SURVEY BRIEF
APRIL 2019

The Role of Medicaid Expansion in Care Delivery at Community Health Centers

Corinne Lewis
Research Associate
The Commonwealth Fund

Akeiisa Coleman
Associate Program Officer
The Commonwealth Fund

Melinda K. Abrams
Vice President and Director
The Commonwealth Fund

Michelle M. Doty
Vice President
The Commonwealth Fund

Community health centers provide comprehensive primary care to medically underserved communities, regardless of patients' insurance status or ability to pay. Health centers have enjoyed bipartisan support for decades, because they provide affordable, cost-effective care for millions of Americans while saving the overall health care system money.[1] When people gained insurance coverage under the Affordable Care Act (ACA), it was expected that reliance on health centers would increase. As a result, Congress doubled federal grant funding for centers and created incentives for clinicians to practice in them.

Previous research has shown that health centers in states that expanded Medicaid have particularly benefitted from the ACA.[2] But less is known about how the delivery of health care in centers has changed. This brief uses data from the Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers to compare the experiences of health centers in states that have and have not expanded Medicaid.

HIGHLIGHTS

- Health centers in Medicaid expansion states, compared to those in nonexpansion states, were significantly more likely to report improvements in their financial stability (69% vs. 41%) and in their ability to provide affordable care to patients (76% vs. 52%) since the ACA took effect. They have also been somewhat more likely to operate under a value-based payment model, like the patient-centered medical home.
- Health centers in Medicaid expansion states were more likely to offer medication-assisted treatment for opioid addiction (44% vs. 25%), provide counseling and other behavioral health services, and coordinate patient care with social service providers in the community (58% v. 48%) than health centers in nonexpansion states.
- However, health centers in states that expanded Medicaid were more likely than those in nonexpansion states to report unfilled job openings for mental health professionals (73% vs. 64%) and social service providers (45% vs. 36%), perhaps indicating higher demand for these professionals and insufficient supply.

The Commonwealth Fund

- While many factors account for the observed differences between expansion and nonexpansion states, community health centers appear to benefit from Medicaid expansion. If Congress does not renew federal funding for health centers this year, there could be a reversal in these gains, jeopardizing the health care safety net in communities throughout the United States.

BACKGROUND

More than 1,300 Federally Qualified Health Center organizations (FQHCs) operate in more than 11,000 sites across the U.S. They provide high-quality, comprehensive primary care to one of every 12 Americans.[3] Health centers serve as a safety net for low-income and uninsured people, providing free or low-cost care regardless of insurance status or ability to pay. They also provide health services in areas of the U.S. where primary care providers are lacking.

For decades, health centers have enjoyed bipartisan support. That's because they benefit all Americans, by:[4]

- reducing the need for more expensive care, like emergency department visits
- lowering overall health care costs
- employing thousands of people
- generating billions of dollars in economic activity through job creation and the purchase of goods and services.

The ACA shifted the landscape for health centers significantly. As millions of previously uninsured people gained health insurance coverage through the marketplaces and the expansion of Medicaid eligibility in many states, demand for health center services increased.[5]

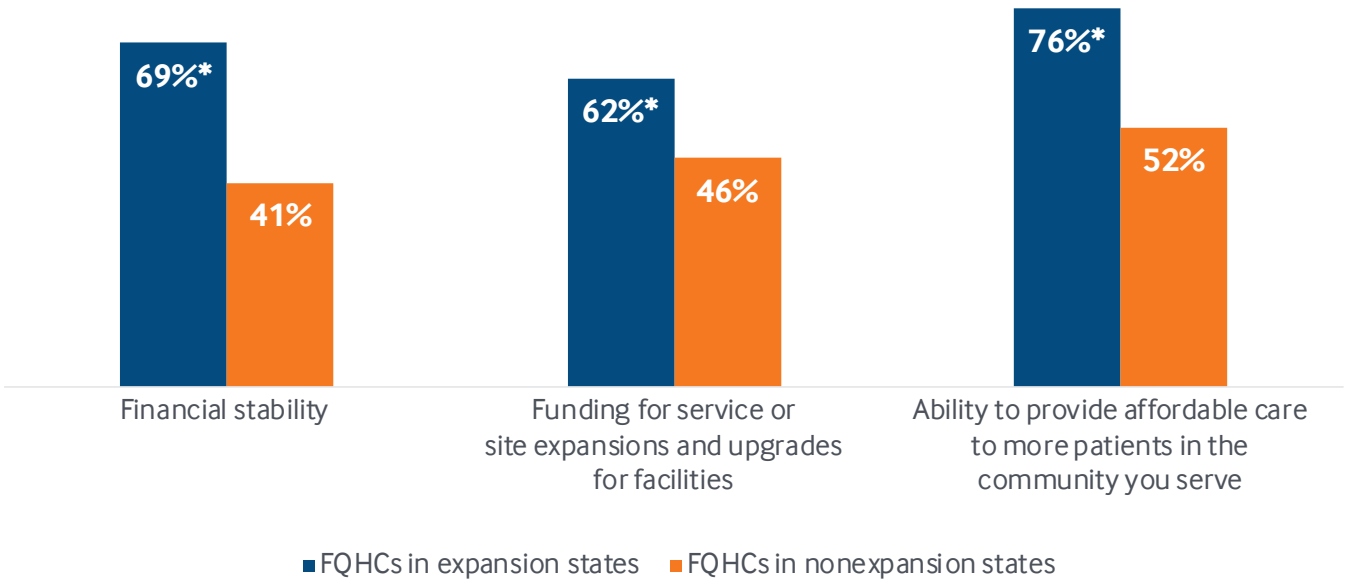
Anticipating this increased demand, the ACA created the Community Health Center Fund, which appropriated $11 billion over five years to support health center expansion — a doubling of federal funding to these providers.[6] To ensure the increased demand could be met, the ACA also enhanced incentives for care providers to work in health centers, through loan forgiveness programs, new training opportunities, and more.[7]

