

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

Policy Research Brief # 47

**Projected Financial Losses Experienced by Community Health Centers under a
Scenario of Major Cuts in Key Sources of Federal Funding: 2018-2022**

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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 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 is a not-for-profit 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 <http://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy> or at rchnfoundation.org.

Executive Summary

Congress is currently considering options to significantly reduce federal funding for the Medicaid expansion and the Marketplace subsidies implemented under the Affordable Care Act (ACA). Separately, the Health Centers Fund, which currently accounts for 70% of all federal health center grant funding, is set to expire in September 2017. These potential changes in federal funding could have a dramatic impact on health centers and the communities they serve. The purpose of this brief is to simulate the potential combined impact of these major changes in federal funding that will directly affect community health centers. Secondly, this brief also assesses the financial burden other state and federal programs would have to assume to help centers maintain services at their current capacity.

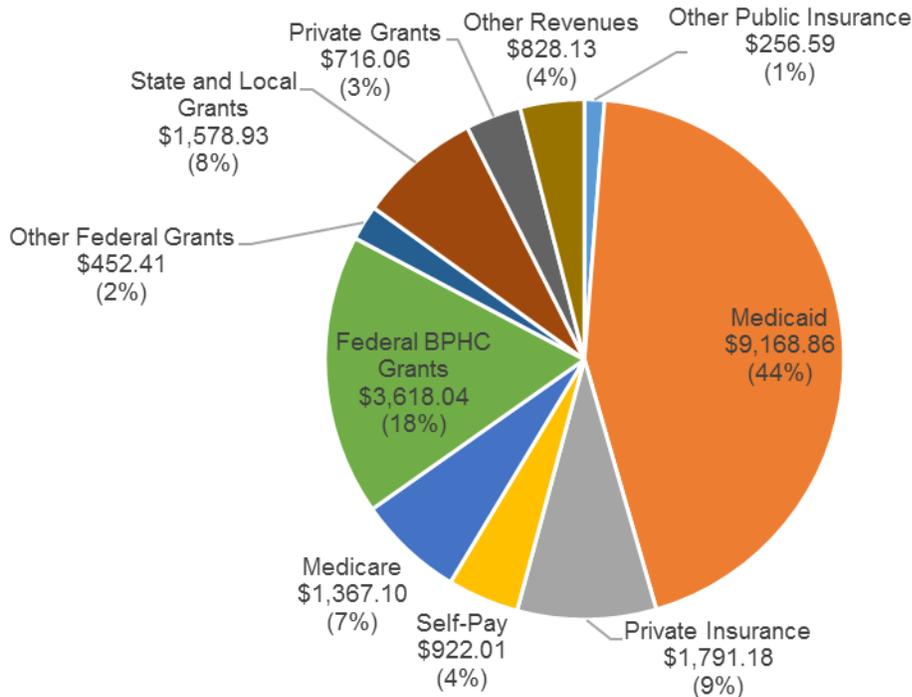
Over the 2018-2022 time period, we estimate that under current law, and with primary care services expanding at the current pace, health centers would realize a total of \$169 billion in revenues from all sources combined. Of that amount, \$37.5 billion would come from funding streams that include Medicaid and private insurance, while some \$10.5 billion would constitute federal grant funding from the Health Centers Fund. Using forecasting models based on historical revenue data from community health centers we project that health centers, operating at their current service levels, would have experienced a \$48 billion shortfall over this time period, were the Medicaid expansion and Marketplace subsidies repealed and the Health Centers Fund not renewed. From the perspective of health centers and their communities, if alternative sources of funding are not found, this shortfall would equal 28.3 percent of the funding that would be required just to maintain services as projected under the ACA.

The change in federal health center funding of the type considered in this simulation is also likely to further strain state budgets. Based on past trends, state and local governments would be expected to provide \$14.5 billion in non-Medicaid grants and programs to help cover the shortfall, while discretionary federal grants would be used to offset part of the remaining gap. Given the shifting priorities in federal funding under the current administration, the burden on states may be higher than projected. Moreover, in the current fiscal environment, the likelihood of funding substitution at either the state or federal level is low. This suggests that health centers may have to scale back services, staff, and clinic sites in order to absorb financial losses.

