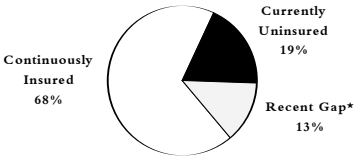
Quality of Care Satisfaction | **Recommended to Family and Friends**

Source: *A National Survey of Patient Experiences in Community and Migrant Health Centers,* National Association of Community Health Centers, sponsored by The Commonwealth Fund, June 1994.

IMPACT OF CHANGES IN THE HEALTH CARE MARKETPLACE

The number of uninsured Americans has continued a slow but steady rise of almost one million people per year, reaching a total of 43 million individuals in 1997, 11 million of whom were children.[8] *The Kaiser/Commonwealth 1997 National Survey of Health Insurance* found that fully one-third of working-age adults were currently uninsured or had a gap in coverage in the last two years.[9] Further, low-income working adults often remained uninsured for relatively long periods.[10]

One-Third of Working-Age Adults Are Currently Uninsured or Had a Recent Gap in Coverage



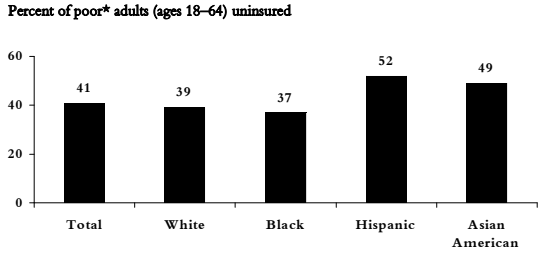
164 million adults ages 18–64

* Recent Gap = Insured when surveyed but had a period in past two years without coverage.

Source: *The Kaiser/Commonwealth 1997 National Survey of Health Insurance* Louis Harris and Associates, Inc.

Lack of health insurance and high rates of disease continue to affect black and Hispanic Americans and foreign-born residents disproportionately. Recent Fund analysis of the *Current Population Survey* shows that 38 percent of Hispanics and 24 percent of blacks and Asian Americans are uninsured, compared with only 14 percent of whites.[11] About one-third of foreign-born residents do not have health insurance, in large part because they are ineligible for public insurance programs and often work for employers that do not provide coverage.

Uninsured Poor Adults by Race and Hispanic Origin, 1996



* Poor = Less than 100 percent of poverty.

Source: Authors' tabulations of the *Current Population Survey, 1997 March Supplement.*

Especially troubling are new reports that enrollment in Medicaid appears to be declining—a development that could signal further expansion of

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THE BASICS OF CHCs

Community health centers (CHCs) originated in the 1960s as a part of President Johnson's War on Poverty. Initially called neighborhood health centers, they were viewed as complementary to the then recently enacted Medicaid program, providing newly insured low-income individuals and the remaining uninsured population with access to the health care system. These health centers were also intended to be a source of employment in the low-income urban and rural areas in which they were located.[33]

Today, CHCs receive funding under the Public Health Service Act to provide primary and preventive health care services in medically underserved areas throughout the nation. The program is administered by the Bureau of Primary Health Care of the Department of Health and Human Services.

CHCs are located mainly in areas where economic, geographic, or cultural barriers limit access to primary health care for a large part of the population. Their target patients are minorities, women of childbearing age, infants, persons with HIV infection, substance abusers, and/or homeless individuals and their families. Besides primary and preventive care services, CHCs provide outreach, links to welfare, Medicaid, and WIC programs, substance abuse treatment, and related services. They also offer laboratory tests, X-rays, environmental health services, and pharmacy services, as well as health education, transportation, translation, and prenatal services.