However, the ACA did not affect health centers uniformly. Previous research has indicated that health centers in states that expanded Medicaid have fared better, particularly because of the fewer number of uninsured patients, compared to centers in states not expanding Medicaid.[8] Since health centers serve a disproportionate number of low-income, medically complex patients, it is important to understand if, and how, care delivery itself differs between health centers in expansion and nonexpansion states.[9]

In this brief, we examine findings from the recent Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers to compare the experiences of health centers in the 31 states and the District of Columbia that had expanded Medicaid as of September 2018 to those in the 19 states that had not (Appendix A). We look at financial stability; participation in payment arrangements, in which reimbursement is tied to performance; availability of behavioral health care and social services; and other characteristics (see "How We Conducted This Study" for more detail). Readers should note, however, that the differences observed may be influenced by factors other than Medicaid expansion, such as whether health centers are located in an urban area or in a particular region of the country (Appendix B), what kind of Medicaid policies a state has in place, or differences in the populations of Medicaid expansion and nonexpansion states.

Health Centers in Medicaid Expansion States Were More Likely to Report Improvements in Capacity and Financial Stability Since the ACA

On the whole, since the Affordable Care Act was passed in 2010, the following have much improved or improved at your health center organization . . .

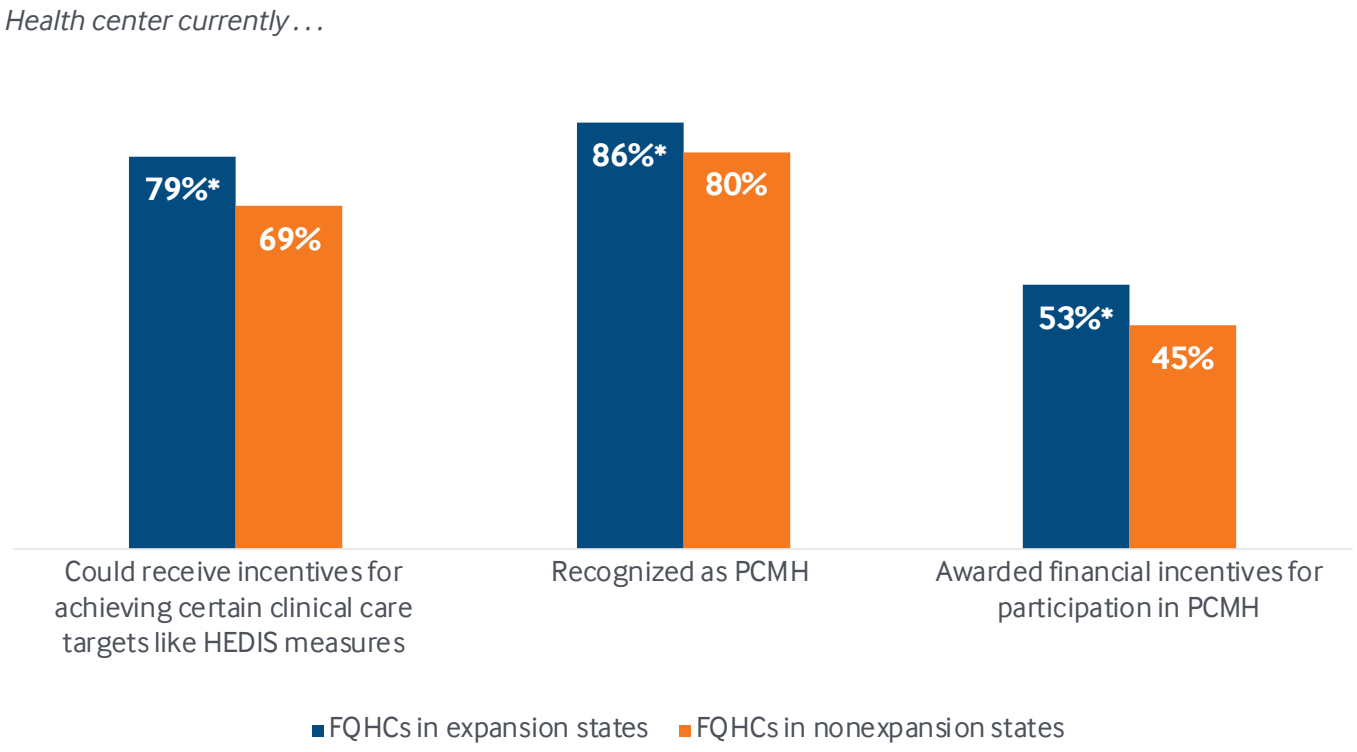


* Statistically significant difference compared to nonexpansion states (p≤.05).

Data: Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

