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How Is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform

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March 2009

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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This report would not have been possible without the active contribution of Patricia Edraos, Health Resources and Policy Director of the Massachusetts League of Community Health Centers, who provided critical advice, helped convene a meeting of community health center directors, and conducted a survey of health center enrollment and finances. We are extremely grateful to directors and staff of health centers who shared their time and experiences with us, including Brockton Neighborhood Health Center, Greater Lawrence Family Health Center, Harbor Health Services, Joseph Smith Community Health Center and South Boston Community Health Center. Staff of the Massachusetts Division of Health Care Financing and Policy, the Commonwealth Health Insurance Connector Authority, Health Care for All, the Massachusetts Health Law Reform Institute, the Urban Institute, and others also provided helpful insights and information for this project.

The research, commissioned by the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, was conducted by GW faculty at the Geiger Gibson/RCHN Community Health Foundation Research Collaborative, located in the Department of Health Policy at The George Washington University School of Public Health and Health Services. We appreciate the support and advice of Feygele Jacobs of the RCHN Community Health Foundation. The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the sponsors or of The George Washington University.

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EXECUTIVE SUMMARY

Massachusetts' landmark 2006 health reform legislation sets an important precedent for national reform. Initial evaluations have demonstrated the law's success in dramatically expanding health insurance coverage and health care access, but less is known about its effects on community health centers, which serve one of every 13 residents and one in four low-income residents. This analysis evaluates the experiences of health centers with the Massachusetts reforms, using administrative data to examine finances and patient enrollment in addition to the qualitative results of in-depth interviews conducted during site visits in August 2008 and the results of a short survey of health centers.

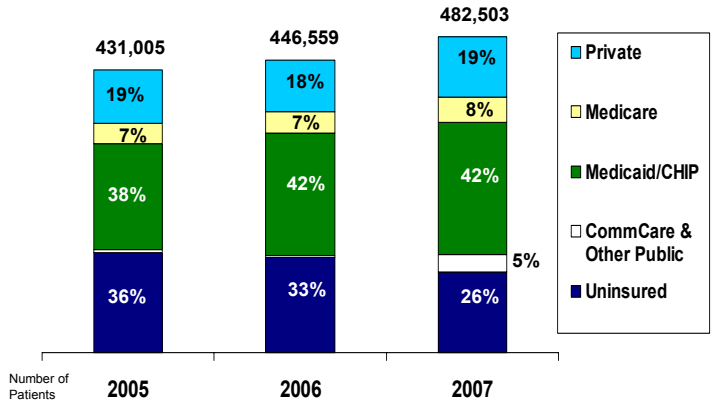
The reforms sought to achieve near universal health insurance coverage for state residents, based on the tenet of shared responsibility for health insurance coverage among the government, individuals, employers, health care providers, and insurers. While the individual mandate that became effective in July 2007 is the best-known dimension of the plan, its success also hinges on a "pay or play" requirement for larger businesses and the establishment of a "Connector" to expand individual and small group health insurance coverage options. The state Medicaid program was expanded in July 2006, and over the next year, a new subsidized insurance program, Commonwealth Care, became available to persons with family incomes below 300 percent of the federal poverty level ($52,800 for a family of three in 2008).

The reforms have been widely credited as successful in expanding insurance coverage in Massachusetts; estimates vary, but the number of uninsured fell by about half in the year following implementation of the reforms. Some individuals are still unable to afford insurance, however. In addition, the experience in Massachusetts indicates that insurance does not guarantee access to care; a shortage of physicians has made it difficult for many to access primary care.

Effects of the Reform on Community Health Centers

- ***Community health centers continue to play a critical role in caring for newly-insured patients while simultaneously serving as the primary care safety net for uninsured residents***. Between 2005 and 2007, the total number of patients at health centers rose by 50,000, during a period when many newly insured residents had problems otherwise securing primary care (see Figure A). While the overall number of uninsured people in Massachusetts fell by about half between 2006 and 2007, the number of uninsured patients served by health centers fell by

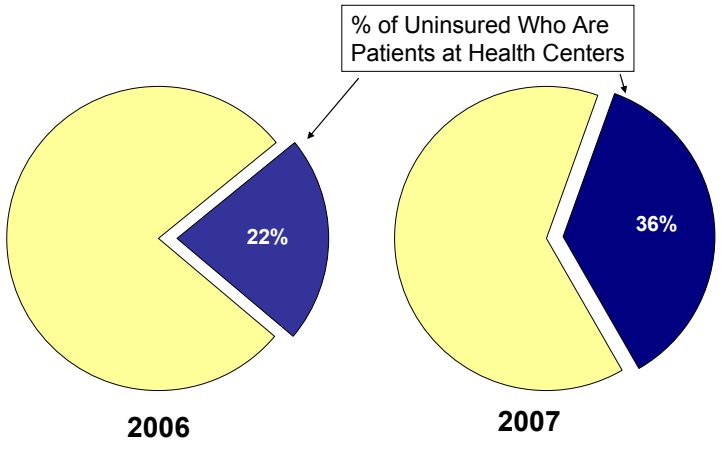
Figure A: Health Center Patient Caseload and Insurance Revenue Sources, 2005-2007



Note: CommCare and Other Public served 1% of patients in 2005 and less than 1% in 2006
Source: GW analysis of Massachusetts Uniform Data System data

only 25 percent. As a result, the proportion of uninsured Massachusetts residents served by health centers grew from 22 percent in 2006 to 36 percent in 2007 (see Figure B).

Figure B. Share of Massachusetts Uninsured Receiving Primary Care at Health Centers, 2006 & 2007

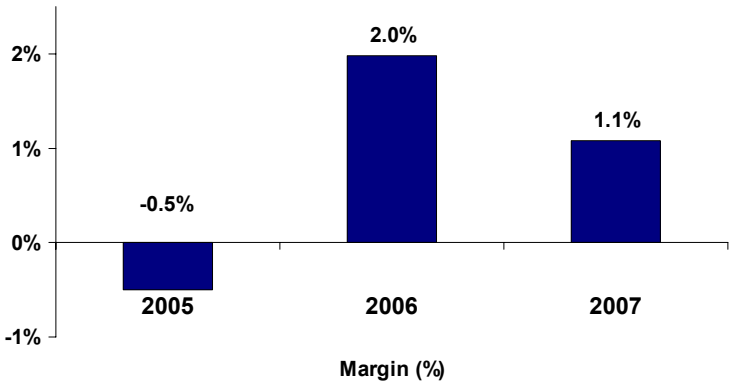


Source: GW analysis of Uniform Data System and Census data

- ***Many of the newly insured patients at health centers had previously been their uninsured patients, but health centers also gained new patients***. Adult patients comprised a disproportionate share of the new patients, since children were already insured. Health centers reported that many of their newly insured new patients were middle-aged or near-elderly adults who had previously been unable to secure care because they were uninsured. Many of these older adults were at higher risk for chronic illness and disability and had a pent-up demand for care. This experience underscores the importance of assuring system readiness for a patient population that may have high initial utilization as untreated health care needs are finally addressed.

- ***The reform did not alter the overall financial status of health centers***. Revenues increased by about 14 percent between 2006 and 2007, but expenditures also climbed by 15 percent. Cost increases were seen for clinical care as well as administrative activities. About half of the centers had positive margins in 2007 while the other half had negative margins; average margins improved from 2005 to 2006 but decreased a little from 2006 to 2007 (see Figure C).

Figure C: Health Centers' Average Total Margins, 2005 to 2007



Source: GW analysis of Massachusetts Uniform Data System data

- ***Health center revenue mix changed, with state grants declining and insurance revenue increasing***. Patient revenue from health insurance, particularly Commonwealth Care and MassHealth (the state's Medicaid/CHIP program) climbed, while state grants and state funding for uncompensated care fell.

- ***Health centers play an important role in enrolling patients in the new system***. Using the state's online "Virtual Gateway," health center staff help patients enroll in MassHealth, Commonwealth Care and the Health Safety Net (the state's uncompensated care program). This responsibility has increased staff administrative workloads as a result of the sheer increase in the volume of patients seeking enrollment assistance and the increasing complexity of the enrollment process.

- ***Health centers had to cope with staffing concerns***. Staff recruitment and retention are ongoing issues at health centers, and insurance expansions led to increased demand for health care services exacerbating this problem. After the reforms, health centers typically raised provider salaries to remain competitive and undertook other staff recruitment and retention efforts. For example, in a manner akin to the National Health Service Corps, a state public/private funding partnership created a special loan repayment program to attract primary care physicians into health center practice.

Lessons for National Health Reform

The effect of the Massachusetts reforms on health centers can inform future state and national reform efforts. It is still early in the implementation of Chapter 58, but several lessons are highlighted by examining the reforms. Insurance does not guarantee access, so insurance expansions need to be accompanied by investments in the health delivery infrastructure, particularly primary care capacity. Safety net providers, especially community health centers, continue to be a vital source of care in a post-health reform world.

- ***Insurance expansions can lead to a surge in the demand for primary health care, especially in medically underserved low-income communities***. In addition, the newly insured patients may require care for chronic health problems that were not treated when they lacked insurance.

- ***In addition to expanding insurance coverage, investments to expand the capacity of the primary care system that will care for the newly insured, as well as for those who remain uninsured will be important***. Both transitional and ongoing support will be needed to help community health centers meet the new demands of a transformed health system, including investments in infrastructure and continued recognition that the vulnerable patients receiving care at health centers may have more complex health and social needs than those of the general population. Programs like the National Health Service Corps may need to be enhanced to help attract clinicians to practice in medically underserved areas.

- ***Even post-reform, there will be a continuing need for sources of care for the uninsured***. If insurance expansions lead to a general increase in the demand for primary care services, the safety net of community health centers may become even more important as a source of care for those who remain uninsured.