Background

Community health centers are the single largest source of comprehensive primary health care in medically underserved rural and urban communities. In 2015, federally-funded community health centers served nearly 23.9 million patients¹ and operated with total combined revenues of \$20.7 billion. Nearly two-thirds of health center revenue (\$13.5 billion) was derived from payments for patient care, mostly from Medicaid, followed by private insurance, Medicare, and patient self-payments. Over one third of health center revenue came from federal, state and local grants as well as from private funders such as foundations (**Figure 1**).

Figure 1: Health Center Revenue by Sources: 2015²



Based on their historical growth pattern and assuming a continuation of current law, health centers are on track to serve an estimated 32.8 million patients in 2022 and to have combined operating revenue that year of 38.6 billion.³

¹ Number of total patients, total combined revenue, and total patient-related revenue are based on authors' analysis of 2015 UDS data. Health centers in U.S. territories are excluded from the analysis.

² Authors' analysis of 2015 UDS data. Health centers in U.S. territories are excluded from the analysis.

³ The growth in patient revenues reflects population growth, rising health care costs nationally, and growing outreach of health centers in underserved areas, with their numbers increasing from 699 in 2000 to 1,375 centers in 2015.

Congress is currently considering options that would result in the end of the Medicaid expansion and in a significant reduction in the size of the Marketplace subsidies. Separately, the Health Centers Fund, which was established through the Affordable Care Act in 2010, and then extended in the Medicaid and CHIP Reauthorization Act of 2015, is currently set to expire in September 2017. Unlike the Medicaid expansion and Marketplace tax credits, which will continue unless Congress acts to change them, continuation of the Health Centers Fund will require that Congress take specific action to extend it before September 30th of this year.

Because these reductions in federal funding to support Medicaid and subsidized private insurance coverage would fall disproportionately on low-income people, it is likely that such changes would have a significant impact on health care providers such as health centers, which are located in and serve poorer and medically underserved communities and populations. In addition, the Health Centers Fund provides the central means by which health centers finance care for uninsured or underinsured patients and for uninsured services (such as adult dental care).

The purpose of the brief is two-fold: First, to project the gap in revenue (shortfall) that would accrue to health centers as a result of cutbacks in Medicaid expansions and Marketplace subsidies, as well as non-renewal of the federal Health Centers Fund; and second, to assess the financial burden other state and federal programs would have to assume to help centers maintain services at their current capacity.

Approach

We use a forecasting model to project the revenue shortfalls that would be incurred by community health centers due to significant decreases in federal funding for the Medicaid expansion and the Marketplace subsidies, using the provisions of the American Health Care Act (AHCA) to set parameters for the simulation model. The AHCA, which was introduced in the House on March 6, 2017 but failed to be put forth for a vote in late March, would have significantly changed the trajectory of current law.⁴ These changes would have included the virtual elimination of enhanced federal funding for the ACA (Affordable Care Act) adult Medicaid expansion population beginning January 1, 2020, as well as a significant reduction, beginning in 2020, in the size of federal tax credits for the purchase of subsidized health insurance. The forecasting

⁴ Congressional Budget Office. (2017). Cost Estimate - American Health Care Act *Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017.* <https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>

model also incorporated assumptions regarding the non-renewal of the Health Centers Fund set to expire in September 2017.

Forecasts are made for the years 2018-2022, including the transition period 2018-2019, followed by the three-year period 2020 to 2022. For the transition years 2018-2019, we assume that Medicaid expansion states continue to expand at the same rate as previously experienced under the ACA. After that period, Medicaid expansions are halted. The Health Centers Fund expires after 2017 so federal health center grant funds are not included in any of the subsequent year projections.⁵

We initially ran projections separately for each revenue source, and then summed all the sources to obtain the national trend line. This allowed us to adjust for policy changes matched to the revenue sources they were designed to impact.⁶ Data for these analyses came from years 2000-2015 in the Uniform Data System (UDS), which is maintained by HRSA's Bureau of Primary Health Care. Information in the UDS is collected annually from all health centers.