The program has grown substantially since the mid-1960s. In the early 1970s, about 104 neighborhood health centers had been established serving 1.4 million people. By 1990, 556 programs were serving 6 million people. Significant expansions in capacity in health center program began in the 1990s owing to a series of Medicaid policy changes enacted in the late 1980s. One policy change mandated improved coverage for poor pregnant women and children, who were now defined by their family income level and not by their eligibility for welfare. The other major change was the establishment of the Federally Qualified Health Center (FQHC) Program in 1989. Under this program, federally funded health centers such as community and migrant health centers, clinics treating homeless patients, and Indian health clinics—as well as non-federally funded "look alike" programs that meet certain statutory requirements—are reimbursed by Medicaid and Medicare for "reasonable costs."[34] By the end of 1998, approximately 700 health centers serving 3,000 sites and 8.3 million people were receiving FQHC funding.[35]

The FQHC legislation requires that Medicaid programs pay full costs for all services supplied by health centers, regardless of whether or not these services are paid for when supplied by other providers such as private physicians or hospital outpatient departments.[36] Somewhat unpopular with the states, the FQHC requirements were waived for states participating in managed care demonstration projects. The Balanced Budget Amendment of 1997 calls for cost-based reimbursement for FQHCs to be phased out by 2003, at which time states will be required to pay FQHCs the difference between the amount received from managed care organizations and the amount they are owed under reasonable cost principles.[37]

The services provided by CHCs and other safety net providers are as important now as they have ever been, especially for uninsured, minority, and foreign-born patients. Carefully crafted state and federal policies can help CHCs survive and thrive in a shifting health care environment.

the uninsured population and greater uncompensated treatment costs for health centers. In New York State, for example, Medicaid enrollment declined by approximately 150,000 from January to May 1998, largely among former recipients of Aid to Families with Dependent Children and Home Relief welfare payments.[12] Although the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which is expected to reduce welfare rolls by 30 to 40 percent by 2001, theoretically does not change Medicaid eligibility, many people terminated from the welfare rolls are losing their Medicaid benefits as well.[13]

Even as the population of uninsured patients continues to grow, difficult financial circumstances could curtail the ability of CHCs to care for the uninsured. Recent changes in the health care marketplace affect CHCs by threatening their traditional sources of payment, eroding their share of publicly insured patients, and expanding the ranks of the uninsured. Studies by The Commonwealth Fund and others demonstrate a direct impact on CHCs and on safety net providers in general.

THE IMPACT OF MANAGED CARE

Managed care—especially the growth of Medicaid managed care—threatens the financial viability of CHCs. By 1997, managed care accounted for nearly 80 percent of employer-based insurance coverage, nearly 50 percent of Medicaid, and 14 percent of Medicare. For CHCs, whose patient populations have traditionally included a substantial share of Medicaid patients, this shift has major implications.

Although most CHCs are able to contract with and participate in managed care plans, the discounted payments offered by plans can lead to substantial losses in Medicaid revenues. This reduction in Medicaid revenues is compounded by the fact that safety net providers are losing market share. Since managed care enrollees consist mainly of relatively healthy women and children, other providers are actively seeking to become primary care providers for this population. In addition, many Medicaid managed care enrollees who fail to select a primary care provider are automatically assigned to providers other than CHCs. Some patients who are involuntarily assigned to other providers experience difficulty receiving care and consequently return to health centers. Care provided to these patients is usually not compensated. Other providers are also experiencing revenue losses and are thus treating fewer uninsured patients. These patients are increasingly relying on CHCs and other safety net providers for health care.

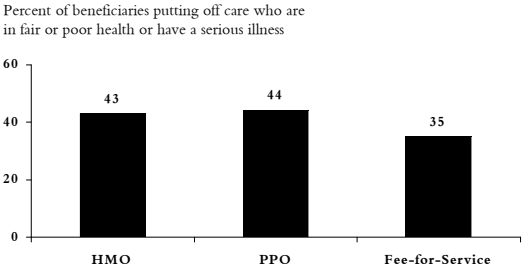
Urban safety net hospitals are also experiencing changes in their patient base as a result of managed care. A Fund-sponsored study that examined managed care's impact on urban safety net hospitals revealed that increased managed care market penetration has reduced outpatient volumes in hospitals in minority neighborhoods, while hospitals in nonminority neighborhoods have experienced a corresponding increase.[14]

