

**Geiger Gibson /
RCHN Community Health Foundation Research Collaborative**

Policy Research Brief # 37

**How Medicaid Expansions and Future Community Health Center Funding
Will Shape Capacity to Meet the Nation's Primary Care Needs:
A 2014 Update**

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June 19, 2014

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 Milken Institute School of Public Health 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, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of 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 <http://sphhs.gwu.edu/projects/geiger-gibson-program> or at rchnfoundation.org.

Executive Summary

Early data indicate that implementation of the Affordable Care Act (ACA) has bolstered health insurance coverage for millions of Americans through enrollment in health insurance marketplaces (exchanges) and Medicaid expansions.¹ An important challenge is to ensure that the capacity of the health care system is sufficient to care for both the newly insured, as well as those who remain uninsured. The Health Resources and Services Administration estimates that 60 million Americans already live in areas with too few primary care providers.² Primary care shortages are expected to deepen in coming years, due to overall population growth, aging of the Baby Boomers and the health insurance expansions.³ Community health centers represent a key safety valve to help guarantee access to care, particularly for those with lower incomes.

This brief estimates the effect of federal and state policy decisions on the capacity of community health centers to meet future health care needs, particularly: (1) the level of federal grant funding for community health centers and (2) whether states expand Medicaid coverage. The ACA provided \$11 billion in “mandatory” funding which augments discretionary appropriations for Section 330 of the Public Health Service Act (the health center program), but this mandatory funding authority is set to expire after September 30, 2015, creating a potential funding cliff. When the ACA was enacted, it was expected that all states would implement a Medicaid expansion, but a Supreme Court decision gave states the option to expand Medicaid. Both these factors affect future health center revenue and patient capacity. This update of our November 2013 report⁴ uses more recent data and estimates the number of patients who could be served in health centers in 2014 and 2020, depending on the outcome of key federal and state policy decisions: whether to support health center funding (either through a continuation of mandatory funding or an increase in discretionary appropriation levels) and state implementation of Medicaid expansion.

We estimate the effect of current FY 2014 funding and state Medicaid expansion decisions on changes in patient caseloads from 2012 to 2014. We then illustrate the projected impact of federal and state policy decisions on 2020 patient caseload, considering multiple scenarios: (1) high vs. low federal health center funding after 2015 and (2) about half the states expanding Medicaid (as currently) vs. all states expanding Medicaid. The “high funding” scenario assumes that total federal appropriations remain sufficient to allow for continued support for health center growth through a continuation of mandatory funding and/or higher appropriations levels. The “low funding” scenario assumes that total federal funding is held at the level of discretionary appropriations in 2014 alone, and does not rise after the loss of mandatory funding. The final policy decisions may be different, but these illustrate the range of

¹ Long S, et al. Early Estimates Indicate Rapid Increase in Health Insurance Coverage under the ACA: A Promising Start. Washington, DC: Urban Institute. April 15, 2014.

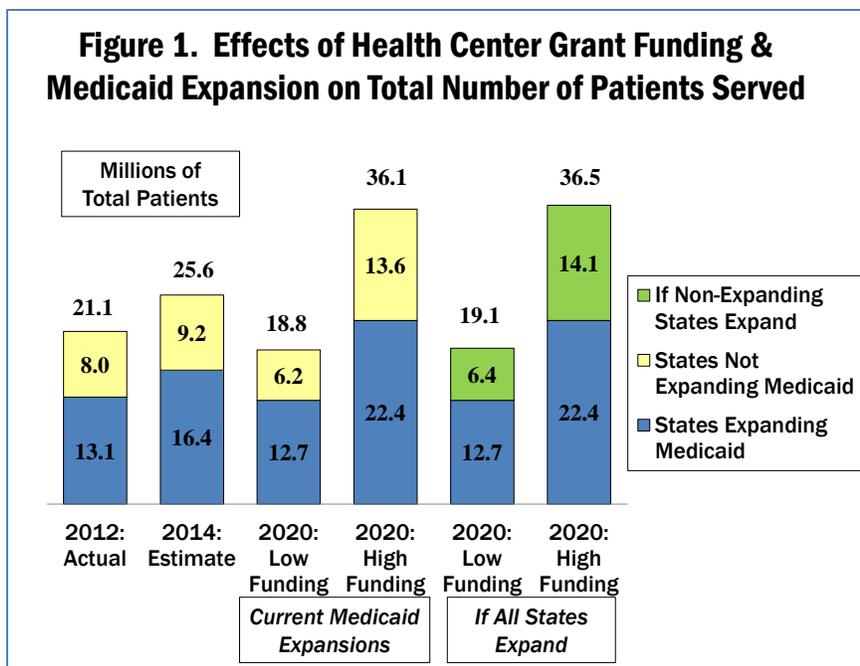
² Health Resources and Services Administration. Designated Health Professional Shortage Areas Statistics, as of May 14, 2014. http://datawarehouse.hrsa.gov/HGDWReports/RT_App.aspx?rpt=HH

