School of Public Health & Health Services
THE GEORGE WASHINGTON UNIVERSITY

Geiger Gibson Program in Community Health Policy

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RCHN Community Health Foundation Research Collaborative

Policy Research Brief # 32

Assessing the Potential Impact of Sequestration on Community Health Centers, Patients, and Medically Underserved Communities

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit operating foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at www.gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Introduction

Unless altered by Congress, the automatic budget sequestration called for under the Budget Control Act of 2011[1] is projected to reduce federal spending by $1.2 trillion over the FY 2013-2021 time period. In 2013 alone, sequestration is expected to reduce domestic discretionary non-defense federal spending by $28.7 billion.[2]

Under the first year of sequestration, the nation's 1,200 community health centers (which in 2011 furnished comprehensive primary health care in more than 8,500 locations to over 20 million residents of medically underserved urban and rural communities)[3] are expected to experience a $120 million loss in grant funding. These losses come from two sources. First, the basic discretionary funding provided annually to operate health centers is not protected from sequestration; as a result, health center grant funding will fall by 5.1% for FY 2013. Second, sequestration will result in cuts to the Health Center Fund, which was established under the Affordable Care Act in order to invest in expanded access to primary health care. Although the White House Office of Management and Budget (OMB) has determined that the Growth Fund is partially protected from the full force of sequestration (with losses held to 2%), OMB also has concluded that this special sequestration protection does not extend to Fund expenditures for homeless populations and residents of public housing. As a result, funding to support these special populations is expected to fall by 5.3%.

Because the $120 million loss will be concentrated in the second half of FY 2013 rather than absorbed throughout the year, especially steep programmatic reductions may be required to absorb the loss. Furthermore, we anticipate that these losses will be particularly severe in the case of health centers that are especially grant dependent, either because they serve heavily uninsured populations (such as farmworkers or people who are homeless), or because they operate in states with limited Medicaid coverage of low income adults, or both.

Translating Dollars into Care, Patients, and Communities

Because of the uncertainty surrounding how the $120 million loss will be absorbed, it is not possible to know with precision how patients and communities will be affected by sequestration. But the extensive data on the federal health center program certainly allows a fairly solid initial assessment of the overall impact of these lost funds.

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[1] Pub. L. 112-125

[2] Congressional Budget Office. See Dylan Mathews, The Sequester: Absolutely Everything You Could Possibly Need to Know in one FAQ. http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/20/the-sequester-absolutely-everything-you-could-possibly-need-to-know-in-one-faq/ (Accessed online, February 23, 2013)

[3] For a comprehensive description of community health centers see the Kaiser Family Foundation, *Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities,* March 2012.

Impact on Health Centers

Using annually reported data to gain a general picture of health center services, staffing, and expenditures on patient care, we estimate that the spending reductions will:

- Affect all 1,200 federal grantees. Cuts will affect operations to some degree (hours and accessibility of services) in more than 8,500 separate service locations.

- Result in approximately 3 million fewer patient visits than expected during 2013.[4]

- Result in a shortfall of approximately $230 million in third party revenues due to sequestration.[5] When health centers invest grant funds in clinical personnel, they realize not only additional patients served but also additional revenues received. This is because health center clinical personnel generate Medicare, Medicaid, and private health insurance revenues when they treat the 64% of health center patients who have some form of health insurance. As a result, translating sequestration into lost care capacity means considering not only the per capita cost of personnel, but also the lost revenue generation that flows from reduced clinical care capacity.

- Affect support for clinical personnel. Depending on the type of personnel considered (salaries and support costs vary, of course), a loss of $120 million represents 450 physicians, 300 dentists, 900 nurses and physician assistants, or 90 mental health providers.[6]

Table 1 shows approximately 41% of all health centers (457 health center grantees) can be considered "grant dependent;" that is, they operate with a higher ratio of grant dollars to Medicaid dollars. Health centers that receive special grants for serving migrant farmworker families, homeless, and public housing residents are much more likely to be dependent on grants than Medicaid.

Table 1. Number and Percentage of Health Centers With Greater Dependence on Grant Funding Than on Medicaid

	Number of health centers
All health centers	457/1,128 (41%)
Public housing grantees	22/58 (38%)
Homeless grantees	104/219 (47%)
Migrant grantees	58/159 (36%)

[4] Estimate based on average of 3.3 visits per health center patient annually; excludes visits for dental, vision, behavioral health, and enabling services.
[5] Medicaid patients account for approximately 39 percent of health center patients.
[6] Based on provider ratios in federally-designated underservice areas. http://bhpr.hrsa.gov/shortage/

Furthermore, because the sequestration reductions will take place in the second half of FY 2013, the impact will be concentrated into a few months, rather than being spread throughout the fiscal year, causing these health centers to have to deeply contract in a short period of time in order to absorb the financial loss.