INTRODUCTION

Because of the central role played by primary health care in a well-functioning health care system,[1] an important policy question about health reform is the effect on primary health care access, capacity, and performance. The nature of this inquiry grows urgent in the case of medically underserved communities and populations at elevated risk for poorer health status, disparities in health and health care access,[2] and a shortage of primary health care professionals.

The nation's more than 1,000 federally and state-supported community health centers represent a principal source of primary care for medically underserved communities and populations, serving more than 16 million patients in 2007 at more than 6,000 sites.[3] Health centers play a particularly important role in Massachusetts; in 2007, health centers served one out of every 13 state residents. Because of the similarities between Massachusetts' 2006 health reform plan and the types of national reforms being considered,[4] the experiences of health centers in Massachusetts can help inform the national debate.

This report assesses the experience of Massachusetts' community health centers—an important part of the health care safety net that provides comprehensive primary care for low-income and uninsured patients—in the early stages of health care reform. We use mixed methods to explore the effect of the reforms on health centers throughout the state, including analyses of administrative data, case study interviews with executives at five health centers, a brief financial and enrollment survey, and discussions with numerous experts in the state. We describe the implementation experience of the reforms at health centers, highlighting the ongoing need for the care provided at community health centers, the enrollment and financial impact of health reform, staffing shortages, and the ways that these changes have affected patients receiving care at health centers.

BACKGROUND

Community Health Centers in Massachusetts

Community health centers provide community-based comprehensive primary health care to low-income and uninsured patients throughout the state. In addition to providing primary care medical services, health centers often provide other services, including dental care, emergency care, mental health counseling, HIV services, migrant health care, case management, WIC supplemental nutrition services, family planning, pharmacy, vision, and other ambulatory care services. Health centers are nonprofit organizations, led by patient-majority boards, and are federally mandated to provide health care to anyone in need, regardless of income or insurance status. Many health centers, particularly the larger ones that are often called federally-qualified

[1] Davis, K., Schoenbaum, S. and Audet, A. "A 2020 Vision of Patient Centered Primary Care." *Journal of General Internal Medicine.* 20(10) 953-957, 2005.
[2] Shi, L., Starfield, B., Politzer, R. and Regan, J. "Primary Care, Self-Rated Health, and Reductions in Social Disparities in Health." *Health Services Research*. 37(3): 529-550, 2008.
[3] George Washington University Analysis of Uniform Data Systems data.
[4] McDonough, J., Miller, M. and Barber, C. "A Progress Report on State Health Access Reform." *Health Affairs*. 27(2): W105-w115, 2008.

health centers (FQHCs), receive federal grants under Section 330 of the Public Health Service Act, administered by the Bureau of Primary Health Care.

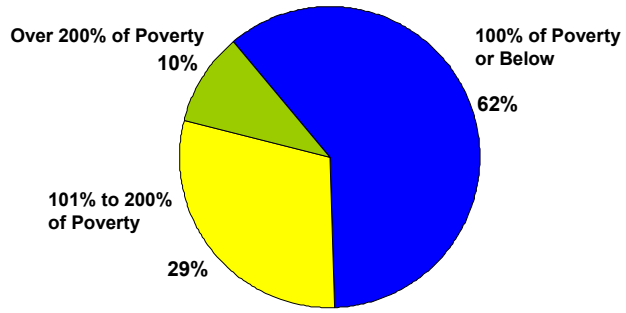


Figure 1: Massachusetts Community Health Center Patients by Income, 2007

Source: GW analysis of 2007 Massachusetts Uniform Data System, HRSA. The percentages are of those with known income; about 28% had unknown income.

One of the first community health centers in the nation was founded in Boston in 1965 by Drs. Jack Geiger and Count Gibson in the low-income ColumbiaPoint housing complex. The Massachusetts League of Community Health Centers, which represents health centers statewide, now has 52 health center members.[5] The Massachusetts Division of Health Care Financing and Policy recognizes 108 licensed health center delivery sites (i.e., clinics) across the state, operating under freestanding health center licenses or under hospital licenses. Although some of the health centers that are members of the Massachusetts League of Community Health Centers or recognized by the state are not FQHCs, all health centers have similar patient characteristics, given their location in low-income and medically vulnerable communities.

Currently, Massachusetts has 34 FQHCs, many of which operate multiple clinic sites. In 2007, these centers served nearly 483,000 patients, or about one out of every 13 Massachusetts residents and one out of every four low-income residents.[6] Figure 1 shows that nine out of ten patients in 2007 had incomes less than or equal to 200 percent of the federal poverty level. Nearly 36 percent of FQHC patients are nonwhite and 40 percent require translation services. Because of their location in communities at high risk of poor health, health centers in Massachusetts help alleviate disparities in health care access and outcomes.

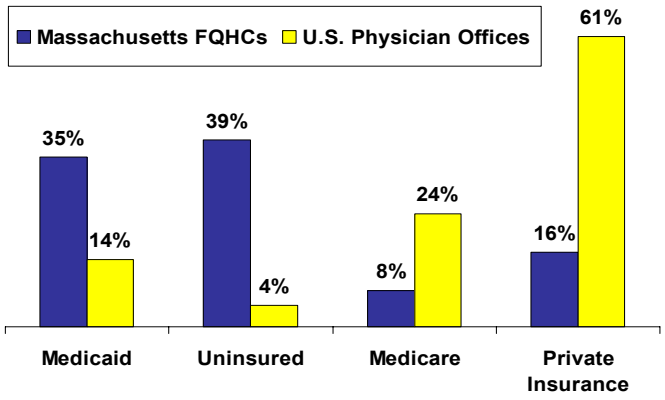


Figure 2: Insurance Coverage for Patients Seen at Community Health Centers in Massachusetts Compared to U.S. Physician Offices

Source: Health center data from 2007 Uniform Data System. Overall physician office data from Cherry, et al. (2008).

Health centers are critical sources of care for uninsured and low-income Medicaid patients. Nearly two-fifths of health center patients in 2007 were uninsured, compared to four percent of the patients receiving care in physicians' offices nationwide in 2006 (Figure 2).

[5] For more extensive information about health centers in Massachusetts, see the Massachusetts League of Community Health Centers' website, www.massleague.org.
[6] 2007 Uniform Data System (UDS), HRSA, and the Census Bureau's March 2008 Current Population Survey.

A much larger share of health center patients are covered by Medicaid than those receiving care in private physician practices. [7]

Health centers in Massachusetts are supported by the state with financing in the form of state grants and the Health Safety Net, which replaced the Uncompensated Care Pool as the source of reimbursement for care for the uninsured. Medicaid funding and federal grant funding are also major financing sources for health centers in Massachusetts.

Health Reform in Massachusetts

In April 2006, Massachusetts enacted a landmark comprehensive health reform law, "An Act Providing Access to Affordable, Quality, Accountable Health Care," also known as Chapter 58. This law was preceded by a series of incremental health reform efforts moving toward universal coverage in the Bay State, including a 1988 health reform law that was subsequently repealed, a 1996 law that expanded coverage under MassHealth (the Medicaid and CHIP program), and other incremental state laws.[8] The state's success in enacting a bipartisan health reform law and implementing it has led Massachusetts to be viewed as a model for health reform at the national level and by other states seeking to reform. Initial evaluations indicate that the law was successful in leading to substantial reductions in the number of uninsured people, and in turn, improving access to health care.[9]

Less is known, however, about the effects of health reform on safety net health care providers who traditionally bear the burden of providing health care to uninsured and low-income patients when the number of uninsured is greatly curtailed. Proposals to expand health insurance coverage are often financed, at least in part, by reducing grants or other subsidies to safety net providers, highlighting the tacit assumption that subsidies can be reduced when insurance coverage is more plentiful.

Chapter 58: The Reforms

Massachusetts has long been a leader in health reform, even before the enactment of Chapter 58 in 2006 and rapid implementation of the law. Before the reforms, Massachusetts had relatively broad health insurance eligibility under public programs, including Medicaid, the State Children's Health Insurance Program and other state-funded coverage programs. Regulation of the private insurance market, including individual and small group markets, was already fairly comprehensive. The state also had a substantial Uncompensated Care Pool that subsidized care for low-income uninsured patients at community health centers and acute care hospitals. Thus,

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[7] 2007 data for health centers from the UDS and 2006 data for overall physician offices is from Cherry, D., et al. "National Ambulatory Medical Care Survey: 2006 Summary" National Center for Health Statistics, National Health Statistics Reports No. 3., Aug. 6, 2008.

[8] McDonough, J., et al. "Massachusetts Health Reform Implementation: Major Progress and Future Challenges," *Health Affairs,* 27(4):w270-84, 2008. Hager, C. "Massachusetts Health Reform." *Journal of Legal Medicine* 29(1): 11-22, 2008. McDonough, J., et al. "The Third Wave of Massachusetts Health Care Access Reform." *Health Affairs* 25: w420-w431, 2006. Turnbull, N. "The Massachusetts Model: An Artful balance." *Health Affairs* 25: w453-w456., 2006.

[9] Long, S. "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs*, 27(4):w270-84, 2008 (2008a). Massachusetts Division of Health Care Finance and Policy. Health Care in Massachusetts: Key Indicators, November 2008.

Massachusetts already had many building blocks in place enabling near-universal health reform initiatives.

The reform law is designed to lead to coverage of almost all state residents. It is based on an assumption of shared responsibility for health insurance coverage by individuals, the government and employers. Key features of the law are as follows:[10]

- *Individual Responsibility.* Persons over age 18 are required to purchase health insurance coverage, if "affordable" coverage is available. Those who do not have coverage will pay an income tax penalty. Certain hardship exemptions are available.