We then sought to determine how much would need to be made up from state and local governments and other federal funding sources as a result of the reduction in Medicaid and private insurance payments along with an end to the Health Centers Fund. We assumed that for current services to be maintained, revenues from other funding sources would need to increase by an equivalent amount to achieve a dollar-for-dollar substitution for all revenue losses.

Results

Trends: 2018-2022

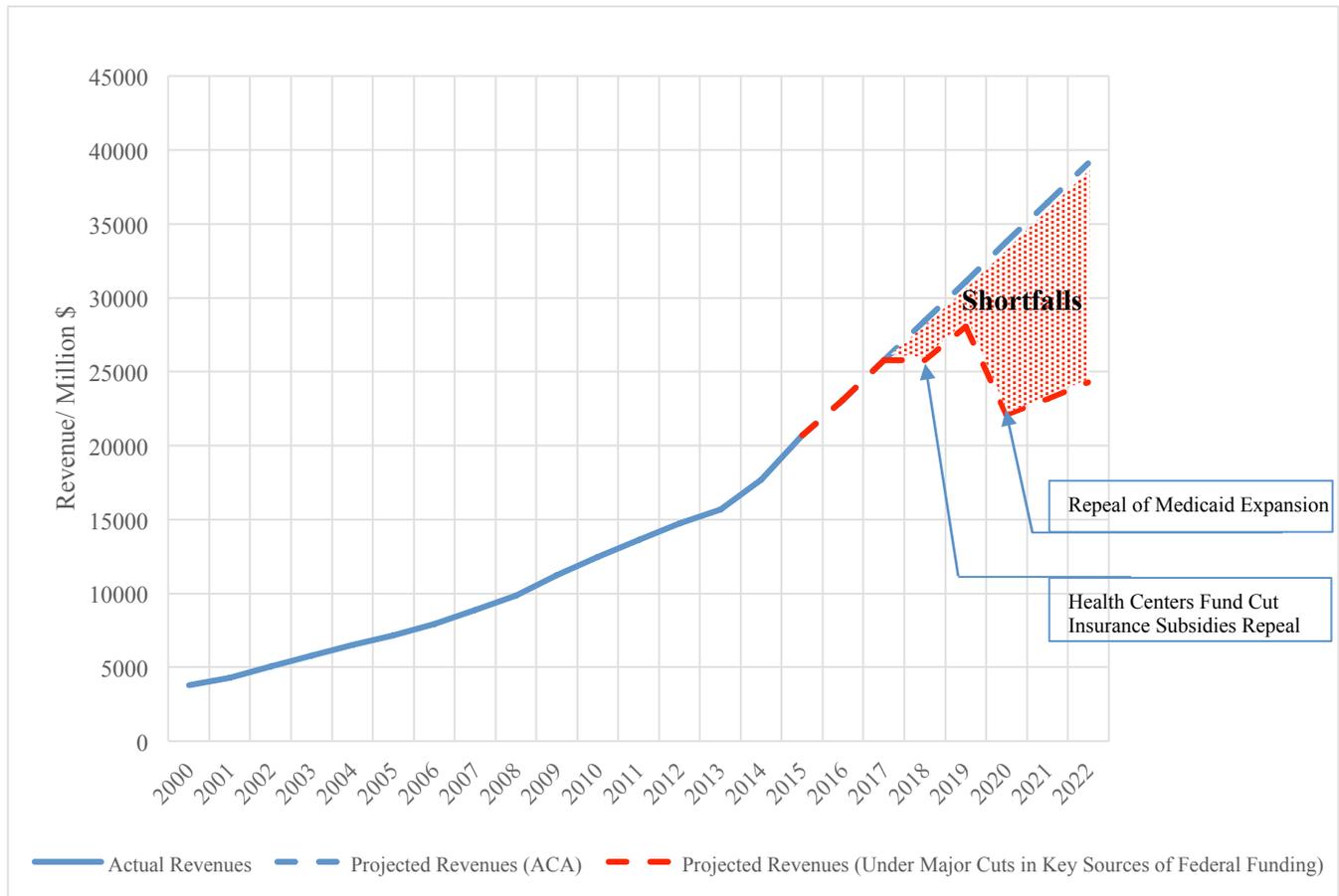
The trend lines in **Figure 2** compare projected health center revenue under current law to expected revenue were provisions of the Affordable Care Act repealed and replaced with significant reductions in federal funding for the Medicaid expansion and the Marketplace subsidies. The gap between the trend lines shows the revenue shortfalls

