

Community Health Centers: A Vital and Stable Provider of Health Services to the Poor and
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Underserved

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Poverty Capstone

Winter 2008

According to the Kaiser Commission on Medicaid and the Uninsured, nearly 47 million Americans under the age of 65 currently lack health insurance.¹ Health insurance determines to a large extent an individual's overall health status and controls whether and when people have access to necessary medical care. Yet, healthier outcomes for the millions of uninsured and underinsured Americans require more than expanded health insurance coverage. These Americans, who are disproportionately low income, are also more likely to live in medically underserved areas (MUAs), in which access to medical services is very limited. Thus, healthier outcomes for poor individuals require increased health insurance coverage as well as expanded access to medical providers. More than 56 million Americans, regardless of insurance coverage status, live in areas in which they have limited access to medical providers.²

Community health centers play a vital role in connecting low income uninsured, underinsured, and publicly insured individuals to the health services they need. Designed to provide comprehensive services to disadvantaged communities, community health centers are “the largest single source of primary health care in the United States.”³ Currently, community health centers serve over 16 million patients per year in 5,000 locations across the United States.⁴ More than 90 percent of patients are low income and most patients are uninsured, underinsured through private insurance coverage, or recipients of public coverage through Medicaid and the State Children Health Insurance Plan (SCHIP). These centers are a vital component of the health care safety net in the United States and should be expanded to meet the needs of the large medically needy population. Unfortunately, threats to federal and private funding of health care

¹ Kaiser Commission on Medicaid and the Uninsured. “Health Centers Reauthorization: An Overview of Achievements and Challenges.” March 2006, p3.

² National Association of Community Health Centers. “Access Denied.” 2007, p 1.

³ Kaiser Commission on Medicaid and the Uninsured. “Health Centers: An Overview and Analysis of their Experiences with Private Health Insurance.” January 2008, p1.

⁴ National Association of Community Health Centers. “Access Denied.” 2007, p3.

centers as well as a lack of understanding of their role in providing medical care and other services to disadvantaged communities throughout the nation prevent millions of Americans from receiving the services they need. With or without a plan for universal health insurance coverage, more community health centers must be developed across the nation to fulfill the medical needs of the 47 million uninsured Americans and the more than 56 million Americans who are “medically disenfranchised” due to the lack of medical providers in their communities.⁵

Following an overview of community health centers, including more information about patients served, costs, and services provided, this study will examine the benefits of and threats to the community health center system, assess its role under the current system and possible changes with universal healthcare, and propose strategies to increase efficiency and expand the program.

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What are Community Health Centers and how do they operate?

Community health centers first came into existence in 1961. Situated in rural and urban areas, community health centers link patients to a “broad array of antipoverty services and supports,” including mental health and social services as well as food and housing assistance.⁶ Community health centers adhere to five principles in order to receive federal funding (Federally Qualified Health Center (FQHC) program): 1) They must be located in a federally designated medically underserved area (MUA) or serve a federally designated medically underserved population (MUP); 2) have nonprofit, public, or tax-exempt status; 3) provide comprehensive primary health care services, referrals, and other services that facilitate access to care, such as case management, translation, and transportation; 4) have a governing board in

⁵ National Association of Community Health Centers. “Access Denied.” 2007, p 4.

⁶ Robert Clark. The War on Poverty. University Press of America: Lanham, MD. p201.

which the majority (51%) of members are health center patients, which empowers the community members and ensures responsiveness and accountability to community needs; and 5) provide services to all in the service area regardless of ability to pay, offering a sliding fee schedule that adjusts to the patients' income. Although federal funding covers a much smaller portion of costs than insurance payments, receipt of the status as a FQHC provides additional benefits such as inclusion in federal prescription drug programs and mandated "true-cost" reimbursement from Medicaid for medical services. In other words, Medicaid pays for the total cost of treatment (also known as cost-based reimbursement) dispensed by community centers and does not try to negotiate lower reimbursement rates.