- *Government Responsibility.* MassHealth was expanded to cover children with incomes below 300 percent of the federal poverty line. A new program, Commonwealth Care (CommCare), was developed to cover uninsured people with incomes below 300 percent of the poverty level, particularly those who are not offered affordable employer-sponsored insurance. There are no premiums for those with incomes below 150 percent of poverty and there are sliding scale premiums for those between 150 percent and 300 percent of the poverty level. In addition, Chapter 58 created the Commonwealth Health Insurance Connector Authority to function as an insurance exchange to provide easier access to approved health insurance products for small businesses and for individuals with incomes above 300 percent of the poverty level. Several plans are offered as Commonwealth Choice (CommChoice) options and employees can use pretax dollars to purchase coverage under approved plans.

- *Employer Responsibility.* Employers with 11 or more employees must either make a "fair and reasonable" contribution toward health insurance premiums for their employees or pay a "Fair Share" assessment per uncovered worker. Firms with 11 or more employees must offer a "Section 125" cafeteria plan to help employees pay for health insurance using pre-tax dollars. Firms that do not comply may be assessed a "free rider" surcharge if their employees receive free care during the year.

- *Provider and Insurer Responsibility.* The Health Safety Net (HSN) replaced the Uncompensated Care Pool (UCP) as the primary mechanism for paying for care received by the uninsured. Low-income individuals who are uninsured (or underinsured) may enroll and receive subsidized care at selected community health centers and acute care hospitals. The funding is made available through assessments placed on health care providers and health insurance plans.

According to state estimates when the law was passed, the reforms were expected to cost about $1.2 billion in FY 2007, $1.3 billion in FY 2008 and $1.6 billion in FY 2009.[11] The main expected budgetary increases were for CommCare subsidies and Medicaid provider rate increases, which were expected to gradually rise. On the other hand, funding levels were expected to dwindle over time for the Uncompensated Care Pool/Health Safety Net (UCP/HSN)

[10] Blue Cross Blue Shield Foundation of Massachusetts. "Massachusetts Health Care Reform Bill Summary." June 30, 2006. Kaiser Commission on Medicaid and the Uninsured. "Massachusetts Health Care Reform: Two Years Later," May 2008.
[11] Blue Cross Blue Shield Foundation of Massachusetts, *op cit.*

for providers and for managed care organization supplemental funding. For example, the UCP/HSN funds were projected to fall by almost half from $610 million in 2007 to $320 million by 2009. There were multiple sources of funding, including federal safety net revenue and new federal Medicaid matching funds.

Impact of Reform

In 2008, as evidence of the effects of the health reform have accumulated, a study by the Urban Institute has received particular attention.[12] Researchers fielded statewide surveys of adults 19 to 64 years old in fall 2006 (immediately prior to the implementation of many of the key reforms) and conducted a second survey in fall 2007 (about a year after the reform efforts began). They found that the rate of uninsurance fell from 23.8 percent to 12.9 percent for low-income adults (below 300 percent of poverty) and from 5.2 percent to 2.9 percent for higher-income adults. The study also documented improvements in both employer-sponsored and other (mostly public) insurance coverage, and found no evidence of "crowd-out," or the substitution of public insurance for private coverage as a result of incentives created by the reform. A second Urban Institute study found that coverage improvements were relatively larger for low-income adults, young adults and those working in small businesses.[13] A recent survey of Massachusetts employers[14] confirmed the Urban Institute's key finding that public coverage expansion does not necessarily lead to measurable evidence of crowd-out.

The Urban Institute study also found evidence of increased access to care, measured by variables such as having a usual source of health care, receiving preventive medical care and receiving dental care, and reductions in the proportion of people who reported not getting needed care in the past year due to cost. People reported having fewer problems paying their medical bills and fewer people incurred large out-of-pocket costs for their medical care post-reform.[15]

The most recent Census data also highlights the same trends. The U.S. Census Bureau recently released findings from the March 2008 Current Population Survey, the most commonly cited national survey for health insurance estimates. Our analysis of the Census data, summarized in Table 1, shows that the number of uninsured fell by about 300,000 between 2006 and 2007, and the percentage of people who were uninsured fell by about half, from 13.0 percent in 2006 to 7.1 percent in 2007. The Census data also show substantial reductions in uninsurance among both adults and children, suggesting that comprehensive reform effectively increases coverage even for populations such as children who previously were eligible for assistance.

In August 2008, the Massachusetts Division of Health Care Finance and Policy (DHCFP) analyzed administrative reports and estimated that the number of people with health insurance grew from 5.02 million in June 2006 to 5.46 million in June 2008, an increase of 442,000. About 40 percent of this increase in covered lives is estimated to be the result of accessible CommCare coverage, 18 percent is attributable to the MassHealth expansions, 33 percent derives

[12] Long, S. (2008a) *op cit.*
[13] Long, S. "Who Gained the Most Under Health Reform in Massachusetts?" Washington, DC: Urban Institute, Oct. 2008. (2008b).
[14] Gabel, J., et al. After The Mandates: Massachusetts Employers Continue To Support Health Reform As More Firms Offer Coverage, *Health Affairs* 27(6 web exclusive): w566-75.
[15] Long, S., (2008a) *op cit.*

Table 1:
Changes in the Level of Uninsured in Massachusetts, 2006 to 2007, Based on Current Population Survey Data

	Uninsured All Ages		Uninsured Children 0-17	Uninsured Adults 18-64
	# in 1,000s	Percent	Percent	Percent
All Incomes				
2006	657	10.4%	7.0%	13.6%
2007	340	5.4%	3.0%	7.0%
Below 300 Percent of Poverty				
2006	408	16.8%	13.0%	23.6%
2007	193	8.1%	3.5%	12.5%

from increases in private group coverage, and 9 percent results from the purchase of individual insurance coverage.[16]

There are modest differences in the estimates from the various sources of the number or percentage of uninsured people, but the estimates consistently point to a trend of substantial reductions in the levels of uninsurance within a year of enactment and implementation.

Chapter 58 has successfully increased access to health insurance coverage, but there have been serious concerns about primary care access. Even after obtaining health insurance, some residents still encounter difficulties obtaining medical care because of a shortage of physicians (and other health professionals) in certain specialties or in certain locations.[17] The Massachusetts Medical Society has reported serious shortages of internists, family practitioners and some specialists in the state.[18] Even absent a numerical shortage, the primary care supply in Massachusetts suffers from the same maldistribution experienced nationally,[19] and many providers are unwilling to treat low-income and uninsured patients.[20] One report found the average wait time for an appointment with an internist in Massachusetts lengthened from 33 days in 2006 to 50 days in 2008.[21] As discussed below, community health centers share these concerns and often have difficulty recruiting physicians and other health professionals, even though Massachusetts is home to many medical schools and residency programs.

COMMUNITY HEALTH CENTERS AND HEALTH REFORM

Our study of the effects of health care reform on Massachusetts health centers had two primary approaches. First, we analyzed enrollment and financial trends for health centers in Massachusetts, using administrative databases and a special survey conducted by the

[16] Massachusetts DHCFP, *op cit.*
[17] Stewart, Z. "Doctor Shortage Hurts a Coverage for All Plan", *Wall Street Journal*, Jul. 25, 2007.
[18] Massachusetts Medical Society, "Physician Workforce Study: Executive Summary," June 2007.
[19] Goodman, D. 2008. "Physician Workforce Crisis? Wrong Diagnosis, Wrong Prescription." *New England Journal of Medicine* 358(16): 1658-1661.
[20] Stewart, Z. *op cit.*
[21] Kowalczyk, L. "Across Mass., Wait to See Doctors Grows," *Boston Globe,* Sept. 22, 2008.

Massachusetts League of Community Health Centers. Second, we assessed the experiences of health centers, based on case study interviews conducted at five health centers in August 2008 and on discussions with a wide variety of experts and stakeholders, including a discussion with executives from numerous health centers and staff of the Massachusetts League of Community Health Centers.

Enrollment and Financial Changes for Massachusetts Health Centers

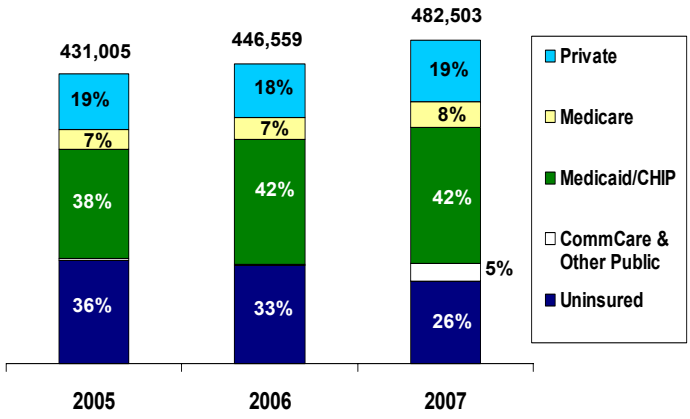
Information about patient enrollment and funding can be found in data reported by FQHCs in Massachusetts for calendar years 2005 through 2007 as part of the annual federal Uniform Data System (UDS) reporting system (participation is required as a condition of federal health center funding). It is important to note that the MassHealth expansion occurred in 2006, but most of the other changes, including the initiation of CommCare, were implemented in late 2006 and early 2007, so the reform continues to have important effects not captured by this data. These analyses are supplemented with information provided by the Massachusetts Division of Health Care Financing and Policy based on cost reports filed by freestanding health centers for fiscal years 2006 and 2007, which also includes information about health center "look-alikes" that do not receive federal FQHC funding, but do qualify for "federally qualified health center" reimbursement under Medicare and Medicaid. These state data exclude health centers that operate under a hospital's license. Finally, a survey conducted by the Massachusetts League of Community Health Centers in late 2008 and completed by 35 health centers provides an additional window through which to view the effects of the reforms.