³ Petterson S., et al. Projecting US Primary Care Physician Workforce Needs: 2010-2025. *Annals of Family Medicine*. 2012 Nov-Dec; 10(6): 503-509

⁴ Ku L, Zur J, Jones E, Shin P, Rosenbaum S. “How Medicaid Expansions and Future Community Health Center Funding Will Shape Capacity to Meet the Nation’s Primary Care Needs” Geiger Gibson / RCHN Community Health Foundation Research Collaborative Policy Research Brief # 34, Nov. 18. 2013.

choices and consequences. We also compare the current scenario in which about half the states expand Medicaid vs. one in which all states expand by 2020.

As seen in Figure 1, current funding levels, combined with Medicaid expansion decisions, are projected to increase the number of health center patients by more than one-fifth, from 21.1 million in 2012 (the most recent year reported) to 25.6 million in 2014.



Under the low funding scenario, if Medicaid expansion plans do not change, national health center capacity would decline by over one-quarter from 25.6 million patients in 2014 to 18.8 million in 2020. This reduction of 6.7 million patients is roughly equivalent to the population of the state of Arizona or of the combined populations of Los Angeles, California and Houston, Texas. The reductions would occur across the board, regardless of each state’s decision to expand Medicaid. In contrast, under the high funding scenario with current Medicaid expansion patterns, total health center capacity would rise to 36.1 million patients in 2020, an increase of 10.5 million patients (41%). In either scenario, health centers would continue to serve a disproportionate share of the residents who remain uninsured; health centers serve all patients, regardless of their ability to pay. This pattern is clear from the experience of health centers in Massachusetts, which served an increasing proportion of the state’s uninsured population after health reform was enacted.⁵

Medicaid Expansions. As of June 2014, 26 states and the District of Columbia have chosen to expand Medicaid eligibility for non-elderly adults to 133% of the federal poverty line beginning in 2014. The remaining 24 states are not currently planning to expand Medicaid, although some states are still considering the issue or have submitted Section 1115 demonstration waiver requests as a condition of expanding.⁶ As seen in the high funding scenario in Figure 1, if all of the non-expansion states were to implement a Medicaid expansion, health centers in these states would serve an estimated 14.1 million patients in 2020, compared to 13.6 million without Medicaid expansions under the high funding scenario. The number of Medicaid patients served in these opt-out states would rise by 1.5 million, from 5.1 million to 6.6

⁵ Ku L, Jones E, Shin P, Burke FR, Long, S. “Safety-Net Providers after Health Reform: Lessons from Massachusetts.” *Archives of Internal Medicine*, 171(15): 1379-84, Aug. 8, 2011.

⁶ See the Methodology section for more detail about how state Medicaid expansion decisions were classified for this report.

million if all states expanded Medicaid. For these 1.5 million additional patients, Medicaid coverage will increase access to the full range of care, from primary care to specialty to inpatient care; those who are uninsured often face barriers to specialty and other services even if they care primary care from a health center. Under the low funding scenario, further Medicaid expansion would permit more patients to be served, but there would still be an overall caseload reduction as a result of reduced direct federal funding, which would lower the number of uninsured patients who would be reached.

Conclusions. Both the level of future Section 330 federal grant funding and each state's decision regarding Medicaid expansion have strong effects on future health center growth. A shortfall in federal grants after the 2015 funding cliff would leave health centers unable to sustain current caseloads, sharply damaging primary care access for the insured and uninsured alike and potentially leading to more costly increases in specialty, emergency and inpatient care. State Medicaid expansions also help increase the capacity of health centers. Continued growth of community health centers is a critical element of policies to support the primary care infrastructure of the nation. Growth would permit not only an expansion of current health centers, but support access in medically underserved rural and urban areas that currently do not have any.