Impact on Patients

Per capita spending estimates for health center patient care indicate that the reduction in funding will translate into approximately 900,000 fewer patients served during 2013, and 3 million visits. Two data sources provide general information on the characteristics of the children and adults who can be expected to lose access to care if other sources of revenue do not offset this spending reduction. These data sources consist of annual reports on health center patients, staffing, services, and expenditures,[7] as well as information obtained through a special nationwide study of health center patients that is periodically carried out by the federal government and that was last conducted in 2009.

Together, these data indicate that as a general matter, community residents losing access to care will have the following characteristics:

- 72% (648,000)[8] will live in families with incomes below 100% of the federal poverty level. Virtually all will have family incomes below twice the federal poverty level.
- 32% (288,000) will be children under 18 years of age and 13% (117,000) will be children under age 6.
- 28% (252,000) will be women of childbearing age (15-44).
- 7% (63,000) will be persons ages 65 and older.
- 57% (513,000) will be members of racial/ethnic minority populations.[9]
- 26% (234,000) will be residents of the Southeastern and South Central states (Regions IV and VI), where poverty is the deepest and Medicaid coverage of adults is, generally speaking, at its most limited.
- 63% (567,000) will live in urban communities, while 37% (333,000) will reside in rural areas of the country.
- 52% (468,000) will have 2 or more chronic health conditions requiring ongoing medical management.[10]

Impact on Communities

As noted, we assume that all communities will experience a loss of health center funding. Our prior research has found that each dollar invested in health centers

[7] These data are found in the Uniform Data System (UDS) which is administered by the HRSA.
[8] Percentage based on 15.6 million patients who reported income in the 2011 UDS.
[9] Percentage based on 16.6 million patients who reported race/ethnicity in 2011 UDS.
[10] Estimate based on survey percentages from the 2009 BPHC Health Center Patient Survey. Chronic conditions include diabetes, asthma, coronary heart disease, emphysema, hypertension, a liver condition, depression and anxiety.

generates, on average, $5 dollars in economic activity.[11] As a consequence, a loss of $120 million in health center funding will impact their communities by $600 million overall in direct and indirect economic benefits.

At the same time, health center spending cuts can be expected to affect individual communities differently because of unique community characteristics as well as the specific characteristics of state Medicaid programs under which health centers operate (See Appendix); in 2011, Medicaid accounted for approximately 38% of health center total operating revenues of $13.9 billion.

- Certain communities have higher than average population of homeless persons and public housing residents. These communities can be expected to experience relatively deeper losses because the partial protections offered under the OMB ruling do not extend to these components of the health centers program.

- Certain communities are located in states with less generous Medicaid coverage of adults. As a result, health centers located in these communities have a lower capacity to generate Medicaid revenues to support their operations, and can be expected to experience a relatively higher impact from sequestration reductions, since they are less able to obtain operational support from Medicaid. Thirteen states[12] maintain adult Medicaid coverage levels that in turn are low enough to create high grant dependency among health centers.

[11] George Washington University: *Community Health Centers and the Economy: Assessing Centers' Role in Immediate Job Creation Efforts*. Sep. 14, 2011. (Geiger Gibson/RCHN Community Health Foundation Research Collaborative Brief #25); *The Economic Stimulus: Gauging the Early Effects of ARRA Funding on Health Centers and Medically Underserved Populations and Communities.* Feb. 16, 2010, (#17) and *How Does Investment in Community Health Centers Affect the Economy?* Feb. 25, 2008. (#1).

[12] Alabama, Georgia, Kansas, Louisiana, Mississippi, Montana, Nebraska, New Hampshire, North Carolina, South Dakota, Texas, Virginia, and West Virginia. See Kaiser Family Foundation, *Medicaid and Community Health Centers: The Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities*. March 2012.

Spotlight on Healthcare for the Homeless
Spotlight on Healthcare for the Homeless Health Center

The 5050 patients served by the Healthcare for the Homeless health center in Houston, Texas in 2012 are overwhelmingly impoverished and uninsured; all have incomes below the federal poverty level and 95% are uninsured. Almost one-third (1,615 patients) have mental illness, including a diagnosis of post-traumatic stress disorder; patients experience conditions ranging from hypertension (1,106 patients) to substance related disorders (928 patients) and alcohol related disorders (707 patients).

Its status as a health program serving homeless patients means that Healthcare for the Homeless is highly (13.63 times more) dependent on grants than an average community health center. Medicaid accounts for only 2% of total revenue, while its federal grant makes up 23% of total revenue. CEO Frances Isbell notes that her center is likely to be more vulnerable to cuts given the depth of the sequestration cut (5.3% rather than the 2% generally applicable to health centers), the virtual absence of third party coverage, and the total impoverishment of her patients, which forecloses any patient cost sharing. Other sources of grant funding, such as awards through the United States Department of Housing and Urban Development (HUD) also will be cut.