Patient Number and Composition

The number of patients receiving care at FQHCs rose appreciably during the early years of the reform: by four percent in 2006 and by an additional eight percent in 2007, rising from 431,005 in 2005 to 482,503 in 2007 (Figure 3; more detailed data are found in Table 2 in the Appendix).[22]

Between 2005 and 2006, the primary reason for caseload growth was increased enrollment in Medicaid and CHIP (MassHealth), which rose by about 24,000. While most of this growth occurred among adult patients, a portion of this increase was undoubtedly the result of the expansion of children's eligibility from 200 percent to 300 percent of the federal poverty level.

Figure 3: Health Center Patient Caseload and Insurance Revenue Sources, 2005-2007



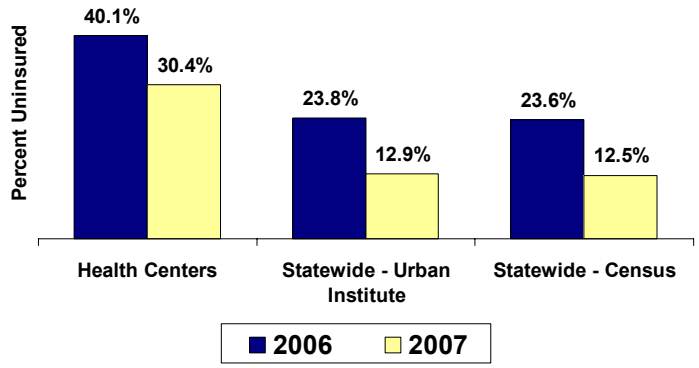
Note: CommCare and Other Public served 1% of patients in 2005 and less than 1% in 2006
Source: GW analysis of Massachusetts Uniform Data System data

[22] GWU analysis of UDS data. The number of FQHCs in Massachusetts rose from 33 in 2005 and 2006 to 34 in 2007.

In both 2006 and 2007, the percentage of uninsured health center patients fell; a five percent decline occurred in 2006 and was followed by a 16 percent decline in 2007. It is important to note that uninsured patients have different financial implications for health centers in Massachusetts because the health care furnished to most, but not all, uninsured patients receiving care at Massachusetts health centers qualifies for subsidy payment from the state's Health Safety Net fund. Only a few states support their health centers with operating subsidies that finance care for uninsured payments.

The number of patients with "other public insurance," primarily CommCare, rose dramatically from 2,170 patients in 2006 to 26,423 patients in 2007, which is a more than tenfold increase of over 24,000 patients. The number of privately-insured patients also climbed from 79,441 in 2006 to 92,531 in 2007, an increase of more than 13,000 patients.[23] There were smaller increases in Medicaid, CHIP and Medicare enrollment in 2007.[24] These findings are broadly consistent with the findings from the Urban Institute, which reported reductions in the percent of adults who were uninsured and increases in the percentage with public and private coverage.[25]

Figure 4: Uninsured Patients Statewide and at Health Centers, 2006 and 2007



Source: Health center data from UDS. Statewide from Long 2008 & Census 2008.

While the number of uninsured patients fell statewide, the proportion of uninsured patients at health centers declined far less steeply (Figure 4). The Urban Institute surveys indicate that the percentage of low-income adults (below 300 percent of the poverty line) who were uninsured dropped by almost half, from 23.8 percent to 12.9 percent.[26] The Census data show that the percentage of uninsured people (all ages) fell by more than half from 16.8 percent to 8.1 percent. But the UDS data show the reduction in the share of adult health center patients who were uninsured fell by only about one-quarter, from 40.1 percent to 30.4 percent. Thus, even after implementation of a health reform initiative that provided generous subsidies to low-income residents, the proportion of health center patients without health insurance remained high, and health centers continued to serve a disproportionate share of residents without health insurance. In addition, in the wake of health reform, health centers provided care for a much larger share of the uninsured population. Based on the Census count of the uninsured and UDS data on uninsured patients, health centers served about 22 percent of the uninsured state residents in 2006; this figure rose to 36 percent of the uninsured in 2007, underscoring the importance of health centers to the health care safety net.

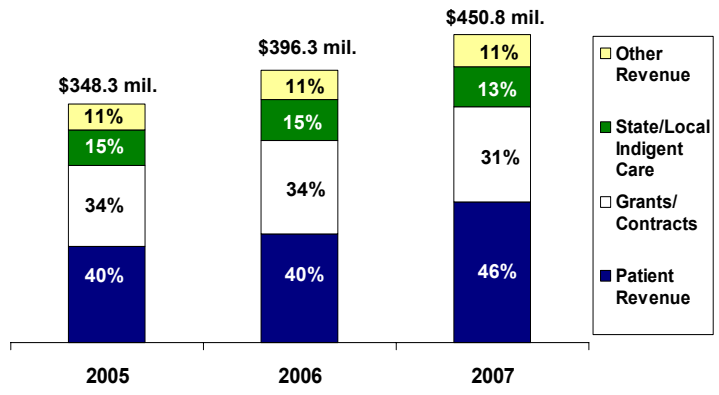
[23] It is possible that there was some misreporting by health centers and that some on CommCare were reported as having private insurance, because CommCare plans were private firms.
[24] George Washington University analysis of UDS data. In UDS data, a patient's insurance status is based on the last time he or she was seen. Thus, a patient who was uninsured in February, but on CommCare by December, is counted as a CommCare patient.
[25] Long, *op cit.* 2008a.
[26] Long, *op cit.* 2008a and 2008b.

The bulk of the 2007 health insurance expansions in Massachusetts was aimed at adults who became eligible for CommCare and private health insurance expansions; MassHealth coverage for children was also expanded, but children's eligibility was already relatively generous. The FQHC data demonstrate that post-reform, adults comprised a slightly greater share of health center caseloads. Although a modest (2.2 percent) increase could be seen in the number of children served between 2006 and 2007, the number of adult patients receiving care at health centers grew five times faster, from 315,058 in 2006 to 348,102 in 2007, a 10.5 percent increase.

Revenues

Total revenues for Massachusetts FQHCs rose by about 14 percent in 2006 and another 14 percent in 2007 (Figure 5). After adjusting for medical cost inflation, these increases correspond to a 10 percent annual increase in constant dollar revenues.[27] (More detailed data are shown in Table 3 at the end of the report.)

Figure 5: Total Patient Revenues and Revenue Sources



Source: GW analysis of Massachusetts Uniform Data System data

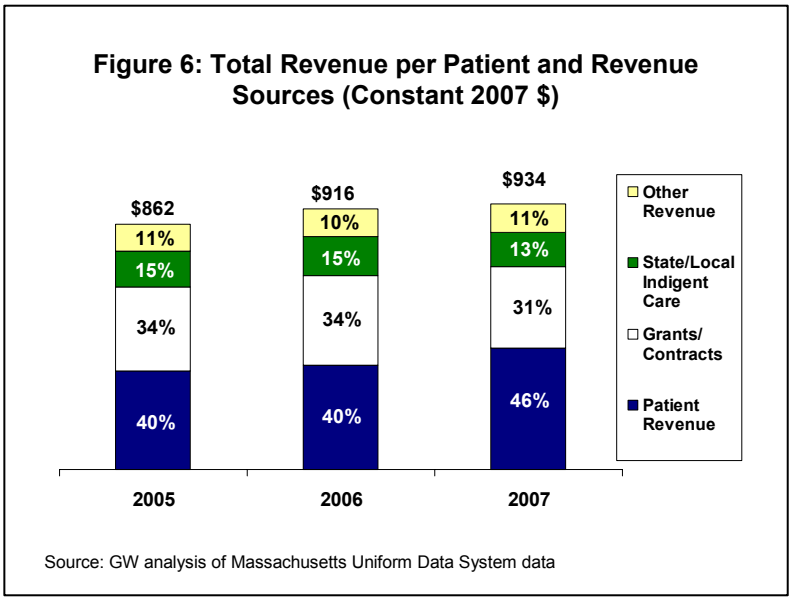
In 2007, patient-related revenue from Medicaid and CommCare payments comprised the major source of revenue growth. Patient revenue rose by 30 percent in 2007, while grant and contract revenue rose by only two percent. Federal grants grew by about four percent in 2007, but state and local grants fell by 12.4 percent and state indigent care funding (i.e., UCP/HSN) fell by four percent. These reductions offset the gains in insurance-related revenue.

The revenue increases did not result solely from volume-related increases; they also reflect changes in payment rates as a result of previous legislation boosting health centers' payments under MassHealth by about $10 million annually.

Figure 6 illustrates changes in constant dollar revenues divided by the total number of patients, providing a more accurate measure of the actual reimbursements paid to health centers on a per patient basis. After adjusting for both patient volume and for inflation, FQHCs' per capita revenue rose by about six percent in 2006 and by two percent in 2007. In 2006, the increases in per capita constant dollar revenues were relatively equally shared across patient

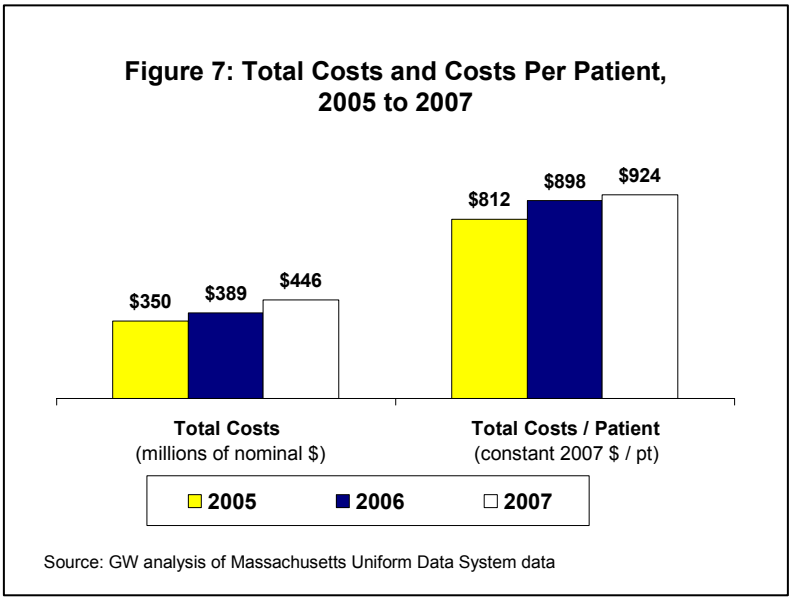
[27] To adjust for inflation, we used the Office of National Health Estimates' medical care implicit price deflator. The estimated levels were 3.4% in 2006 and 3.2% in 2007. Office of National Health Estimates, CMS, "National Health Expenditure Projections 2007-2017," Jan. 2008.

revenue, grant revenue and indigent care funding. In 2007, however, growth in per capita patient care revenue outstripped growth in per capita grant and indigent care revenue.