The survey found significant differences between health centers in Medicaid expansion states and nonexpansion states related to finances and capacity to serve patients (Appendix C). Health centers in expansion states were significantly more likely to believe their financial stability and funding had improved since the ACA took hold, with nearly 70 percent reporting increased financial stability compared to 41 percent in nonexpansion states. Three of four health centers in expansion states felt they were better able to provide affordable care to their community, while only half did in health centers in nonexpansion states.

Health Centers in Medicaid Expansion States Were More Likely to Report Participation in Value-Based Payment Arrangements



* Statistically significant difference compared to nonexpansion states (p≤.05).

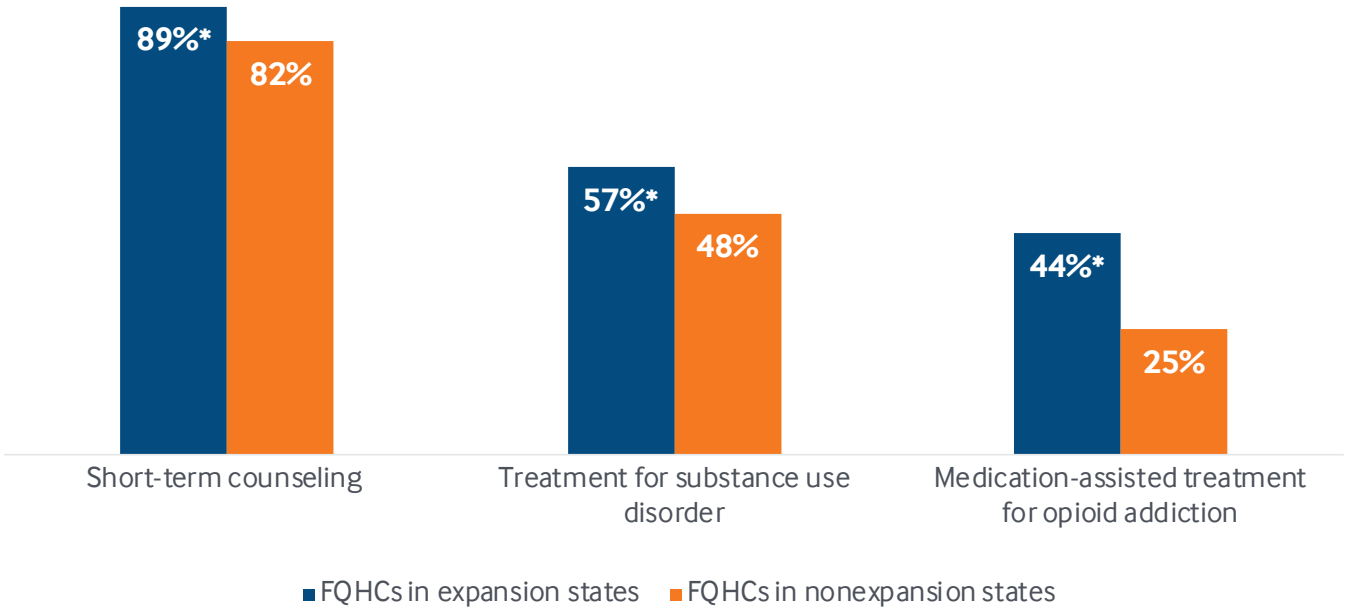
Notes: HEDIS = Healthcare Effectiveness Data and Information Set. PCMH = patient-centered medical home. Respondents were asked to think of their largest site if their health center organization operated more than one health center site.

Data: Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

Paying health care providers based on the value of care they deliver to patients has the potential to lower the costs of care while improving health.[10] We found that health centers in expansion states were significantly more likely to participate in models in which they or their clinicians could receive financial incentives for achieving quality-of-care targets. They were also more likely to be recognized as patient-centered medical homes and receive financial incentives for participating in such programs. Patient-centered medical homes have been shown to improve health outcomes and reduce health disparities for low-income populations.[11] However, for some models of value-based payment, there were no significant differences between health centers in expansion and nonexpansion states (Appendix D).