The combined effect of the growing ranks of uninsured patients and the reluctance of other providers to treat them has resulted in a jump in the number of uncompensated patients treated at CHCs. According to the Bureau of Primary Health Care, from 1990 to 1997 the number of uninsured patients at CHCs increased by 49 percent.[15] In 1980, 2.5 million health center patients, or 50 percent, were uninsured; by 1996, this number had increased to 3.2 million, or 40 percent. The uninsured are the single largest group of CHC patients.[16]

In the past, funding for uninsured patients has been generated from expanding Medicaid revenues rather than increases in government appropriations. In 1980, federal grants accounted for 52 percent of revenues, while Medicaid payments accounted for 14 percent of the total. By 1995, the federal government's revenue portion had shrunk to 32 percent; Medicaid's, on the other hand, had climbed to 33 percent.[16] Since that time, however, managed care plans have started to steer their Medicaid patients away from CHCs.[17] Because CHCs serve relatively few privately insured patients, cost-shifting to other revenue sources to offset reduced Medicaid payments is not an option.

Managed care may also be creating problems in access to care and the quality of care received by vulnerable populations. Some evidence indicates that health plans attract disproportionately healthier patients and that, when chronically ill patients do

Managed Care Beneficiaries in Poor Health Have Difficulty Getting Needed Care



Source: *The Kaiser/Commonwealth Low-Income Coverage and Access Survey,* 1997 Louis Harris and Associates. Inc.

enroll, some plans may skimp on care.[18] Data from the Medical Outcomes Study show that poor and chronically ill patients in managed care experience worse health outcomes than those in fee-for-service care.[19] In addition, managed care enrollees in fair or poor health seem to be more likely to postpone receiving needed care under certain types of managed care arrangements.[20]

As more low-income patients in poor health enroll in managed care, CHCs, which often serve the sickest patients, must work to ensure that the quality of care they deliver to those patients is not jeopardized.

NEW DIRECTIONS FOR COMMUNITY HEALTH CENTERS

Strategies to Survive and Compete

Current changes and pressures in the health care system are pushing CHCs to address these challenges while preserving their mission as providers of care for vulnerable populations. In addition to strategies such as updating facilities and improving scheduling and appointment systems, many centers are altering their organizational structures in order to compete effectively in the new managed care environment.

CHCs have undertaken a variety of activities in response to managed care. Some have established contractual relationships with managed care organizations, formed networks with other health centers and public hospitals, or created their own managed care organizations. Many of these strategies are driven by real threats to CHCs' institutional survival, including Medicaid market share erosion and future reduction in federally qualified health center cost-based reimbursements.[21] Today, at least one-third of all federally qualified health centers are participating in prepaid managed care arrangements.[22] According to BPHC, approximately 26 CHCs own managed care plans.[23]

A 1996 Fund-supported study examined the experiences of CHCs in Florida, Hawaii, and Washington that had formed their own health plans in response to their states' conversion to Medicaid managed care.[24] At the time, Hawaii and Washington were in the process of extending health insurance coverage to uninsured patients, many of whom were already CHC patients. Although both plans were able to generate profits within the first year of operation, managed care plans can also present CHCs with substantial risks. Competitive pressure will likely increase over time, constraining profits and the ability of plans to support uncompensated care provided by health centers.

CHCs that form their own health plans may ultimately discover a fundamental conflict between their mission and the plan's desire to constrain cost and utilization of services. Furthermore, contracting on a fully capitated basis may increase CHCs' financial vulnerability unless strategies are devised to limit the amount of risk incurred. Plans will also need to meet new demands for quality performance and show evidence of providing cost-efficient, high-quality care.

The ability to function and compete through CHC-sponsored health plans is likely to become increasingly important. Good plans formed by safety net providers could become a powerful and positive force in Medicaid managed care, particularly if for-profit plans continue to withdraw.

In attempting to improve their competitive position in the health care market, CHC plans should employ strategies that continue to build on such historic strengths as comprehensive services, culturally sensitive care, and patient satisfaction.