⁵ The ACA Health Centers Fund provides \$11 billion to be distributed to health centers between 2011 and 2015. The Medicare Access and CHIP Reauthorization Act of 2015 extended this funding by mandating \$3.6 billion and \$3.7 billion in fiscal years 2016 and 2017, respectively. See Han, X., Luo, Q. and Ku, L., 2017. Medicaid Expansion and Grant Funding Increases Helped Improve Community Health Center Capacity. *Health Affairs*, 36(1), pp.49-56.

⁶ For instance, the federal FMAP (Federal Medical Assistance Percentage) payment for newly eligible Medicaid patients was applied only to the 31 states that expanded Medicaid by 2016. State-level models were used to account for difference in the initial expansion year.

health centers would experience cumulatively in the period 2018-2022 if the replacement were to take place.

Figure 2: Health Center Revenues and Shortfalls⁷



The gap begins to appear in 2018, coinciding with the expiration of the Health Centers Fund⁸ and the reduction in private insurance subsidies for low-income individuals above the Medicaid eligibility threshold. The gap widens substantially with the elimination of the enhanced funding for the ACA expansion population beginning in 2020. Initially the

⁷ Authors’ analysis of UDS data. Health centers in U.S. territories are excluded from the analysis.

⁸ The House bill (American Health Care Act) provides supplemental funding for community health centers of \$422 million for FY 2017. We assume it to be budget neutral, as this amount is likely to come from defunded family planning activities. (See Congressional Budget Office, 2017, op. cit., and Rosenbaum, S. (2017). Can Community Health Centers Fill The Health Care Void Left By Defunding Planned Parenthood?)

<http://healthaffairs.org/blog/2017/01/27/can-community-health-centers-fill-the-health-care-void-left-by-defunding-planned-parenthood/>) Changing this assumption would not affect projections in future years.

revenue gap is significant but relatively moderate, at approximately \$3.0 billion in 2018 and \$3.5 billion in 2019, but it rises dramatically to \$12.2 billion in 2020 (**Exhibit 1**). The total shortfall in the full five-year projection period amounts to \$48 billion. From the perspective of health centers and their communities, if other sources of funding are not found, this shortfall would equal 28.3 percent of the funding that would be required to maintain services growth at the rate expected under ACA.

Exhibit 1: Projected Revenue Shortfalls 2018-2022 [\$ Millions]⁹

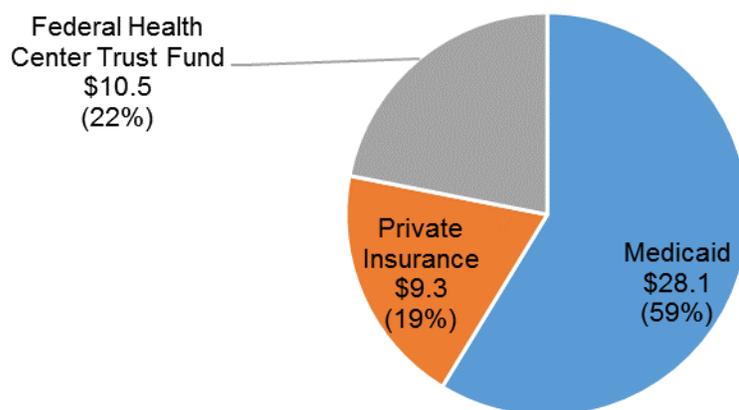
	Projected Revenue (Under current law)	Projected Revenue (Under major cuts)	Shortfalls	Shortfalls as Share of Revenues (Under current law)
2018	\$28,440	\$25,462	\$2,978	10.47%
2019	\$31,108	\$27,646	\$3,462	11.13%
2020	\$33,776	\$21,620	\$12,156	35.99%
2021	\$36,444	\$22,649	\$13,795	37.85%
2022	\$39,113	\$23,678	\$15,434	39.46%
Total	\$168,881	\$121,056	\$47,825	28.32%