Background

Community health centers are a critical element of the nation's health care delivery system. In 2012 about 1,200 grantees operating in about 9,000 locations provided comprehensive primary health care to 21 million patients in medically underserved communities without regard to patients' ability to pay.⁷ Health centers provide a broad range of primary health care as well as dental and mental health services, plus an array of other social and enabling services to meet the complex needs of patients in vulnerable communities. Health centers provide high quality care and can be effective in controlling chronic diseases and medical expenditures for disadvantaged patients.^{8,9} Most health experts believe that expanding access to affordable primary and preventive health care is particularly vital. After Massachusetts expanded health coverage several years ago, community health centers and safety net hospitals became even more important as sources of ambulatory care.¹⁰

As of 2012, two-fifths of health center patients (40%) were covered by Medicaid and 36% were uninsured/self-pay patients. As shown in Figure 2, health centers have very diverse funding sources: about three-fifths of total revenue was generated from patient-related revenue,

⁷ This paper focuses on health center grantees funded by the Bureau of Primary Health Care under Section 330 of the Public Health Services Act. Care delivery sites operated by these grantee organizations are certified by CMS as federally qualified health centers (FQHCs). Similar non-profit health providers that do not receive these grants exist (FQHC lookalikes) are not included. Most of the data in this report come from the Uniform Data System (UDS) reports files annually by health centers.

⁸ Richard P, Ku L, Dor A, Tan E, Shin P, Rosenbaum S. Cost Savings Associated with the Use of Community Health Centers. *Journal of Ambulatory Care Management*, 2012 Jan-Mar. 35(1):50-59.

⁹ Goldman, LE, Chu P, Tran H, Romano M, Stafford R. Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures. *American Journal of Preventive Medicine* 2012;43(2):142-149.

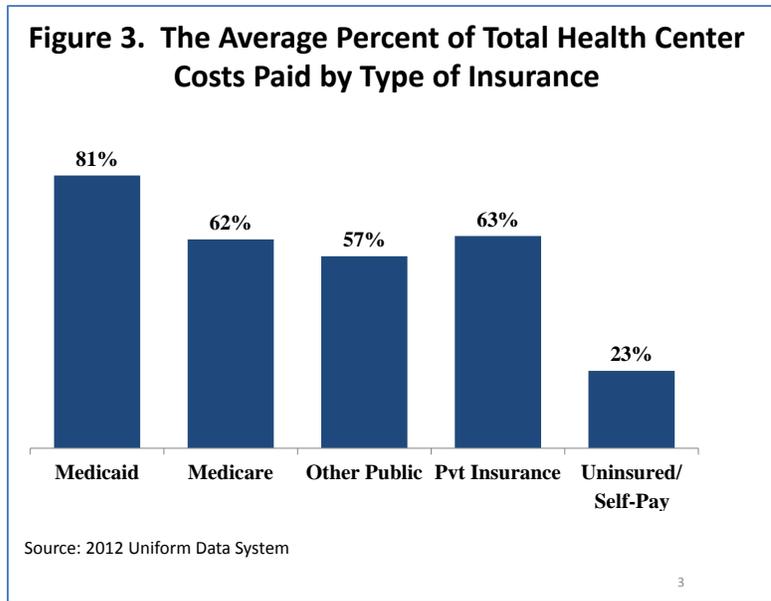
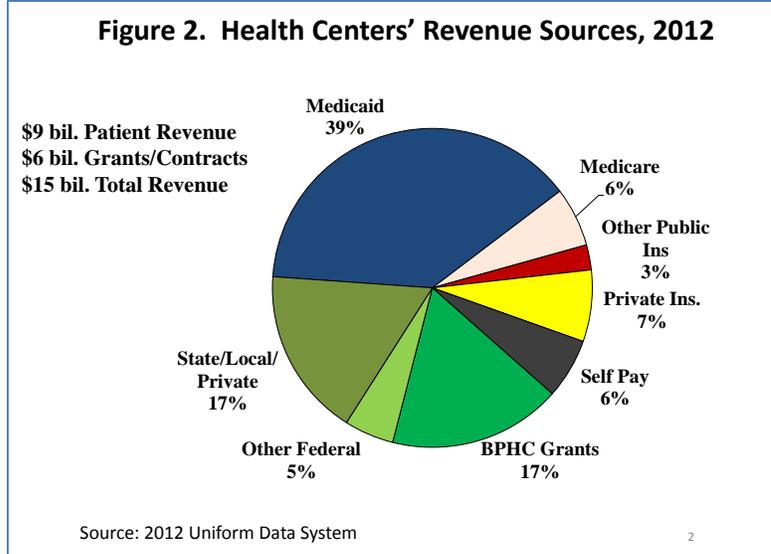
¹⁰ Ku, Jones, et al. *op cit*.

mostly insurance reimbursements from Medicaid, the largest source of revenue. Health centers also receive self-payments from uninsured patients, based on income-related sliding fees.