Costs

While health center revenues climbed appreciably, their expenditures on patient care also rose. UDS data show that health center expenditures related to operating costs—including both administrative and service expenditures—grew by 11 percent in 2006 and by 15 percent in 2007 (Figure 7; see Table 3 in the Appendix for more detail.)



Similarly, total costs per patient rose seven percent in 2006 and six percent in 2007. After adjustment for medical inflation, the total costs per patient rose by four percent in 2006 and three percent in 2007.

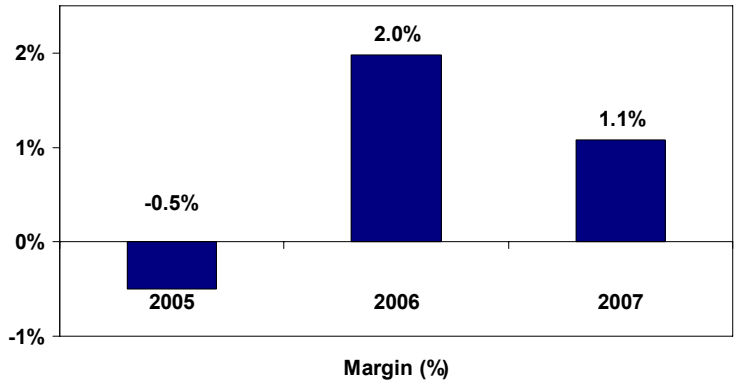
Margins

The availability of cost-related expenditure and revenue data enable a preliminary analysis of health centers' financial margins. Since FQHCs are non-profit, they cannot earn a profit, but they may carry balances (or debts) from one year to the next for operational purposes. UDS data do not report cost and revenue figures consistently, however. Revenue data are reported on a cash basis (actual funds received during the year), but costs are measured on an accrued basis (expenses charged for that period, even if not paid in that year). Thus, the margins shown here are not properly measured financial margins, but they nonetheless give a sense of cash flow and the relative balance of costs and revenues.

In aggregate, nominal terms, Massachusetts health centers lost $1.7 million in 2005, but made $7.8 million in 2006 and $4.9 million in 2007. As a percent of revenue, margins rose from negative 0.5 percent in 2005 to positive 2.0 percent in 2006, but then declined to 1.1 percent in 2007 (Figure 8). In terms of inflation-adjusted margins per patient, the net margins per patient fell from $18.11 in 2006 to $10.11 in 2007.

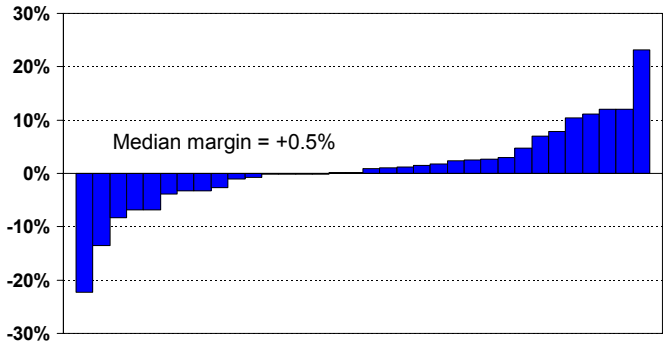
These average margins do not adequately portray the distribution of FQHCs' financial status, however. Figure 9 shows the distribution of margins across the 34 FQHCs in 2007. Margins ranged from negative 22 percent to positive 23 percent, and about half (15) of the centers had negative margins, while the other half (19) reported positive margins. Some of the negative margins were due to larger revenue reductions that affected some health centers (such as those that were affiliated with certain safety hospitals, discussed more below), but some of this variation is part of the usual variation in business practices. In 2006 there was a similar wide distribution of gains and losses, although the gainers and losers differ in each year.

Figure 8: Health Centers' Average Total Margins, 2005 to 2007



Source: GW analysis of Massachusetts Uniform Data System data

Figure 9: Health Center Total Margins Post-Reform, 2007



Source: Analysis of Massachusetts Uniform Data System data

The state's Division of Health Care Finance and Policy (DHCFP) arrived at similar findings about the financial status of freestanding community health centers for fiscal years 2006 and 2007.[28] Their analyses indicated health centers' median operating margins stood at 0.3 percent in 2006 and 0.0 percent in 2007, but measured median total margins at 1.1 percent in 2006 and 2.3 percent in 2007. As was the case with our results, DHCFP found that many health centers had negative balances while others had positive balances. The findings are broadly comparable, but direct comparisons between our data and the DHFCP figures are not possible given the differences in types of health centers reporting (our analysis of UDS data includes FQHCs only, while DHCFP figures include all freestanding health centers, both FQHC and look-alike) and reporting periods (calendar versus fiscal years).

[28] Mass. DHCFP, *op cit.* Health centers' fiscal years vary somewhat, but most often run from July 1 of one year to June 30 of the next. Thus, fiscal year 2007 typically ended June 30, 2007. The UDS data are for calendar years, so 2007 ends December 31, 2007.

In addition, the DHCFP data show that the level of funding paid to freestanding health centers under the Uncompensated Care Pool/Health Safety Net fell by about one-fifth between the third quarter of 2006 and the third quarter of 2008, from $21 million to $18 million. UCP/HSN funding for hospitals and hospital-based facilities, including community health centers licensed under hospitals dropped much more sharply, falling 40 percent from $310 million to $186 million.

In the early fall of 2008, the Massachusetts League of Community Health Centers sought to collect more current data about health centers' enrollment and revenue trends by fielding an e-mail survey. Of the 52 community health centers contacted, 23 responded with financial data. While these partial responses cannot safely be generalizable to the entire state, they tend to confirm our findings and suggest a continuation of these trends into 2008.[29] They indicate that state uncompensated care revenues received by health centers continued to decline in 2008, while revenues from MassHealth and CommCare continued to rise, leading to an overall increase. Among the 23 centers, UCP/HSN funding fell an estimated 18 percent from fiscal year 2007 to fiscal year 2008, while revenue from MassHealth and CommCare rose continued to rise by 33 percent from fiscal year 2007 to fiscal year 2008. This survey also indicated that MassHealth and CommCare enrollment levels continued to rise in 2008, as they had in 2007.

Summary of Utilization, Payers, and Financial Status

Health care reform in Massachusetts had a major impact on the health care activities of health centers. Overall, patient caseloads rose by about 50 thousand—roughly 11 percent—between 2005 and 2007. Simultaneously, health centers experienced a significant reduction in the number of uninsured patients, but these reductions were more than offset by gains in the number of patients with insurance, particularly MassHealth and the new Commonwealth Care program. Partial data for 2008 suggest that these trends appear to continue through mid-2008.

A crucial question is whether the presence of newly insured patients in health centers makes it harder for uninsured health center patients to access services, which would be contrary to the mission and purpose of health centers. The evidence reviewed below indicates that many of the newly insured patients in fact were health centers' previously uninsured patients; that is, to a considerable degree, health center patients remained in place while their source of financing shifted from uncompensated care funding to patient-related revenue (i.e., health insurance). Furthermore, the statistics on care to the uninsured presented above reinforce health centers' continuing safety net role for the uninsured, since they show that over this early reform time period, the provision of care to uninsured state residents became more concentrated at health centers. Indeed, although there was a decline in uninsured patients receiving care in health centers, the reduction was only half the size of the decline in the overall number of uninsured people in the state. Thus, community health centers remained critical providers of care for patients, in part because of the shortage of private primary care providers able or willing to provide services for uninsured or newly-insured patients in Massachusetts. Community health centers continue to anchor the safety net in Massachusetts, even after reform.

[29] In the league's surveys, data were collected for fiscal years 2006 (October 2005-September 2006), 2007 and the first three quarters of fiscal year 2008, through June 30, 2008. To enable comparisons between years, data from the first three quarters of 2008 were extrapolated to yield full year data estimates for 2008.

Revenues rose appreciably for health centers, but costs rose at about the same pace; as a result, average financial margins remained close to zero in 2006 and 2007. In 2007, about half the centers had negative margins, while the other half experienced positive margins. The composition of revenues changed considerably between 2006 and 2007. State grants and uncompensated care revenues fell, but insurance reimbursements from MassHealth and CommCare rose, roughly offsetting the decline in these other revenues. Preliminary data for 2008 suggests that these trends have continued. Of course, whether these offsetting changes can be sustained is more difficult to assess, in light of the recent economic downturn and the heightened pressure for deep state budget cuts.

IMPLEMENTATION OF HEALTH REFORM BY HEALTH CENTERS

In late August 2008, GWU researchers conducted site visits in Massachusetts and interviewed managers and staff of five health centers of various sizes. Researchers also participated in a broader discussion about the effects of the reforms with representatives of more than a dozen health centers and staff of the Massachusetts League of Community Health Centers. In addition, we conducted telephone interviews about health reform with local experts and state officials.