Changes in Revenue Sources: Health Center Revenue Shortfalls and Projected Offsets, 2018-2022

Figure 3 shows the revenue shortfall by source, while **Figure 4** shows the projected financial burden placed on other revenue categories, 2018-2022. In **Figure 3**, the bulk of the losses (59 percent) are attributable to lost federal Medicaid payments, followed by the loss of revenue from the Health Centers Fund (22%), and finally payments from private insurance (19%).

⁹ Authors' analysis of UDS data. Health centers in U.S. territories are excluded from the analysis.

Figure 3: Health Center Revenue Shortfalls by Sources of Loss (\$ Billions)¹⁰



Assuming that other sources of federal funding could be found to substitute for the loss of payments from public and private insurance and Health Centers Fund revenue, we then sought to determine, based on current spending patterns, the level of financial burden that would need to be absorbed by these other funding sources (i.e., states and localities, projected annual appropriations for the community health center program,¹¹ other federal grant programs, and patient self-pay revenue). Based on past trends, other federal grant funds would need to make up 53% of the additional burden, with the balance made up by state and local programs (30%), private foundation support (12%), and self-pay revenue (5%), as seen in **Figure 4**.¹²

¹⁰ Authors' analysis of UDS data. Health centers in U.S. territories are excluded from the analysis.

¹¹ The projected annual appropriations of the community health center program is the projected BPHC grant funding without ACA's Health Centers Fund based on past trends. Annual appropriations were the only BPHC grant funding source before ACA's Health Centers Fund, and the projected annual appropriations take into account the substitution between annual appropriations and the Health Centers Fund.

¹² Following the CBO report, our forecasting model assumes that low-income individuals who lose coverage in the Marketplaces and individual markets switch to low premium/higher-deductible plans due to the limited tax credit in the AHCA or they become uninsured. See Congressional Budget Office, 2017, op. cit.

Figure 4: Health Center Revenue Shortfalls by Projected Funding Burden (\$ Billions)¹³