Health Centers in Medicaid Expansion States Were More Likely to Address Behavioral Health Needs of Patients

Health center usually or often offers the following for patients with emotional or behavioral health needs . . .



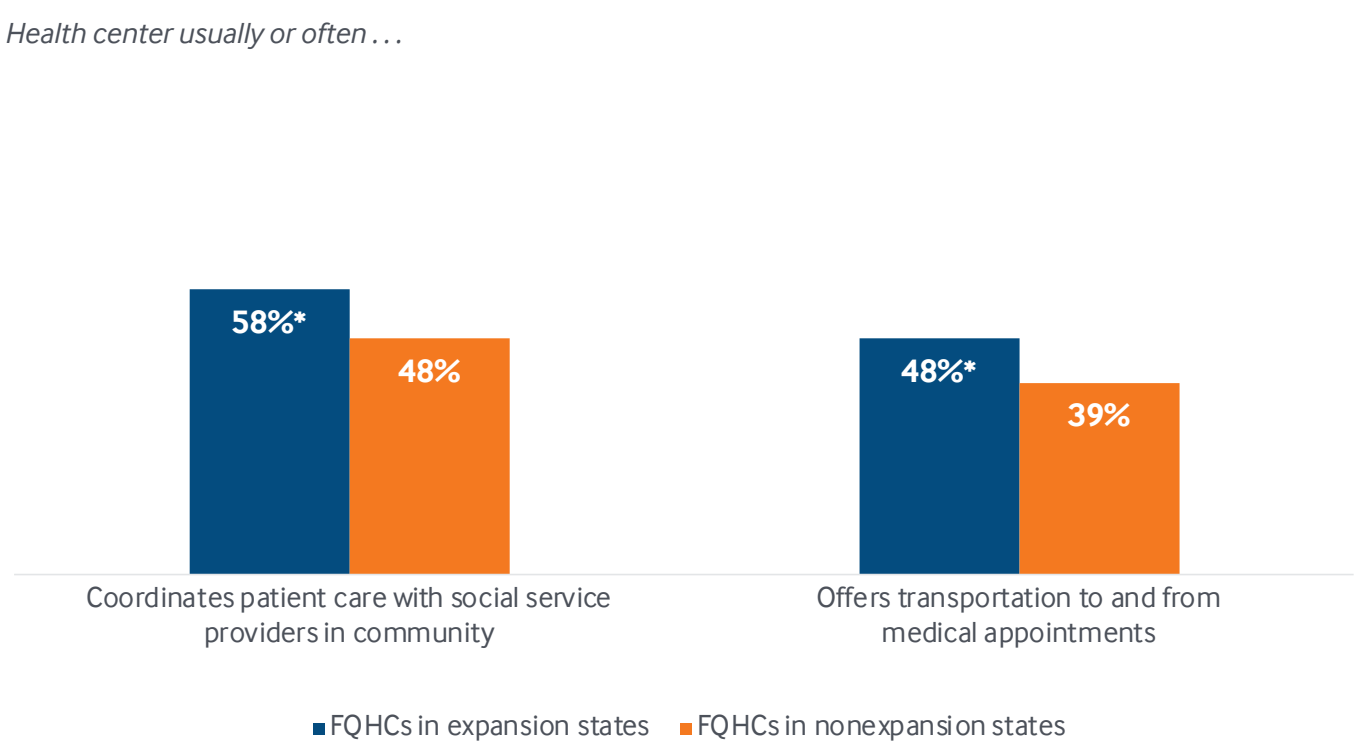
* Statistically significant difference compared to nonexpansion states (p≤.05).

Note: Respondents were asked to think of their largest site if their health center organization operated more than one health center site.

Data: Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

Behavioral health issues, including substance use and mental health disorders, disproportionately affect low-income people, but accessing behavioral health services is difficult for many.[12] As the safety-net provider for millions of low-income people in the U.S., health centers play a key role in addressing patients' behavioral health problems. A large majority of health centers surveyed offered onsite, short-term counseling to patients, with centers in expansion states significantly more likely to provide this critical service. Health centers in Medicaid expansion states were more likely to offer treatment for substance use disorder as well as medication-assisted treatment for opioid addiction at a rate almost twice as high as in centers in nonexpansion states (Appendix E).