Health Centers' Overall Perspective on Health Reform

Both before and after the enactment and implementation of Chapter 58, community health centers have been enthusiastically supportive of efforts to expand health insurance in Massachusetts, and they are proud to be part of what they view as a vanguard for national change. Because they serve patients who are disproportionately uninsured and low-income and because they have community-based boards, health centers view themselves as both health care providers and as advocates for the uninsured and poor at a community level. While the interviews highlight a number of implementation concerns, health center interviewees remain firmly committed to the overall goals of health reform and believe that policies crafted by the state were generally well constructed and implemented.

Even though health centers already served the uninsured and provided community-based primary care before the reforms, they believed that the patients who acquired insurance gained access to a broader array of services, including specialty care, prescription drugs, and inpatient care. Many newly-insured patients are empowered to seek services now that they finally have insurance; newly insured individuals who formerly delayed care are now able to access care more easily. Since chronic conditions may be managed better, some expensive ER visits can be averted, and lives may be saved. Most patients seem satisfied, but there are anecdotal stories about unhappy patients. While patients who gained coverage are better off than they were before the reforms, a limited number of other patients may be worse off post-reform because they may have lost some subsidies and it may be harder to find primary care.

As shown in the data analysis above, although health centers revenues generally climbed, so did their costs. While health reform did not bring windfalls to health centers, the additional revenues allowed them to expand services to reach more patients and in some cases to broaden the scope of the care they could offer.

More Patients, Fewer Uninsured

Since implementation of reform, health centers reported to us that they typically experienced increases in overall patient caseload, and a decline in the proportion of uninsured patients. Health centers believed that most of their newly patients who now had CommCare coverage were already patients, and the only thing that changed was their source of payment. In addition, they also reported serving some new patients who had not previously received care at their facilities. However, in some cases, the caseload increases were the result of planned facility expansions which enabled them to see more patients. One center had built a large new clinic facility in a central location and closed older and smaller sites, thereby enabling the center to see more patients. Another center reported responding to increased demand by expanding hours to serve more patients within the same space.

Health centers also believed that some patients selected community health centers because of the difficulty finding primary care physicians who accepted CommCare. Because of the general shortage of primary care providers in Massachusetts, private doctors' offices could be more selective about the types of patients they wanted to see and may have preferred privately-insured patients or patients who could pay in cash. Health centers were generally well-represented in the provider panels of the health plans that serve MassHealth and CommCare.

Before health reform, some health centers worried that insurance expansion might reduce their patient volumes, since newly insured patients would have other medical care options. But this did not prove to be the case, according to the health center executives interviewed. Patients tended to remain with health centers because they were very satisfied with the care they received at these facilities, and in some cases, because health centers had capabilities—such as bilingual clinicians or interpreters—or services that other primary care providers lacked, including urgent care, mental health or dental services. Indeed, as also shown by the administrative data, health centers generally gained more patients after health reform. This increase in patient caseload, coupled with a surge in new patients, means that in certain parts of the state, patients may still have a substantial wait to get an appointment in a health center.

Another post-reform change reported by centers is the shift to an older adult patient population. Before Chapter 58, Massachusetts already had relatively generous coverage of children in MassHealth, but coverage of adults was more limited. CommCare expansions particularly aided low-income adults who had more limited public coverage beforehand. Some health centers observed that many of the initial new enrollees were middle-aged or near-elderly adults with chronic health conditions, who had delayed seeking medical or dental care for a protracted period when they were uninsured. In some cases, these chronic conditions were silent diseases such as hypertension or diabetes, whose symptoms were not previously recognized. As a result, medical care pressures and costs may have been heightened because of the pent-up demand for care among these adults. It is unclear if these needs will abate over time, as the newly insured begin to receive more routine primary care services. Other research has shown, for example, that Medicaid expenditures are higher when people first enroll, then gradually decline.[30]

[30] Ku, L. and Cohen-Ross, D. "Staying Covered: The Importance of Retaining Health Insurance Coverage for Low-income Families," Commonwealth Fund, Dec. 2002.

There was some turnover in patients as a result of managed care enrollment procedures in CommCare and MassHealth, which are both administered by managed care plans. After enrolling in the program, patients must select one of four participating health plans (Boston Medical Center HealthNet, Fallon Community Health Plan, Neighborhood Health Plan or Network Health, owned by Cambridge Health Alliance) and then select a primary care provider from each plan. Those who do not select a plan are auto-enrolled (that is, automatically enrolled into a plan), but these auto-enrolled members may switch plans during the 60-day period following enrollment. Thus, some health center patients may fail to select a plan that is affiliated with the health center (or they are auto-assigned to another provider), but with help from health center staff, they are often able to change plans or providers. There were, of course, some transitional problems with the roll-out of the new system, including the additional time required for health centers and the health plans to understand their respective positions and obligations.

Although health reform substantially expands coverage, all Massachusetts residents are not covered. Health center staff observed that some key groups remain ineligible for public or private health insurance and thus continue to lack coverage. Undocumented immigrants are ineligible for MassHealth (except for emergency coverage) and for CommCare, and they are frequently not offered private health coverage. They are eligible for the HSN, however, if they have low incomes.[31] Low-income people are ineligible for CommCare if they refuse to enroll in available employer-sponsored health coverage within the previous six months that is considered affordable under state standards (the employer covers at least one-third of an individual policy or one-fifth of a family policy).[32] In these cases, individuals are also ineligible for HSN subsidies, which might make it harder for them to obtain care in some cases. (FQHCs, however, are required to serve patients without regard to their insurance status.)

Finally, health center staff noted new problems for those who failed to re-enroll in CommCare on a timely basis or who missed their premiums and were "locked out" of coverage until they paid their back-owed premiums. Individuals are required to reenroll in CommCare annually, but many enrollees were unaware of this requirement, especially those who were automatically enrolled by the state when CommCare first began. Those who fail to reenroll in the program are terminated from coverage and usually become uninsured until they complete the reenrollment process. In addition, if beneficiaries who are required to pay premiums fail to pay those premiums for 60 days, they are terminated from the program. Both these situations can present problems for individuals who may experience gaps in coverage as a result of these terminations, but they can also present problems for health centers. Individuals who lose coverage for either of these reasons are ineligible for HSN coverage (a change in policy from the old Uncompensated Care Pool arrangement). Consequently, health centers treating these newly uninsured individuals would not receive HSN subsidy payments as compensation for the care provided.

[31] State residents are eligible for the Health Safety Net if they are uninsured or underinsured and unable to obtain affordable coverage and either have low-income (below 400 percent of the federal poverty line) or have high medical bills. Those with incomes between 200 and 400 percent of poverty get partial coverage and must meet an income-related deductible.

[32] Some exceptions are permissible and there is a process for obtaining hardship exceptions.

Challenges in Finding and Retaining Staff

As is the case nationally, one of the major problems cited by health centers was the shortage of qualified and available providers. Some say the provider shortage is the "biggest problem right now," and the problem worsened after health reforms increased the demand for care. All the health centers we visited described special efforts they had made in the previous year to recruit or retain staff, particularly primary care physicians, but also mid-level professionals such as nurse practitioners, nurses, and pharmacists. As noted earlier, health care reform has made the general shortage of primary care practitioners more apparent in Massachusetts.

Many different types of initiatives were used to recruit and retain staff. To remain competitive and to retain providers, many health centers increased salaries in 2007, in some cases by as much as 50 percent. Health centers often need to use special programs to help attract clinicians. One health center that had undertaken a substantial expansion hired six physicians in the previous year: one recruit used the loan repayment program described below, two were National Health Service Corps doctors who received federal support to pay for their education or to repay loans, and the other three were international medical graduates who received special visa status (J-1 visa waivers or H-1B visas) to live and work in the U.S. because they were willing to practice in health centers.[33] It may take months, even years, to recruit physicians under these circumstances.

To attract new doctors, the Massachusetts League of Community Health Centers began a special program, similar to the federal National Health Service Corps, that helps repay student loans for new primary care physicians who are willing to commit to practicing in a health center; this program was sponsored by grants from the Bank of America, the Blue Cross Blue Shield of Massachusetts Foundation, Neighborhood Health Plan, and Partners HealthCare System; the program also received state matching funds. This new program essentially makes health center practice for underserved populations more affordable for medical school graduates with high loan burdens.

Health centers also encountered problems with the credentialing process. Health plans typically require that participating providers meet certain qualifications, and network providers must be credentialed by the entity before they can bill to the plan. However, it could take months for the managed care organizations to credential a new physician. In such cases, the uncredentialed physicians could only treat uninsured patients, for whom credentialing is not required, until the process was completed. This made workflow and scheduling more complicated in the interim and meant that newly hired physicians could not be used as effectively as the health center had desired.

All of the centers that we spoke with report problems achieving adequate provider staffing levels; as a result, they developed various strategies for using staff as efficiently as possible. Many centers maintain months-long waiting lists for new patients (a phenomenon reported anecdotally by patients who use other practice settings and who are attempting to newly register). Health centers might also exclude patients who do not live in their service areas.

[33] J-1 visa waivers can be applied to extend visas of foreign physicians who originally came to the U.S. for training if they agree to practice in health professional shortage areas after completing their training. H-1B visas can be used to hire foreign workers with specialized skills, such as doctors, who are sponsored by American employers who must indicate that this will not displace U.S. citizen doctors.

One health center implemented an "open access" scheduling protocol[34] in order to help reduce waiting time from six to eight weeks to less than one week. Open access permits patients to return for follow-up visits without having to make appointments months in advance, thereby reducing the problem of missed appointments, which can be caused by an inability to take time off from work, find transportation, or make child care arrangements for an appointment that the patient made months ago but forgot about. Open access also has positive effects on continuity of care, because this scheduling system enables patients to visit the same provider as often as possible (at least for non-urgent care).

Varying Financial Risk

As seen in the previous section, revenues and costs alike have been rising for health centers since 2006. However, health center financial status varies widely: some have increased their margins, while others have experienced negative margins (that is, they have lost money, relative to the status quo before the reforms). For some centers, the additional insurance revenues offset the increased administrative burdens and the loss of some grant or UCP/HSN funding. For other centers, however, the gains in CommCare, MassHealth or private insurance revenue were insufficient to defray the impact of declines in other state funds and increased administrative responsibilities, so they lost money.