Support for Children and Youth

Expanding and improving child development services should be one of the priority goals for CHCs. By capitalizing on their capacity for providing nontraditional services, CHCs would help accommodate parents' desire for assistance in fostering their young child's early cognitive and behavioral growth.[25]

New findings on early brain development highlight the need for a more comprehensive approach to pediatric care, such as that taken by the BPHC's Bright Futures initiative and the Fund's own program, Healthy Steps. *The Commonwealth Fund Survey of Parents with Young Children* identified many areas in which parents want more support from the health care system, including information on development and helping children learn.[26] The survey also showed that low-income parents are less likely to engage in certain important parenting activities, such as reading daily to their young children, than are parents with higher incomes.

The Healthy Steps program is now supporting a multisite initiative to develop models for providing important child development services, including home visits by a nurse or child development specialist, enhanced well-baby visits, a telephone information line, a child health and development record, informational materials for parents, parent groups, and liaison to community services. The Fund has also initiated a second initiative, Assuring

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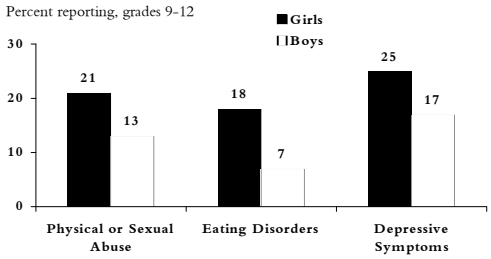
Better Child Health and Development (ABCD), to study ways to finance these services for low-income children and their families.

The health care needs of adolescents also deserve special attention from CHCs. A 1997 Fund survey on adolescent health found disturbing evidence of serious health issues for many young people.[27] Among older adolescents, 21 percent of girls and 13 percent of boys reported a history of physical or sexual abuse. These adolescents were far more likely to report mental health problems, engage in risky behaviors such as drinking, and fail to get needed health care. A Fund-supported domestic violence training program in 10 Connecticut CHCs demonstrated that centers can play an important role in addressing complex and urgent problems of this nature.[28]

Many Adolescents Report Significant Health Problems



Source: *The Commonwealth Fund Survey of the Health of Adolescent Girls,* 1997 Louis Harris and Associates, Inc.

Maintaining and Improving Quality of Care

Beyond financial problems, CHCs can expect additional challenges to their ability to provide high-quality comprehensive services in the years ahead. Growth in the most difficult-to-serve populations and new administrative demands will require careful strategies. CHCs must continue to strive to maintain the quality of services for which they are well recognized while also expanding their work into new areas.

Special services such as translators and culturally competent health care workers will become increasingly important. The population of foreign-born residents, many of whom need translation and other services to receive medical care, grew from 14 million in 1980 to 26 million in 1997 and will continue to grow as the U.S. population becomes increasingly diverse in coming decades.[29] Many Medicaid managed care plans, such as those operating in California, are now required to ensure the provision of effective and acceptable services for racially and ethnically diverse populations.[30] In rural areas, CHCs must also be aware of the unique needs of transitory farm workers.

Systems for measuring the quality of care have expanded since the advent of managed care and will become increasingly important. Measures developed by the National Committee for Quality Assurance (NCQA) and others in response to the danger that health plans were skimping on care are now being used for purchasing by employers, by the Medicare program, and by states to evaluate plans participating in Medicaid. A project of the American Public Human Services Association and NCQA, supported by the Fund, will facilitate the development of a national database on the performance of Medicaid managed care plans.

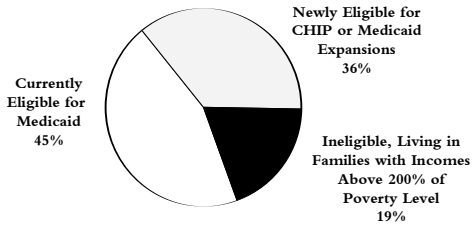
Federal and state policies could promote a uniform set of standards for quality care and patient satisfaction. For example, new standards for pediatric care could establish the importance of developmental services and other supports for parents of young children. Policymakers should also recognize, however, that providers need resources to comply with data reporting requirements associated with those standards. Clearly, many CHCs will need to expand their capacity to collect and report quality data in order to keep pace with this trend.