Health Centers in Medicaid Expansion States Were More Likely to Address Social Needs of Patients



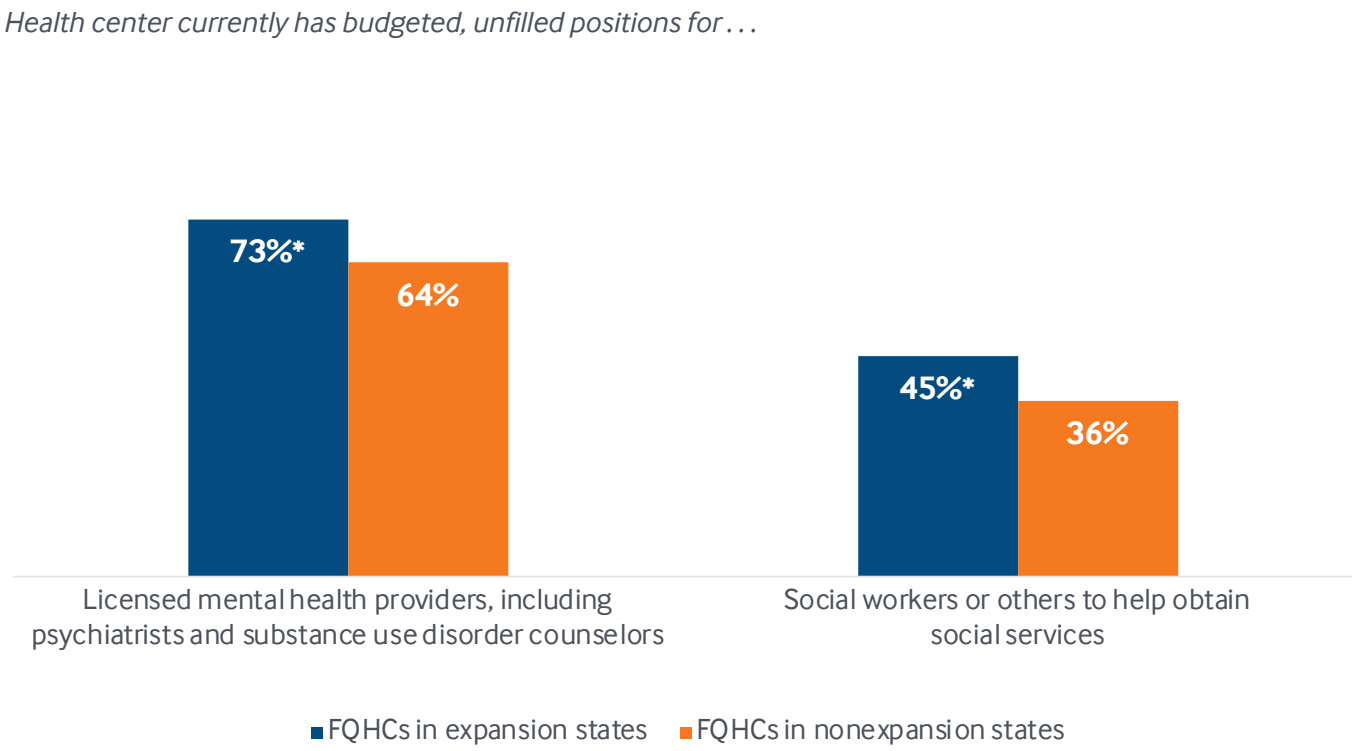
* Statistically significant difference compared to nonexpansion states (p≤.05).

Note: Respondents were asked to think of their largest site if their health center organization operated more than one health center site.

Data: Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

Patients served by health centers are disproportionately living in poverty and therefore are at greater risk for hardships like homelessness, transportation barriers, or food insecurity than are other patients.[13] Because unmet social needs can have a negative impact on physical health and access to health care, the majority of health centers offered some services to identify and address them. Health centers in expansion states were more likely to address the social needs of their patients, typically by coordinating patient care with social service providers in the community and offering transportation to and from medical appointments (Appendix F).

Health Centers in Medicaid Expansion States Were More Likely to Report Behavioral Health and Social Service Staffing Needs



* Statistically significant difference compared to nonexpansion states (p≤.05).

Note: Respondents were asked to think of their largest site if their health center organization operated more than one health center site.

Data: Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

While health centers in expansion states were more likely to offer behavioral health and social services to their patients, they were still struggling to hire more mental health and social service providers. Health centers in expansion states were more likely to report having budgeted but unfilled positions for mental health providers, social workers, and staff to help patients obtain social services. As health centers in expansion and nonexpansion states alike look to expand provision of these services, such shortfalls in workforce capacity could present a barrier to care (Appendix G).

CONCLUSION AND POLICY IMPLICATIONS

Compared to community health centers in nonexpansion states, centers in expansion states reported greater financial stability, engagement in value-based payment arrangements, and availability of behavioral health care and social services. While many factors other than Medicaid expansion likely influence these differences, the increased Medicaid revenue that health centers in expansion states receive may help them improve the way they deliver care. Medicaid expansion also may incentivize health centers to offer the behavioral health care and nonmedical services that a growing share of patients requires.