The remaining two-fifths comes from federal, state, local and private grants and contracts, of which the largest share comes from the Bureau of Primary Health Care (BPHC), in the form of Section 330 (of the Public Health Service Act) grants. These grants comprise the “core”

funding for community health centers, helping to provide access to uninsured patients, as well as supporting infrastructure and administrative costs and other critical services, such as enabling services, for vulnerable patients. Other sources of grant funding include the federal Ryan White program for HIV care and prevention, Title X family planning, the Women, Infants and Children (WIC) nutrition program, state and local grants, and funding under the American Recovery and Reinvestment Act (ARRA) for capital improvements and the adoption and meaningful use of electronic health records.

Grant funding also supports the costs of care for insured patients. Insurance payments typically fail to cover the full costs of care for patients.¹¹ As seen in Figure 3, average payments received from Medicaid, Medicare, CHIP, and private insurers were well below the estimated total costs of care. Since health centers are non-profit organizations, revenue and costs must roughly balance. Thus, a dollar gap in insurance payments must be filled by a dollar drawn from grant/contract funds received by the health center.



¹¹ Reasons for the gaps include low insurance payment rates, insurance cost-sharing requirements that health center patients cannot afford, so costs are borne by the health center, and services provided to patients that are not covered by the insurers but are considered appropriate by the health centers and within their scope of services (e.g., dental care, support or enabling services, case management, interpretation, etc.).

In 2012, Medicaid paid an average of 81% of the total costs of the care provided to health center patients, leaving a 19% gap that must be covered by other sources, particularly grants. The gaps for Medicare, other public programs and private insurance were even greater, ranging between 37% and 43%.¹² (The Medicare gap should be reduced in the future; a recent federal regulation raises Medicare payments to health centers by about one-third.¹³) The largest gap (77%) is for uninsured self-pay patients. The sliding scale fees paid by the patients themselves are generally far below the costs of the care provided.

States now have the option of expanding Medicaid under the ACA. This analysis counts the District of Columbia and the following 26 states as expanding Medicaid: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia. The remaining 24 states and the U.S. territories (which also have health centers) are counted as not expanding. The situation is evolving and there may be changes in expansion decisions in the future, including states that have submitted or are considering Section 1115 waivers for expansions.

Even before Medicaid expansions, health centers in the expansion states had higher caseloads of Medicaid patients (43.1% of total patients) than centers in non-expansion states, where 34.1% of health center patients were covered by Medicaid, on average, as seen in Table 1. States that are not expanding Medicaid typically had more restrictive Medicaid eligibility criteria even before 2014. As a result, centers in non-expansion states had a larger fraction of uninsured/self-pay patients (41.1% of total patients) than health centers in states expanding Medicaid, where an average of 32.8% of patients were uninsured. States' Medicaid expansion decisions could increase the disparities in insurance coverage across states.

Because the non-expansion states historically had fewer Medicaid patients and more uninsured patients, the gap between total patient-related revenue and actual costs is much higher in states that are not expanding Medicaid (44.5%) than in the Medicaid expansion states

Table 1. Insurance Coverage of Health Center Patients and Gaps in Patient-Related Payments and Costs by State Medicaid Expansion Status, 2012

Medicaid Expansion (26 States + DC)			
	Health Center Patients		% Gap in Patient-Related Payments and Costs
	Number	Percent	
Medicaid	5,627,023	43.1%	-18.1%
Medicare*	989,835	7.6%	-37.8%
Other Public	359,542	2.8%	-33.4%
Private Insurance	1,800,948	13.8%	-43.8%
Self-pay/Uninsured	4,292,679	32.8%	-77.9%
TOTAL	13,070,027	100.0%	-37.6%
No Current Medicaid Expansion (24 States)			
	Health Center Patients		% Gap in Patient-Related Payments and Costs
	Number	Percent	
Medicaid	2,737,242	34.1%	-20.2%
Medicare*	705,609	8.8%	-37.0%
Other Public	135,375	1.7%	-52.0%
Private Insurance	1,150,472	14.3%	-41.0%
Self-pay/Uninsured	3,303,666	41.1%	-76.3%
TOTAL	8,032,364	100.0%	-44.5%

Note: Medicare payments to FQHCs are expected to rise 30% under a proposed rule.
Source: Analysis of 2012 Uniform Data System reports

¹² Gaps between payments and costs vary for many reasons, including variation in states' Medicaid payment rates and rules and in the cost structures of different health centers. However, the total gaps in payment to cost levels is strongly affected by the higher level of uninsured/self-pay patients in non-expansion states.