As Ms. Isbell approaches the task of cutting her services, she plans to prioritize primary health care while focusing on reducing social services such as assistance in locating housing. She assumes that this will increase the numbers of homeless patients who live on the streets, with an attendant increase in the number who show up in hospital emergency rooms and county jails, both extremely costly to the community.

Conclusion

Sequestration will significantly impact health center performance just as the national emphasis moves toward strengthening primary care. The Health Center Fund established by the Affordable Care Act, coupled with basic health center appropriations and expanded Medicaid coverage, has positioned health centers to roughly double their capacity by 2019. Clearly, sequestration will lead to a significant impairment of this effort to expand primary health care in medically underserved communities. To the extent that Growth Funds are diverted into payments to health centers to offset the losses generated by sequestration, this offsetting activity will further slow health center growth, which already has been adversely affected by the initial round of budget reductions enacted under the 2011 budget agreement. Sequestration can be expected to further diminish this effort.

Sequestration can be expected to affect all communities served by health centers. But community characteristics related to the population, the depth of poverty and

uninsurance, and the extent of adult Medicaid coverage, can be expected, in combination, to create worse-than-average conditions for health center operations in some locations. To the degree that Congress restores sequestered funds, these adverse results eventually can be mitigated. But in the interim, the expected impact of the reductions is considerable.

Appendix

Table A describes the profile of health centers by their level of dependence on grant dollars relative to their Medicaid revenue. Key findings include:

- Health centers with high dependence are much more susceptible to changes in federal grants. Approximately 44 percent of their total revenue is derived from BPHC grants.
- More than a third of health centers are already operating at or below the margin. General reductions in revenue are likely to pressure these financially vulnerable health centers the most to cut services or staffing as well as close or reduce hours of operation at some sites.
- A smaller proportion of health centers with medium and high dependence are likely to be located in states with more generous Medicaid eligibility standards for adults. This further underscores the importance of grant funding for these health centers.
- A significant number of health centers at risk include homeless, public housing, and migrant health centers.

Table A. Health Centers Dependence on Federal Grants Relative to Medicaid

	Low dependence on BPHC grants (<100%)	**Medium dependence on BPHC grants (100 %-< 200%)**	**High dependence on BPHC grants (200%+)**
Distribution (#)	671	197	260
Distribution (%)	59.5%	17.5%	23.0%
Average % of total revenue that is federal BPHC grants at current funds	15.7%	30.3%	44.4%
Operating at or below the margin	36.8%	39.6%	38.6%
Located in a Medicaid generous state (n=486)[13]	69.8%	16.5%	14.2%
Grantee Type			
Is a migrant health center grantee	15.1%	12.7%	12.7%
Is a community health center grantee	97.0%	96.4%	77.3%
Is a healthcare for the homeless grantee	17.1%	20.3%	24.6%
Is a Public Housing Primary Care grantee	5.4%	6.6%	3.5%

[13] Percentages based on 25 states: 12 states identified as having expansive eligibility thresholds for adults and 13 states with limited eligibility for adults over the past decade. For more details on classification of generous (AZ, CT, DE, HI, IL, ME, MN, NJ, NY, RI, VT, WI) and limited (AL, GA, KS, LA, MS, MT, NE, NH, NC, SD, TX, VA, WV) states, see Kaiser Family Foundation, *Medicaid and Community Health Centers: The Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities*. March 2012.

Table B suggests uninsured patients are most likely to be impacted by the sequestrations. Health centers highly dependent on grant dollars and most vulnerable to the cuts serve a larger proportion of patients who are uninsured. Approximately 55 percent of patients in health centers with high dependence on grant funding are uninsured compared with only 32 percent of patients in health centers with relatively low dependence.

Table B also suggests that given the lack of insured patients and limited revenue sources, health centers highly dependent on grant funds have smaller physician capacity. As a result, health centers with high dependence on grant funds tend to rely more heavily on mid-level providers and enabling service staff to support care coordination and delivery.

Table B. Patient Mix and Staffing Capacity of Health Centers by Level of Dependence on Federal Grants

	Low dependence on BPHC grants (<100%)	**Medium dependence on BPHC grants (100 %- < 200%)**	**High dependence on BPHC grants (200%+)**
Health Center Patient Characteristics			
Percentage of Medicaid patients	42.2%	28.1%	18.5%
Percentage of uninsured patients	32.1%	41.7%	55.0%
Health Center Staffing			
Doctor FTEs per 10,000 patients	5.0	4.5	4.0
Mid-level provider FTEs per 10,000 patients	3.7	4.3	5.9
Dental FTEs per 10,000 patients	5.9	5.4	5.0
Behavioral health FTEs per 10,000 patients	4.4	2.2	3.7
Enabling services provider FTEs per 10,000 patients	6.8	5.5	9.1