One key factor that affected health centers in a variable fashion was differential treatment under the former Uncompensated Care Pool and the current Health Safety Net. Although both the UCP and HSN provide subsidies for health centers and hospitals, they have been managed differently. As noted earlier, a small number of health centers are treated distinctly by the state because they have operated historically under a hospital's license, even though they might be functionally independent. Hospital-licensed health centers used to receive higher subsidies under UCP than the freestanding health centers, in recognition of the historical importance that hospitals and health centers played in the safety net. Now, both types of health centers are paid on the same basis under HSN, based on the number of visits by HSN enrollees (although the hospital-licensed health centers receive some supplemental payments, as do those hospitals). Moreover, payment rates under CommCare are lower than the rates paid by the UCP to hospital-licensed health centers. Consequently, as previously uninsured patients who were formerly subsidized through the UCP gained coverage under CommCare, reimbursements to hospital-licensed health centers for those patients declined. Thus, the transition from UCP payment rates to HSN and CommCare payment rates led to reductions in payments for hospital-based health centers, but increases in payments for freestanding centers.

These changes are not surprising. The budgetary design of health reform assumed reductions in overall UCP/HSN funding over time, and it was known that hospital-licensed health centers would experience stronger effects. The administrator of a hospital-licensed health center acknowledged the importance of the supplemental assistance payments that helped him retain staff through salary increases and hopes that an increase in the volume of care that his center will provide will eventually offset the loss of funds if the supplemental payments expire.

[34] Mehrota, A., et al. "Implementing Open-Access Scheduling of Visits in Primary Care Practices: A Cautionary Tale," *Annals of Internal Medicine*, 148(12): 915-22, Aug. 2008.

Greater Administrative Burdens and Costs

In addition to providing care, health centers are also actively engaged in enrollment and patient education. Health reform meant that health centers had to assume many new administrative responsibilities, particularly related to new insurance plans. All of the health centers we visited had staff actively assigned to help enroll people in MassHealth, CommCare or HSN, using the state-run Virtual Gateway internet portal. While the staff generally gave high ratings to the Virtual Gateway for functioning well, they also reported that their workloads had gone up because of these new enrollment activities. Because there was no enrollment process for those who were uninsured before (even if payments were made through the Uncompensated Care Pool), the creation of CommCare and the requirement for HSN enrollment has greatly increased the number of patients who must be enrolled by health center staff. In addition, the workload requirements per patient have often increased. While health centers understood the reasons for these new requirements, there were administrative costs associated with these new responsibilities. Transition costs comprise an often unnoticed administrative cost of reform initiatives.

Enrollment staff expressed hope that the state could find ways to simplify and expedite the application process; it was estimated that it takes three trips to a health center for an applicant to finally gather and present the necessary materials to complete an application. Burdensome paperwork includes documentation requirements (e.g., Medicaid citizenship documentation requirements),[35] and proof that the patient was not offered affordable employer-sponsored insurance. Staff also noted that the process for obtaining hardship exceptions for those who cannot afford employer-sponsored health insurance premiums could be simplified and streamlined.

In addition, after enrollment is complete, those enrolled in CommCare must be educated about the requirement to select a plan and a primary care provider, or fall into the auto-enrollment or auto-assignment traps. Finally, as noted before, many CommCare enrollees must pay premiums, which increases the risk of dropped coverage and the need to reapply, also increasing enrollment workloads. One health center director said that he had to triple the number of staff dedicated to enrollment functions after health reform, even though health centers are not explicitly reimbursed for enrollment help.

Claims administration also has become more complex. With four plans administering MassHealth and CommCare (a substantial increase from previous practice under the state's Medicaid managed care system), multiple types of claims forms must be processed. Health center staff thus underscored the importance of including providers in discussions about how to design new claims systems, since they had to reorganize their patient accounts and billing formats for various payers. Claims are submitted electronically and some health centers were concerned about the possibility of increased burdens due to enhanced requirements for the verification of claims.

[35] See Repasch, L. et al. "Assessing the Effects of Medicaid Documentation Requirements on Health Centers and Their Patients: Results of a "Second Wave" Survey." George Washington University, Oct. 2008.

Positive Impact on Patients' Access to Care

Health centers generally believed that these changes have been positive for patients; medical staff expressed the belief that access to comprehensive, appropriate care had improved with the reforms. Reform helped health centers expand their caseloads so that they could upgrade patient access and, in some cases, expand the scope of services offered. In addition, granting health insurance to patients helped patients get other services. Previously, regardless of insurance status, patients could obtain primary care services at health centers but they might not have been able to obtain other services, like prescription drugs or specialty care. Thus, for example, they could be more assured that a patient with diabetes was able to get prescribed drugs or insulin or access an ophthalmologist to conduct an eye exam for diabetic retinopathy.

The changes in patients' access depended in part on the scope of services already available at each health center. For example, some large health centers had their own pharmacies, which are able to purchase medications at substantial discounts under the Section 340B program, and felt that having insurance did not greatly change patients' ability to get drugs, but many health centers lacked pharmacies and believed that medication access improved. All health centers had historical relationships with local specialists and hospitals to provide specialty or hospital care for uninsured patients. For example, hospital-licensed health centers believed that their uninsured patients were already able to get care at their affiliated safety net hospitals. Other centers found that access to specialists or hospitals improved once the providers knew that their patients had insurance.

There was some initial confusion as health centers became familiar with new managed care networks. Specialists or hospitals with whom the health centers had relationships were not always participating providers in the health plans that patients had selected. This meant that health centers needed to develop new relationships based on plan membership. Transitional problems like these often occur when new managed care plans are initiated.

SUMMARY AND CONCLUSIONS

While this study focuses on Massachusetts, the findings can be generalized to the national debate, since the proposals currently under consideration bear a striking resemblance to the Massachusetts' reforms in their approach to expanding coverage. In this regard, the most important lesson to be learned is the continued importance of safety net providers, especially community health centers, in a post-health reform world. Even if the number of uninsured is greatly reduced, there must still be a health care infrastructure of primary care facilities to provide care for the newly insured, as well as those who remain uninsured. Expanding health insurance is important, but there also must also be a health care delivery system in place that can respond to the increased demand for care. Therefore, health reform must not only involve expansion of coverage but also greater investment in primary care infrastructure to ensure access to care.

The reform efforts in Massachusetts highlight the following issues as informative as national health reform is considered:

- ***Health insurance expansions can lead to a surge in the demand for primary health care, especially in medically underserved low-income communities***. When people gain health insurance coverage, this will naturally stimulate the demand for medical care. In addition, there is often pent-up demand for care by newly insured people who were unable to afford getting health care when they were uninsured.

- ***In addition to the expansion of insurance coverage, investments to expand the capacity of the primary care system that will care for the newly insured, as well as for those who remain uninsured will be important***. This analysis of the early phase of health reform in Massachusetts suggests that direct and explicit investments in transforming and supplementing primary health care capacity represents a key component of national health reform, particularly for populations and communities at risk of medical underservice. Massachusetts' ongoing investment in the health center infrastructure is crucial, supporting the viability of health centers as they undergird the primary care safety net and move beyond this role to serve insured patients. Policy makers will need to remember that the types of vulnerable patients receiving care at health centers may have more complex needs for medical care, as well as for social and supportive services. An explicit investment policy can take the form of direct financing like Massachusetts' uncompensated care pool, or it could involve increasing support of other programs such as the National Health Service Corps, the loan repayment program used to attract and retain health care professionals. Over time, these direct investment mechanisms may change, but sustained investment is critical to the long term goal of rebalancing health care investments as part of health insurance coverage reforms.

- ***Transitional assistance and resources may be needed for health care providers that serve low-income and vulnerable populations***. During the implementation of reform, health centers and other safety net providers need assistance while they help their patients secure coverage and make the operational and management shift away from grant funds and toward the patient-specific revenues that flow from health insurance. These investments allow providers to manage the costs associated with system change while they simultaneously respond to a surge in higher need patients and a shift in revenue sources.

- ***Even post-reform, there is a continuing need for sources of care for the uninsured, due to both the limitations of reform as well as a redistribution of uninsured patients toward the safety net***. This is especially true in the case of primary health care systems for underserved populations; even though health centers served over 16 million patients in 2007, another 56 million low-income residents remain without a regular source of health care.[36]

[36] National Association of Community Health Centers, the Robert Graham Center, and the George Washington University School of Public Health and Health Services. "Access Transformed: Building a Primary Care Workforce for the 21st Century." August 2008.

It is important to remember that health reform is still in its early stages in Massachusetts; the first phases began over two years ago but full implementation is much more recent. The serious budget problems that now confront Massachusetts will provide a much more difficult test of the resiliency of the state's reforms and of its safety net providers. The continued strength of community health centers in Massachusetts will remain critical to the overall success of the reform efforts. National reform efforts will be bolstered if the safety net is directly fostered; policymakers should remember that the goal is to improve the access to quality health care, not just to increase the number of people with insurance policies. Insurance expansions can only succeed if there are enough physicians, nurses and clinics to care for the patients.