¹³ Centers for Medicare and Medicaid Services. Medicare Program; Prospective Payment System for Federally Qualified Health Centers. Federal Register 79(85): 25435, May 2, 2014.

(37.6%), even before the expansions were implemented. Health centers in the non-expansion states are even more reliant on grant funds, since they receive less revenue from insurers. Despite these funding gaps, health centers serve millions of patients because they also earn revenue from grants and contracts.

Policy Options and Methods

This paper estimates the impact of two key federal and state decision points on health center capacity and future patient caseloads:

- The level of future federal funding through a continuation of mandatory funding through the health center expansion fund established under the ACA and/or discretionary appropriations for Section 330; and
- State Medicaid expansion decisions.

Methodology. Based on detailed 2012 data from the Uniform Data System, the administrative reports filed annually by community health centers with BPHC, we tabulated patient and financial data as the basis for future year projections. We use our model to estimate 2014 caseload levels based on known FY 2014 health center funding levels (\$3.545 billion, including \$2.2 billion in mandatory funds). Future federal Section 330 grant funding levels are not yet established, so we developed two scenarios for future grant funding for health centers by estimating projected “low” and “high” funding levels for health center grants in 2020. While the total amount of grant funds is smaller than patient-related revenue, the level of grant funding helps define how many patients can be served. Since nonprofit health centers serve patients without regard to their ability to pay, by law and according to their core principles, direct funding levels help determine the total number of both uninsured and insured patients who can be served. Higher funding through grants and special investments such as the ACA expansion fund enable health centers to expand capacity to serve Medicaid, Medicare, privately insured and uninsured patients. If there is not sufficient funding, health centers must reduce their total patient capacity.

A key input in our model is the level of federal Section 330 funds that will be available for health center operations. The model assumes that the percentages of total costs covered by Medicaid, Medicare, private insurance and the uninsured/self-pay patients are equal to the levels observed in 2012 (which are comparable to those in prior years). We reduce the Medicare gap in light of the recently announced change in Medicare payment rates. As of 2012, there were no data about health center payments by Qualified Health Plans under the health insurance marketplace. Under the ACA, health centers are supposed to be paid at least the Medicaid payment rate, unless health centers and the insurer mutually agree upon a lower payment rate.¹⁴ Preliminary anecdotal information suggests that health centers are often not being paid the Medicaid rate by Qualified Health Plans under the marketplaces and are being told that a lower rate is being applied. In this report we conservatively assume the payment gap and average costs for marketplace plans are midway between the Medicaid and private insurance levels.

¹⁴ National Association of Community Health Centers. Final Medicaid and Exchange Regulations: Implications for Federally Qualified Health Centers. April 2012.

Table 2. Funding Scenarios by State Medicaid Expansion Status, 2014 and 2020

(millions of \$)	2014 Based on Actual Funding			2020 with High Funding			2020 with Low Funding		
	Total	Medicaid	No Medicaid	Total	Medicaid	No Medicaid	Total	Medicaid	No Medicaid
		Expansion	Expansion		Expansion	Expansion		Expansion	
Bureau of Primary Health Care	\$3,545	\$1,997	\$1,548	\$6,996	\$3,940	\$3,056	\$1,400	\$788	\$612
Other Federal Grants	\$630	\$427	\$203	\$844	\$572	\$272	\$844	\$572	\$272
State, Local, Private Grants	\$2,269	\$1,573	\$696	\$3,041	\$2,108	\$933	\$3,041	\$2,108	\$933
Non-Patient Funding	\$619	\$470	\$149	\$829	\$630	\$199	\$829	\$630	\$199
Total Grants, Contracts, Etc.	\$7,062	\$4,466	\$2,597	\$11,710	\$7,249	\$4,460	\$6,114	\$4,098	\$2,016

Our budget/caseload model uses the FY 2014 funding level for health centers of \$3.545 billion, which includes \$2.145 billion in mandatory ACA funding and regular discretionary appropriated funding of \$1.4 billion.¹⁵ Our low funding scenario assumes that the \$1.4 billion level is sustained through 2020, with no replacement of lost mandatory funding. This level is equivalent to the appropriated funds for CHCs from 2011 to 2014. Our high funding scenario assumes that Section 330 funding gradually rises to \$7.0 billion in 2020. This assumes about 12% annual growth from 2014 to 2020, slightly less than the 12.8% growth that existed from 2010 to 2014. In other words, the high funding scenario assumes that federal funding is sufficient to sustain an increase roughly comparable to the recent historical trend. In both scenarios, we assume that all other federal, state, local, and private grant and contract funds rise by 5% annually, which is consistent with historical trends. We assume that actual costs per patient rise 4% annually, also based on historical trends. The revenue levels used in our model are shown in Table 2.