However, health centers in expansion states were more likely than their counterparts to report unfilled positions for mental health and social service staff, a potential barrier to meeting needs for behavioral health and social care. It's also important to note that differences in care and capacity in Medicaid expansion states versus nonexpansion states were sometimes modest. In addition, although not demonstrated by our analysis, other changes since the ACA took effect, such as the national, enhanced federal funding for health centers and the increase in private, subsidized health insurance coverage, likely impacted health centers in all states as well.

Any further weakening of the ACA, like the enactment of Medicaid work requirements and other policies that restrict health insurance coverage, could increase the number of uninsured, thereby reducing health centers' revenue from insurance and increasing costs. This ultimately could have a negative impact on the financial stability of health centers. Moreover, if Congress fails to renew federal funding — set to expire in September 2019 — health centers may be forced to halt their efforts to innovate, expand, and improve care. Such outcomes could affect the entire U.S. health care system, whose success and efficiency depends on a high-performing safety net.

HOW WE CONDUCTED THIS STUDY

The Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers was conducted by SSRS from May 16, 2018, through September 30, 2018, among a nationally representative sample of 694 executive directors or clinical directors at Federally Qualified Health Centers (FQHCs). The survey sample was drawn from the Uniformed Data System (UDS) list of all FQHCs in 2016 that have at least one site that is a community-based primary care clinic. The list was provided by the National Association of Community Health Centers (NACHC). All 1,367 FQHCs were sent the questionnaire and 694 responded, yielding a response rate of 51 percent. The survey consisted of a 12-page questionnaire that took approximately 20 to 25 minutes to complete. Data were weighted by number of patients, number of sites, geographic region, and urban/rural location to reflect the universe of primary care community centers as accurately as possible. Expansion status was determined using the FQHC-reported largest site address. If the largest site address was not provided, and the FQHC had only one site, we used UDS data to determine the site's state. We excluded 21 responses because we were unable to determine their largest site through one of these methods, yielding a total sample of 673 responses. We used chi-square tests to assess differences between health centers in expansion states and those in nonexpansion states.

NOTES

1. National Association of Community Health Centers, *Health Centers Provide Cost Effective Care* (NACHC, July 2015).

2. Julia Paradise et al., *Community Health Centers: Recent Growth and the Role of the ACA* (Henry J. Kaiser Family Foundation, Jan. 2017).

3. National Association of Community Health Centers, *Community Health Center Chartbook* (NACHC, Jan. 2019).

4. NACHC, *Health Centers Provide*, 2015.

5. Sara Rosenbaum et al., *Community Health Centers: Growing Importance in a Changing Health Care System* (Henry J. Kaiser Family Foundation, Mar. 2018).

6. Health Resources and Services Administration, *The Affordable Care Act and Health Centers* (U.S. Department of Health and Human Services, 2012).

7. Melinda K. Abrams et al., *Realizing Health Reform's Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers* (Commonwealth Fund, Jan. 2011).

8. Paradise et al., *Community Health Centers*, 2017.

9. Julia B. Nath, Shaughnessy Costigan, and Renee Y. Hsia, "Changes in Demographics of Patients Seen at Federally Qualified Health Centers, 2005–2014," *JAMA Internal Medicine* 176, no. 5 (May 2016): 712–14; and Leiyu Shi, "The Impact of Primary Care: A Focused Review," *Scientifica* (May 2012): 1–22.

10. Rachel Donlon, Hannah Dorr, and Kitty Purington, *State Strategies to Develop Value-Based Payment Methodologies for Federally Qualified Health Centers* (National Academy for State Health Policy, May 2018).

11. National Committee for Quality Assurance, *Latest Evidence: Benefits of NCQA Patient-Centered Medical Home Recognition* (NCQA, Oct. 2017).

12. Judith Weissman et al., *Serious Psychological Distress Among Adults: United States, 2009–2013* (Centers for Disease Control and Prevention, May 2015); and Stacy Hodgkinson et al., "Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting," *Pediatrics* 139, no. 1 (Jan. 2017): 1–9.

13. Nath, Costigan, and Hsia, "Changes in Demographics," 2016.

APPENDIX A. Medicaid Expansion Status of States Included in the Analysis

Expansion states	Nonexpansion states
Alaska	Alabama
Arizona	Florida
Arkansas	Georgia
California	Idaho
Colorado	Kansas
Connecticut	Maine
Delaware	Mississippi
Hawaii	Missouri
District of Columbia	Nebraska
Illinois	North Carolina
Indiana	Oklahoma
Iowa	South Carolina
Kentucky	South Dakota
Louisiana	Tennessee
Maryland	Texas
Massachusetts	Utah
Michigan	Virginia
Minnesota	Wisconsin
Montana	Wyoming
Nevada	
New Hampshire	
New Jersey	
New Mexico	
New York	
North Dakota	
Ohio	
Oregon	
Pennsylvania	
Rhode Island	
Vermont	
Washington	
West Virginia	

NOTE
Maine and Virginia were included as nonexpansion states because, although expansion had passed at the time of the survey in both states, expansion coverage did not become effective until January 2019. Idaho, Nebraska, and Utah, which passed Medicaid expansion by ballot measure In November 2018, after our survey was conducted, were counted as nonexpansion states.