APPENDIX:

DETAILED DATA TABLES

Table 2:
Key Patient Indicators for Federally Qualified Health Centers in Massachusetts: 2005 to 2007 (from UDS)

	Calendar Year			% Difference from	
	2005	2006	2007	2005 to 2006	2006 to 2007
Number of Centers	**33**	**33**	**34**	**0.0%**	**3.0%**
Number of Patients	**431,005**	**446,559**	**482,503**	**3.6%**	**8.0%**
Number of Patients by Insurance Coverage*					
Uninsured patients	153,085	145,964	123,388	-4.7%	-15.5%
0-19 years	*23,097*	*19,507*	*17,608*	*-15.5%*	*-9.7%*
20 years or older	*129,988*	*126,457*	*105,780*	*-2.7%*	*-16.4%*
Medicaid/SCHIP patients	162,156	186,238	201,815	14.9%	8.4%
0-19 years	*80,829*	*87,594*	*89,606*	*8.4%*	*2.3%*
20 years or older	*81,327*	*98,644*	*112,209*	*21.3%*	*13.8%*
Medicare	30,850	32,746	38,346	6.1%	17.1%
0-19 years	*22*	*22*	*16*	*0.0%*	*-27.3%*
20 years or older	*30,828*	*32,724*	*38,330*	*6.2%*	*17.1%*
Other Public Insurance	3,388	2,170	26,423	-36.0%	1117.6%
0-19 years	*1,898*	*833*	*2,904*	*-56.1%*	*248.6%*
20 years or older	*1,490*	*1,337*	*23,519*	*-10.3%*	*1659.1%*
Private Insurance	81,526	79,441	92,531	-2.6%	16.5%
0-19 years	*23,337*	*23,545*	*24,267*	*0.9%*	*3.1%*
20 years or older	*58,189*	*55,896*	*68,264*	*-3.9%*	*22.1%*
Total Patients	431,005	446,559	482,503	3.6%	8.0%
0-19 years	*129,183*	*131,501*	*134,401*	*1.8%*	*2.2%*
20 years or older	*301,822*	*315,058*	*348,102*	*4.4%*	*10.5%*

				Percentage Point Difference	
Percent of Total Patients by Insurance Coverage				2005 to 2006	2006 to 2007
Uninsured patients	35.5%	32.7%	25.6%	-2.8%	-7.1%
0-19 years	*5.4%*	*4.4%*	*3.6%*	*-1.0%*	*-0.7%*
20 years or older	*30.2%*	*28.3%*	*21.9%*	*-1.8%*	*-6.4%*
Medicaid/SCHIP patients	37.6%	41.7%	41.8%	4.1%	0.1%
0-19 years	*18.8%*	*19.6%*	*18.6%*	*0.9%*	*-1.0%*
20 years or older	*18.9%*	*22.1%*	*23.3%*	*3.2%*	*1.2%*
Medicare	7.2%	7.3%	7.9%	0.2%	0.6%
0-19 years	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
20 years or older	*7.2%*	*7.3%*	*7.9%*	*0.2%*	*0.6%*
Other Public Insurance	0.8%	0.5%	5.5%	-0.3%	5.0%
0-19 years	*0.4%*	*0.2%*	*0.6%*	*-0.3%*	*0.4%*
20 years or older	*0.3%*	*0.3%*	*4.9%*	*0.0%*	*4.6%*
Private Insurance	18.9%	17.8%	19.2%	-1.1%	1.4%
0-19 years	*5.4%*	*5.3%*	*5.0%*	*-0.1%*	*-0.2%*
20 years or older	*13.5%*	*12.5%*	*14.1%*	*-1.0%*	*1.6%*
Total Patients	100.0%	100.0%	100.0%	0.0%	0.0%
0-19 years	*30.0%*	*29.4%*	*27.9%*	*-0.5%*	*-1.6%*
20 years or older	*70.0%*	*70.6%*	*72.1%*	*0.5%*	*1.6%*

* If a patient changes insurance coverage over the year, the type is the last form of coverage.

Table 3:
Key Revenue Measures for Federally Qualified Health Centers in Massachusetts: 2005 to 2007 (from UDS)

	Calendar Year			% Difference from	
	2005	2006	2007	2005 to 2006	2006 to 2007
Nominal Dollars					
Total Revenue	**$348,314,734**	**$396,382,576**	**$450,750,284**	**13.8%**	**13.7%**
Grants/Contracts	**$119,090,346**	**$136,168,541**	**$139,101,108**	**14.3%**	**2.2%**
Federal	$65,028,246	$67,370,162	$70,249,414	3.6%	4.3%
BPHC	*$40,722,733*	*$41,742,894*	*$43,641,672*	*2.5%*	*4.5%*
Other Federal	*$24,305,513*	*$25,627,268*	*$26,607,742*	*5.4%*	*3.8%*
Non-Federal	*$54,062,100*	$68,798,379	$68,851,694	27.3%	0.1%
State/Local	*$35,088,861*	*$45,379,614*	*$39,744,014*	*29.3%*	*-12.4%*
Private	*$18,973,239*	*$23,418,765*	*$29,107,680*	*23.4%*	*24.3%*
Patient Revenue	**$139,722,420**	**$158,455,210**	**$205,416,457**	**13.4%**	**29.6%**
Insurance	$131,852,144	$149,725,123	$196,540,540	13.6%	31.3%
Medicaid	*$84,933,540*	*$94,124,782*	*$117,059,436*	*10.8%*	*24.4%*
Medicare	*$15,957,505*	*$20,304,265*	*$25,064,114*	*27.2%*	*23.4%*
Other Public Insurance (incl. non-Medicaid SCHIP)	*$4,072,842*	*$3,494,207*	*$10,246,576*	*-14.2%*	*193.2%*
Other & Private	*$26,888,257*	*$31,801,869*	*$44,170,414*	*18.3%*	*38.9%*
Patient Self-Pay	$7,870,276	$8,730,087	$8,875,917	10.9%	1.7%
State/Local Indigent Care Revenue	**$51,321,869**	**$60,138,501**	**$57,884,590**	**17.2%**	**-3.7%**
Other Revenue	**$38,180,099**	**$41,620,324**	**$48,348,129**	**9.0%**	**16.2%**
Total Revenue/Total Patients	**$808**	**$888**	**$934**	**9.8%**	**5.2%**
Grant Contract Revenue/Total Pt	$276	$305	$288	10.4%	-5.5%
Patient Revenue/Total Pt	$324	$355	$426	9.5%	20.0%
Indigent Care Rev/Total Pt	$119	$135	$120	13.1%	-10.9%
Other Rev/Total Pt	$89	$93	$100	5.2%	7.5%
Constant 2007 Dollars*					
Total Revenue	**$371,682,473**	**$409,066,818**	**$450,750,284**	**10.1%**	**10.2%**
Grants/Contracts	**$127,079,879**	**$140,525,934**	**$139,101,108**	**10.6%**	**-1.0%**
Federal	$69,390,861	$69,526,007	$70,249,414	0.2%	1.0%
BPHC	*$43,454,740*	*$43,078,667*	*$43,641,672*	*-0.9%*	*1.3%*
Other Federal	*$25,936,121*	*$26,447,341*	*$26,607,742*	*2.0%*	*0.6%*
Non-Federal	$57,689,018	$70,999,927	$68,851,694	23.1%	-3.0%
State/Local	*$37,442,903*	*$46,831,762*	*$39,744,014*	*25.1%*	*-15.1%*
Private	*$20,246,116*	*$24,168,165*	*$29,107,680*	*19.4%*	*20.4%*
Patient Revenue	**$149,096,118**	**$163,525,777**	**$205,416,457**	**9.7%**	**25.6%**
Insurance	$140,697,841	$154,516,327	$196,540,540	9.8%	27.2%
Medicaid	*$90,631,561*	*$97,136,775*	*$117,059,436*	*7.2%*	*20.5%*
Medicare	*$17,028,062*	*$20,954,001*	*$25,064,114*	*23.1%*	*19.6%*
Other Public Insurance (incl. non-Medicaid SCHIP)	*$4,346,081*	*$3,606,022*	*$10,246,576*	*-17.0%*	*184.2%*
Other & Private	*$28,692,136*	*$32,819,529*	*$44,170,414*	*14.4%*	*34.6%*
Patient Self-Pay	$8,398,277	$9,009,450	$8,875,917	7.3%	-1.5%
State/Local Indigent Care Revenue	**$54,764,951**	**$62,062,933**	**$57,884,590**	**13.3%**	**-6.7%**
Other Revenue	**$40,741,525**	**$42,952,174**	**$48,348,129**	**5.4%**	**12.6%**
Total Revenue/Total Patients	**$862**	**$916**	**$934**	**6.2%**	**2.0%**
Grant Contract Revenue/Total Pt	$295	$315	$288	6.7%	-8.4%
Patient Revenue/Total Pt	$346	$366	$426	5.9%	16.3%
Indigent Care Rev/Total Pt	$127	$139	$120	9.4%	-13.7%
Other Rev/Total Pt	$95	$96	$100	1.8%	4.2%

* Using CMS medical care implicit price deflator 3.2% in 2007, 3.4% in 2006, 3.5% in 2005.

Table 4:
Key Costs and Margins for Federally Qualified Health Centers in Massachusetts: 2005 to 2007 (from UDS)

	Calendar Year			% Difference from	
	2005	2006	2007	2005 to 2006	2006 to 2007
Nominal Dollars					
Total Costs	**$350,073,991**	**$388,546,372**	**$445,870,565**	**11.0%**	**14.8%**
Total Costs/Total Patients	$812	$870	$924	7.1%	6.2%
Net Margin (Revenue - Costs)	**-$1,759,257**	**$7,836,204**	**$4,879,719**		
Net Margin/Total Patients	-$4.08	$17.55	$10.11		
Net Percent Margin	-0.5%	2.0%	1.1%		
Constant 2007 Dollars*					
Total Costs	**$373,559,755**	**$400,979,856**	**$445,870,565**	**7.3%**	**11.2%**
Total Costs/Total Patients	$867	$898	$924	3.6%	2.9%
Net Margin (Revenue - Costs)	**-$1,877,282**	**$8,086,963**	**$4,879,719**		
Net Margin/Total Patients	-$4.36	$18.11	$10.11		
Net Percent Margin	-0.5%	2.0%	1.1%		

* Using CMS medical care implicit price deflator 3.2% in 2007, 3.4% in 2006, 3.5% in 2005.

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