Results

Estimated Insurance Coverage Patterns in 2014 and 2020

Based on estimates of insurance coverage anticipated under the ACA for the general population,¹⁶ patterns experienced in Massachusetts health centers¹⁷ and early information about marketplace and Medicaid enrollments,¹⁸ we estimated insurance coverage patterns in health

¹⁵ This does not include funding for health center tort claims or the National Health Service Corps.

¹⁶ Congressional Budget Office. Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014.

¹⁷ Ku, Jones, et al. *op cit.*

¹⁸ Long S, et al. *op cit.*; HHS Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Marketplace: Summary Enrollment Report For The Initial Annual Open Enrollment Period, May 1, 2014; Centers for Medicare and Medicaid Services, Medicaid & CHIP: March 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report, May 1, 2014.

centers in 2014 and 2020, as shown in Table 3. We assume that insurance coverage rates rise over the years as ACA expansions are more fully implemented.

In all states, there is some increase in health center caseloads for Medicaid enrollees and for marketplace enrollees in both 2014 and larger increases by 2020. The increase in Medicaid enrollment is larger in expansion states, but there is a slight increase in Medicaid participation even in non-expansion states due to outreach and coordination of enrollment with health insurance marketplaces and the individual responsibility mandate. We assumed moderate levels of enrollees from Qualified Health Plans purchased through marketplaces in 2014, but assume this would grow by 2020. Higher Medicaid and marketplace enrollment leads to higher insurance revenue and a reduction in the share of the caseload that is uninsured.

Table 3. Estimated CHC Patient Distribution by Health Insurance Type & State Medicaid Expansion Status: 2014 & 2020

	2014 Estimated		
	Total	Medicaid Expansion	No Medicaid Expansion
Medicaid	43.9%	48.1%	36.1%
Medicare	8.0%	7.6%	8.8%
Other Public	2.4%	2.8%	1.7%
Private	12.0%	11.6%	12.8%
Health Ins Marketplaces	5.0%	5.0%	5.0%
Self-Pay/Uninsured	28.7%	25.0%	35.6%
Total	100.0%	100.0%	100.0%
	2020 Estimated		
	Total	Medicaid Expansion	No Medicaid Expansion
Medicaid	44.9%	49.2%	37.1%
Medicare	8.5%	8.1%	9.3%
Other Public	2.3%	2.7%	1.6%
Private	10.0%	9.6%	10.8%
Health Ins Marketplaces	10.8%	10.2%	12.0%
Self-Pay/Uninsured	23.4%	20.2%	29.2%
Total	100.0%	100.0%	100.0%

Preliminary information about the extent to which Qualified Health Plans are contracting with health centers and the terms of their contracts is still mixed and many health centers appear confused about whether they have contracts or under what terms. This phenomenon is not restricted just to health centers; a recent survey of California physicians also found considerable confusion about whether they are or are not in the networks of marketplace policies. It appears that providers sometimes were automatically enrolled in plans without explicit notification when insurers exercised “all products” clauses in existing contracts.¹⁹ Thus, providers might be included or excluded from marketplace networks without clear notifications or negotiations.

Estimated Health Center Patient Caseloads in 2014

Table 4 compares actual 2012 and estimated 2014 caseloads, based on 2014 funding levels. The combination of higher Medicaid and marketplace enrollment and \$2.2 billion in ACA mandatory funding leads to a substantial increase in health center capacity, rising from 21.1 million patients in 2012 to an estimated 25.6 million in 2014, about 21% higher. The growth is substantially higher in states with Medicaid expansions, but even non-expansion states experience growth. This will expand primary care access for those who are newly insured, although health centers will continue to serve a large share of those who remain uninsured.

¹⁹ California Medical Association. Straightforward Contracting for a Stronger Health Care System. April 28, 2014.