PUBLIC POLICY AND THE FUTURE OF COMMUNITY HEALTH CENTERS

Preserving CHCs is an important element in federal and state policies to maintain the health care safety net for vulnerable populations. Broadly and in ways specific to CHCs, these policies should address two challenges: paying for care for the uninsured and safeguarding essential providers in an era of managed care.

The increasing number of Americans without health insurance can be met with strategies to expand coverage. Incremental options that build on current initiatives seem the most promising direction at the moment. The federally sponsored State Child Health Insurance Program (CHIP) could provide the basis for expanding coverage to

Uninsured Children's Eligibility for Medicaid and CHIP



Source: Kenneth E. Thorpe and Curtis S. Florence, *Covering Uninsured Children and Their Parents: Estimated Costs and Number of Newly Insured,* July 1998.

low-income parents as well as their children.[31] If states succeed in enrolling all children eligible for CHIP and Medicaid, approximately 9 of 11.3 million uninsured children in 1996 would have health insurance.

Covering and enrolling parents of eligible children would reduce the number of uninsured parents by about 5 million. Other incremental options could allow purchasing pools to make insurance affordable for small businesses or enable individuals to buy in to Medicaid, Medicare, or state or federal public employee plans.

Short of universal insurance coverage, state and federal governments can continue to develop new mechanisms to pay for care delivered to the uninsured. Since the ability to cross-subsidize care from private patients has eroded under managed care, other sources could be developed, such as increased federal funding to CHCs and other safety net providers or dedicated uninsured pools. Safety net providers in states with such pools are in a much stronger position to provide care to all patients.

If CHCs are to maintain a place in the health care system, Medicaid, their major source of patient care funding, must continue under new state arrangements. As states convert their Medicaid programs to managed care, CHCs could be in a position to compete for Medicaid contracts and patients. State policies on enrollment could help by assigning patients to CHCs as their primary care providers. States could also pay attention to new reimbursement guidelines, especially those that require analyses of the cost-effectiveness of the care, in developing proposals to reimburse CHCs adequately for the services they provide. Awarding start-up funds and technical assistance could facilitate formation of CHC-based plans. Finally, states could favor providers that serve uninsured as well as Medicaid-insured patients through Medicaid managed care rates.

Some of the states that actively encourage the formation of managed care plans by CHCs include Florida, which has instituted more lenient reserve requirements for plans formed by public providers serving Medicaid patients; Hawaii, which caps the number of publicly insured patients in any one plan; and Washington, which permits CHC plans to reimburse out-of-network providers at Medicaid rates.[32]

Federal and state funding of the administrative costs of enrollment would help extend coverage to more patients and provide much-needed patient care funds to CHCs. Enrollment of eligible beneficiaries in Medicaid or CHIP has become a central issue since the enactment of the latter program. CHCs and other safety net providers were granted the power to assess patients for eligibility—a policy that offers convenience to patients and increases CHCs' chances of retaining those patients. Even so, the policy has hit practical barriers as a result of inadequate funding for administrative costs and lack of support at the state level.

Government policy can also play a role in mobilizing action on behalf of vulnerable populations. For example, in response to the widening disparities in health status between minority and nonminority populations, President Clinton last year announced a $400 million, five-year race and health initiative. Collaboration between foundations and the public sector will lead to innovative solutions to reducing disparities in health and access to care across racial and ethnic groups in six areas: infant mortality, cancer screening and management, HIV/AIDS, cardiovascular diseases, diabetes, and child and adult immunizations.

CHCs will likely remain an important part of the health care system, providing high-quality care to vulnerable populations. With strong leadership and a supportive environment, these centers can meet the challenges ahead. CHCs should also continue to advocate for their patients on insurance coverage, quality of care, access to culturally sensitive and competent care, and improving the health of those most at risk.

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