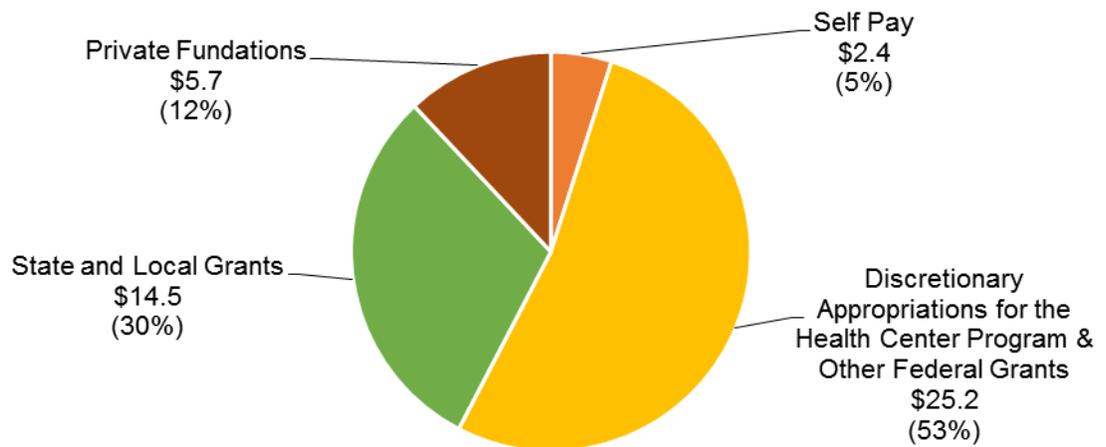


Exhibit 2 summarizes our analysis of the additional funding requirements by year. In 2018, approximately \$0.8 billion are projected to come from state and local grants, while roughly \$1.6 billion will be needed from annual appropriations for the community health center program and other federal grants. In 2020, these amounts increase to approximately \$3.8 billion from state and local grants and \$6.4 billion from annual appropriations and other federal grants. Over the 2018-2022 time period, state and local government spending for health centers would need to increase by \$14.5 billion, funding from annual appropriations and other federal grants would need to rise by an additional \$25.2 billion, and private contributions, including foundations and self-pay, would need to rise by \$8.1 billion in order to offset the projected loss of revenues attributable to Medicaid, private insurance, and the Health Centers Fund.

¹³ Authors' analysis of UDS data. Health centers in U.S. territories are excluded from the analysis.

Exhibit 2. Health Center State and Federal Funding Requirements (Transition from ACA to Major Cuts, Projected [\$ Millions])¹⁴

Year	All Other Revenues	Funds for Medicaid Newly Eligible ¹⁵		(Grant Offsets Needed for) Revenue Shortfalls		
		Federal	States	Federal Burden	State Burden	Private Burden ¹⁶
2018	\$22,668	\$5,426	\$346	\$1,560	\$763	\$654
2019	\$24,182	\$6,441	\$485	\$1,804	\$885	\$773
2020	\$33,776	\$0	\$0	\$6,424	\$3,779	\$1,953
2021	\$36,444	\$0	\$0	\$7,284	\$4,291	\$2,221
2022	\$39,113	\$0	\$0	\$8,143	\$4,803	\$2,488
Total	\$156,183	\$11,867	\$831	\$25,215	\$14,521	\$8,089

Summary and Conclusions

This analysis attempts to gauge the fiscal impact on health centers of major reductions in key sources of federal funding over the 2018-2022 time period. Our model projects revenue losses of \$48 billion over this five-year period, resulting from cut-backs in Medicaid, private insurance supports, and federal funding reserved for community health centers. Maintaining the service capacity of community health centers at current levels would require large increases in funding from other sources. Our estimates are that dramatic increases would be required in federal grant funds other than the federal health center grants, funding from states and localities, and private payments; the additional funding required from states would amount to at least \$14.5 billion over the 2018-2022 period. Given the strains on all federal discretionary funding and on states and localities, the likelihood of substitution to this degree is low. As a result, in the five-year period of 2018-2022, health centers could expect to lose 28 percent of the revenues they would expect under current law. As reported elsewhere,¹⁷ health centers

¹⁴ Authors’ analysis of UDS data. Health centers in U.S. territories are excluded from the analysis.

¹⁵ The ACA newly eligible FMAP rates (described in section 1905(y)(1) of the Act) are: 100 percent in calendar years 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in calendar year 2019, and 90 percent in calendar years 2020 and beyond.

¹⁶ Private burden in Exhibit 2 represents the combined burden on private foundation and self-pay patients.

¹⁷ Rosenbaum, S., Sharac, J., Tran, T.-C., Markus, A.R., Reynolds, D., Shin, P. (2017) How Could Repealing Key Provisions of the Affordable Care Act Affect Community Health Centers and their Patients? Geiger Gibson /

anticipate the need to address such large revenue losses by scaling back their staff, services and clinic sites. This would aggravate shortages in primary care and other services in the safety-net, at a time when more individuals would be expected to rely on it.¹⁸

RCHN Community Health Foundation Research Collaborative_Policy Research Brief # 46. Washington, DC: The George Washington University Milken Institute School of Public Department of Health Policy and Management.

¹⁸ Op cit.