APPENDIX B. Characteristics of Health Centers Surveyed

	Total (unweighted n=673)	FQHCs in expansion states (unweighted n=435)	FQHCs in nonexpansion states (unweighted n=238)
	%	%	%
Insurance status of patients 25% or more of patients are insured by . . .			
Medicaid/CHIP	77	87*	58
Medicare	14	13	16
Other public insurance	2	3	1
Private insurance	25	22*	30
Self-pay	32	17*	61
Geography of largest site			
Large city	33	37*	26
Suburb or small city	38	37	39
Rural area	27	24*	34
Percent of Medicaid patients covered by managed care plans			
Less than one-third	21	16*	32
More than one-third	72	78*	61
Race and ethnicity of patient population 25% or more of patients are . . .			
African American or Black	31	27*	37
Hispanic or Latino	42	43	41
Served in a language other than English	36	38*	30

* Statistically significant difference compared to nonexpansion states (p≤.05).

NOTES
Respondents were asked to think of their largest site if their health center organization operated more than one health center site. Percentages do not always sum to 100 percent because of blank or "not sure" responses.

DATA
Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

APPENDIX C. Improvements Since Affordable Care Act Passage

On the whole, since the Affordable Care Act was passed in 2010, the following are . . .	Total (unweighted n=673)			FQHCs in expansion states (unweighted n=435)			FQHCs in nonexpansion states (unweighted n=238)		
	Much improved or improved %	About the same %	Much worse or worse %	Much improved or improved %	About the same %	Much worse or worse %	Much improved or improved %	About the same %	Much worse or worse %
Financial stability	59	27	7	69*	20	6	41	40	10
Funding for service or site expansions and upgrades in facilities	56	31	6	62*	28	4	46	35	9
Patient satisfaction and experiences with care	48	42	3	52*	38	2	40	49	3
Ability to provide affordable care to more patients in the community	68	23	4	76*	17	3	52	34	8
Staff retention	23	59	11	24	58	11	20	60	13
Staff shortages	15	58	20	17	56	20	12	60	20
Provider and staff satisfaction	26	52	14	28	51	12	22	54	17
Ability to provide after-hours care outside normal working hours, including evening and weekends	32	58	4	34	57	3	30	59	5
Ability to provide treatment for mental health and substance use disorder	59	28	7	64*	25	5	50	33	10
Ability to connect patients to social service providers	36	50	7	43*	46	6	24	58	8

* Statistically significant difference compared to nonexpansion states ($p \leq .05$).

NOTE
Percentages do not always sum to 100 percent because of blank or "not sure" responses.

DATA
Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

APPENDIX D. Participation in Value-Based Payment Arrangements

Largest site of your health center organization currently . . .	Total (unweighted n=673) %	FQHCs in expansion states (unweighted n=435) %	FQHCs in nonexpansion states (unweighted n=238) %
Participates in program where provider or center could receive financial incentives for high patient satisfaction ratings	37	38	36
Participates in program where provider or center could receive financial incentives for achieving certain clinical care targets (e.g., performance on HEDIS-like measures)	75	79*	69
Participates in patient-centered medical home	84	86*	80
Participates in an accountable care organization	39	36*	44
Participates in bundled payments	23	21	25
Participates in any other alternative payment models	22	25*	16
Receives enhanced payment for patient-centered medical home recognition	50	53*	45
Receives enhanced payment for accountable care organization participation	23	23	23
Receives enhanced payment for bundled payments	12	12	13
Receives enhanced payment for any other alternative payment models	16	18	13

* Statistically significant difference compared to nonexpansion states (p≤.05).

NOTES
HEDIS = Healthcare Effectiveness Data and Information Set. Respondents were asked to think of their largest site if their health center organization operated more than one health center site.