Table 4. Actual 2012 and Estimated 2014 Health Center Caseloads (millions of patients)

	2012 Actual			Estimated 2014 Levels		
	Total	Medicaid	No Medicaid	Total	Medicaid	No Medicaid
		Expansion	Expansion		Expansion	Expansion
Medicaid	8.36	5.63	2.74	11.22	7.98	3.24
Medicare	1.70	0.99	0.71	2.04	1.26	0.79
Other Public	0.49	0.36	0.14	0.61	0.46	0.15
Private Insurance	2.95	1.80	1.15	3.07	1.92	1.15
Marketplace	n/a	n/a	n/a	1.28	0.83	0.45
Self-Pay/Uninsured	7.60	4.29	3.30	7.34	4.14	3.20
Total	21.10	13.07	8.03	25.56	16.59	8.98
Growth 2012-14			# change	4.46	3.52	0.95
			% change	21%	27%	12%

Estimated Caseloads in 2020

The next set of estimates focus on 2020, a few years after the expiration of ACA mandatory funds and a year by which all ACA expansions should be fully implemented. In Table 5, we examine four scenarios based on whether there are: (1) high vs. low federal Section 330 grants, as described earlier, and (2) whether state Medicaid expansions remain as they are today or all states expand Medicaid by 2020. It is likely that none of these scenarios will exactly match what happens by 2020, but they demonstrate the range of potential outcomes.

2020: High Grant Funding, Current Medicaid Expansion Status. This scenario assumes that there is federal support to sustain the growth of health centers, even after the expiration of mandatory ACA funds. It assumes that Section 330 funding in 2020 equals \$7 billion and Medicaid expansion decisions remain as they are today. The model indicates that 36.1 million patients will be served, 10.5 million more than in 2014, a 41% increase. There will be substantial capacity expansions in both Medicaid expansion and non-expansion states. This level of funding would be sufficient to open new health center sites in additional medically underserved areas.

2020: Low Grant Funding, Current Medicaid Expansion Status. This scenario assumes that only \$1.4 billion in Section 330 grants is available in 2020, the same level of discretionary appropriations provided in 2014. While the model assumes gradual growth in other sources of grant funding and additional patient revenue from Medicaid and health marketplace expansions, total health center patient capacity will fall by 26% from 25.6 million patients in 2014 to 18.8 million by 2020, about 6.7 million fewer. This reduction is about the same size as the current population of the state of Arizona or of the combined population of Los Angeles, California and Houston, Texas. These reductions would occur in both Medicaid expansion and non-expansion states. This would likely require closing a number of health center sites as well as shrinking remaining sites.

2020: High Grant funding, All States Expanding Medicaid. This scenario assumes the 24 states that are not currently expanding Medicaid decide to expand before 2020. This would raise the total capacity of health centers to 36.5 million by 2020. The capacity in the “later expansion”

Table 5. Estimated CHC Capacity in 2020 by High vs. Low Grants and Medicaid Expansion Status (millions of patients)

Levels in 2020, Based on Current Medicaid Expansion Plans

	<u>2020 with High Sec. 330 Funding</u>			<u>2020 with Low Sec. 330 Funding</u>		
	<u>Total</u>	<u>Medicaid</u>		<u>Total</u>	<u>Medicaid</u>	
		<u>Expansion</u>	<u>No Medicaid</u>		<u>Expansion</u>	<u>No Medicaid</u>
Medicaid	16.09	11.04	5.05	8.52	6.24	2.28
Medicare	3.08	1.82	1.27	1.60	1.03	0.57
Other Public	0.82	0.61	0.22	0.44	0.34	0.10
Private	3.62	2.15	1.47	1.88	1.22	0.66
Health Ins Marketplaces	3.92	2.29	1.63	2.03	1.29	0.74
Self-Pay/Uninsured	8.51	4.53	3.97	4.36	2.56	1.80
Total	36.05	22.44	13.61	18.84	12.69	6.15
Change 2014-20 #	10.49	6.07	4.43	-6.72	-3.69	-3.03
%	41%	37%	48%	-26%	-23%	-33%

If All States Expand Medicaid Before 2020

	<u>2020 with High Sec. 330 Funding</u>			<u>2020 with Low Sec. 330 Funding</u>		
	<u>Total</u>	<u>Expansion</u>		<u>Total</u>	<u>Expansion</u>	
		<u>Now</u>	<u>Later</u>		<u>Now</u>	<u>Later</u>
Medicaid	17.68	11.04	6.64	9.24	6.24	3.00
Medicare	3.13	1.82	1.31	1.62	1.03	0.59
Other Public	0.83	0.61	0.23	0.44	0.34	0.10
Private	3.61	2.15	1.45	1.87	1.22	0.66
Health Ins Marketplaces	3.73	2.29	1.44	1.94	1.29	0.65
Self-Pay/Uninsured	7.56	4.53	3.03	3.93	2.56	1.37
Total	36.54	22.44	14.09	19.06	12.69	6.37
Change 2014-20 #	10.98	6.07	4.91	-6.50	-3.69	-2.81
%	43%	37%	53%	-25%	-23%	-31%