DATA
Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

APPENDIX E. Availability of Onsite Behavioral Health Care

Largest site of your health center organization offers the following for patients with emotional or behavioral health needs . . .	Total (unweighted n=673)		FQHCs in expansion states (unweighted n=435)		FQHCs in nonexpansion states (unweighted n=238)	
	Usually or often %	Sometimes, rarely, or never %	Usually or often %	Sometimes, rarely, or never %	Usually or often %	Sometimes, rarely, or never %
Short-term counseling for mental health problems	87	13	89*	11	82	18
Long-term counseling for mental health problems	68	32	69	31	67	33
Treatment for substance use disorders	54	46	57*	43	48	52
Medication-assisted treatment for opioid addiction	37	63	44*	56	25	75

APPENDIX F. Identifying and Addressing Social Needs of Patients

Largest site of your health center organization currently . . .	Total (unweighted n=673)		FQHCs in expansion states (unweighted n=435)		FQHCs in nonexpansion states (unweighted n=238)	
	Usually or often %	Sometimes, rarely, or never %	Usually or often %	Sometimes, rarely, or never %	Usually or often %	Sometimes, rarely, or never %
Coordinates patient care with community social service providers	55	45	58*	41	48	51
Offers transportation to and from medical appointments	45	54	48*	51	39	60
Receives a report back from the social service organization about services received	23	76	25	74	20	79

* Statistically significant difference compared to nonexpansion states (p≤.05).

NOTES
Respondents were asked to think of their largest site if their health center organization operated more than one health center site. Percentages do not always sum to 100 percent because of blank or "not sure" responses.

DATA
Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

APPENDIX G. Ongoing Staffing Needs

Largest site of your health center organization has budgeted positions that are currently unfilled for . . .	Total (unweighted n=673) %	FQHCs in expansion states (unweighted n=435) %	FQHCs in nonexpansion states (unweighted n=238) %
Primary care physicians	65	67	62
Nurse practitioners (including certified nurse midwives/physician assistants)	39	46*	25
Complex care managers	42	45	38
Medical assistants	49	51	45
Nurses (including RNs and LPNs)	54	56	50
Dentists	42	40	45
Benefit and insurance eligibility counselors	18	18	17
Licensed mental health providers, including psychiatrists and substance use disorder counselors	70	73*	64
Social workers or others to help obtain social services	42	45*	36
Community health workers or other community-based patient advocates	29	30	28

* Statistically significant difference compared to nonexpansion states (p≤.05).

NOTES
Respondents were asked to think of their largest site if their health center organization operated more than one health center site.

DATA
Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers.

ABOUT THE AUTHORS

Corinne Lewis, L.M.S.W., is the research associate in the Commonwealth Fund's Delivery System Reform Program, where she performs a variety of duties including writing, editing, and research, as well as general program-wide coordination and management. Before joining the Fund, she was a health research analyst with Mathematica Policy Research, Inc., where she gained extensive experience in mixed methods research on federal demonstrations of innovative models of care. Before joining Mathematica, she was a project coordinator at the Laboratory for Youth Mental Health at Harvard University and had internships with the Centers for Medicare and Medicaid Services and NYU Augustana Center at NYU Lutheran Medical Center. Ms. Lewis holds a B.A. in psychology from Boston University and a master of science in social policy from Columbia University's School of Social Work.

Akeiisa Coleman, M.S.W., is an associate program officer in the Federal and State Health Policy (FSHP) initiative at the Commonwealth Fund and is responsible for the Medicaid and state-facing grants and coordinating the cross-program Medicaid initiative. As part of the FSHP team, she advises on strategy around federal and state policy, contributing to Fund research and publications and helping to execute projects and events to inform and educate policymakers at the state and federal level. Prior to joining the Fund in August 2018, Ms. Coleman was a senior policy analyst with the National Governors Association, where she managed multiple projects related to social determinants of health, Medicaid, and behavioral health. Before that, she was a health policy associate with the Missouri Foundation for Health. Ms. Coleman earned her Master of Social Work from Washington University in St. Louis and her B.A. in sociology from the University of Southern California.

Melinda K. Abrams, M.S., vice president at the Commonwealth Fund, leads the foundation's Health Care Delivery System Reform program. Since coming to the Fund in 1997, Ms. Abrams has worked on the Fund's Task Force on Academic Health Centers, the Child Development and Preventive Care program, and most recently, she led the Patient-Centered Primary Care Program. Ms. Abrams has served on many national committees and boards for private organizations and federal agencies, and is a peer-reviewer for several journals. Ms. Abrams holds a B.A. in history from Cornell University and an M.S. in health policy and management from the Harvard T.H. Chan School of Public Health.

Michelle McEvoy Doty, Ph.D., is vice president of survey research and evaluation for the Commonwealth Fund. She has authored numerous publications on cross-national comparisons of health system performance, access to quality health care among vulnerable populations, and the extent to which lack of health insurance contributes to inequities in quality of care. Dr. Doty holds an M.P.H. and a Ph.D. in public health from the University of California, Los Angeles.

ACKNOWLEDGMENTS

The authors thank Michelle Proser of the National Association of Community Health Centers (NACHC) for providing input on our survey instrument; Robyn Rapoport, Erin Czyzewicz, and James Noack of SSRS for assistance designing and administering the survey; and Yaphet Getachew and Mekdes Tsega of the Commonwealth Fund for assistance with verifying data.

The Commonwealth Fund

Affordable, quality health care. For everyone.

About the Commonwealth Fund
The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.