states would be increased by about 4.9 million people, compared to 2014 levels. There would be 1.6 million more Medicaid enrollees in health centers located in opt-out states, but there would be a modest decrease in marketplace enrollees, since those with incomes in the 100 to 133% of poverty range would be eligible for Medicaid. (It is, of course, possible that some of the Medicaid expansions would involve using the marketplaces to serve newly eligible Medicaid enrollees under Medicaid Section 1115 waivers; we are counting them as Medicaid in these models, since that would still be the ultimate source of funding.) The number of uninsured patients would decline by 0.9 million. In addition to increasing health center capacity, the Medicaid expansion would also improve access to specialty and other medical care that may be appropriate as a follow-up for primary care; uninsured patients treated at health centers often experience difficulties securing specialty care. Like the earlier scenario with high grants, this would offer capacity for a substantial increase in primary care capacity in future years.

2020: Low Section 330 Grants with All States Expanding Medicaid. This option would result in 19.1 million patients served in 2020, 6.5 million fewer than in 2014 or 25% less. The reduction in the later expansion states would be somewhat less. Like the other low grant option, this reduction in capacity would likely require that a number of health center sites be closed and remaining sites shrink.

Although the models do not present estimates of the number of health centers (or health center sites) that are operational, larger Section 330 funding levels would permit continued growth of health centers into areas that are medically underserved but lack a health center, whereas the cutbacks associated with the low funding scenarios in 2020 would severely hinder the potential for an expansion of health center locations.

Conclusions

The U.S. population is growing and the demand for primary care is expected to rise by about 17% in the coming years.²⁰ Our models essentially pose two alternative visions for the future. In one, community health center capacity will rise by more than 40% by 2020, continuing a long pattern of growth that has had bipartisan support. This will enable low-income insured and uninsured residents to secure access to good quality primary care services in medically underserved areas. This path requires adequate core federal funding for health centers after the mandatory ACA funding expires and at least some Medicaid expansions. It helps address the growing demand for primary care that will arise from natural demographic forces of population growth, aging and rising utilization of primary care, as well as support the mission of the ACA to expand health coverage and health care access.

The alternative path is to limit growth in health centers by not replacing funds lost after the ACA mandatory funds expire and, to a lesser extent, by limiting Medicaid expansions. In this vision, the capacity of health centers would dwindle by at least one-quarter between 2014 and 2020 (or by nearly half compared with the high funding scenarios in 2020). Given the increasing demand for primary care services due to demographic changes and insurance expansions, the effective reduction in access to care would be even greater. Millions of Americans across the nation would experience greater difficulties securing primary and preventive care services. Earlier analyses indicated that low-income patients who receive care at community health centers have lower total medical expenditures than non-users.²¹ Thus, the absence of community health center services could actually increase overall national medical costs, if the lack of primary care leads more people to get expensive specialty, emergency or inpatient care.

This analysis shows the importance of two key policy issues on the future capacity of health centers: the level of federal Section 330 funding and state decisions about Medicaid expansion. Higher grant funding levels would permit health centers to expand the number of insured and uninsured patients that they can serve. Expanding Medicaid eligibility brings in more Medicaid revenue and reduces uncompensated care needs. These policies act synergistically to empower health centers to serve more patients in their communities. While

²⁰ Petterson S, et al. *op cit.*

²¹ Richard P, Ku L, Dor A, et al. *op cit.*

policies about health insurance marketplaces are discussed less in this paper since the marketplaces and federal tax credits are available in all states, these policies also help support health center services and capacity expansions.

Health centers have a strong track record of providing high-quality care for vulnerable patients in a cost-effective fashion. While the federal funding and state Medicaid policies are important in bolstering their capability to meet future needs, it is also important to consider the need for a sufficient supply of primary care clinicians and other health professionals who can staff health centers. This would require other changes in training and practice patterns of health professionals in the U.S., such as increased funding for the National Health Service Corps. But health centers are already ahead of the curve in their staffing patterns; they are more likely to use nurse practitioners, physician assistants, and other staff in innovative practice patterns that are both efficient and that improve the quality of care.²²

Both the federal government and state governments can implement policies to support this critical health delivery system in order to meet tomorrow's health care needs. It will be important to continue fundamental support for Section 330 grant funding, in addition to bolstering Medicaid coverage. This will continue a growth trajectory that has enabled non-profit community health centers to provide comprehensive primary care services to low-income insured and uninsured patients in medically underserved rural, suburban and urban communities across the nation.

²² Hing E, Hooker R, Ashman E. Primary Health Care in Community Health Centers and Comparison with Office-Based Practice. *Journal of Community Health*. 2012; 36:406–413