Areas are designated as medically underserved by a variety of criteria including "existing primary care capacity, health status, economic vulnerability, and demand for care" which are quantified using the Index of Medical Underservice (IMU). This index is calculated from four data variables: Ratio of primary medical physicians per 1,000 people in the population (most emphasis placed on this variable), rate of infant mortality, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. Weighed on a scale of one to one hundred, a score of 62 or lower qualifies an area as a medically underserved area (MUA).⁷

The FQHC status is also bestowed upon Rural Health Clinics that function similarly to community health centers but are not bound by as many stipulations. Rural Health Clinics are staffed substantially by nurse practitioners and physicians' assistants and are located in federally designated rural areas with limited access to primary care services. Unlike community health centers, rural health clinics are not mandated to provide care regardless of ability to pay. Most patients in Rural Health Clinics are covered by Medicare or private insurance. Nevertheless,

⁷ NPHF Background Paper. "The Fundamentals of Community Health Centers." August 2004, page 7.

because they provide necessary access to care to primary care for lower- income people, Rural Health Clinics are eligible for cost-based reimbursement from federal medical insurance programs.

Who do Community Health Centers serve?

Community health centers serve the neediest populations within American society. The health center patient population is predominantly female, low-income, under the age of 65, and is ethnically and racially diverse. Approximately fifty-nine percent of patients are female, of which twenty-nine percent are of childbearing age. Over ninety-three percent of patients are under the age of 65. Two-thirds of all patients are members of ethnic or minority groups and thirty percent of patients are best served in a language other than English.⁸ Approximately thirty-seven percent of health center patients are children, “making health centers a major source of pediatric health care for low-income children.”⁹ Only seven percent of patients are elderly.

According to statistics from the National Association of Community Health Centers and from the National Health Policy Forum, health centers serve one in nine Medicaid beneficiaries, one in five low-income uninsured persons, and one in seven low-income non-elderly U. S, residents. In 2004, forty percent of health center patients lacked insurance and thirty-six percent of patients were covered by Medicaid. Seventy percent of health center patients had incomes lower than 100% FPL and ninety-one percent of patients had incomes below 200% of FPL. In 2003, health centers served about five million uninsured patients, a little more than ten percent of

⁸ NPHF, 8

⁹Kaiser Commission on Medicaid and the Uninsured. “Health Centers: An Overview and Analysis of their Experiences with Private Health Insurance.” January 2008, p2.

the estimated forty-seven million uninsured nationwide.¹⁰ The placement of health centers, as well as its finance structure allowing everyone to access medical aid regardless of ability to pay, expands access of services to millions of disadvantaged Americans every year.

How are Community Health Centers financed?

The common factors among the patient population are a lack of insurance or underinsurance and low socioeconomic status. The mandate that community health centers provide care regardless of ability to pay allows individuals of any background to receive care. This includes individuals with private insurance, who may not be able to access other medical providers due to high levels of cost-sharing or high premiums.

Community Health Centers are financed through a combination of Medicaid, Medicare, and private insurance reimbursement rates along with federal, state, and local grants that allow the centers to financially cover the cost of the uninsured. Medicaid is the largest and most consistent source of revenue. CHCs serve about ten percent of Medicaid enrollees nationally. Approximately thirty-six percent of health center revenues come from Medicaid reimbursement, which is mandated to cover the full cost of treatment (cost-based reimbursement) for the publicly insured. In fact, the Federally Qualified Health Center program “established a preferential payment policy for health centers by requiring cost-based reimbursement for both Medicaid and Medicare.”¹¹ This payment program was designed to prevent grants set aside for uninsured coverage from being used to offset financial losses from insurance reimbursement schedules, reducing the total number of uninsured persons the center is able to service. Unfortunately,

¹⁰ Kaiser Commission on Medicaid and the Uninsured. “Health Centers: An Overview and Analysis of their Experiences with Private Health Insurance.” January 2008, p4.

¹¹ NPHF, 6.

changes in the policy have allowed Medicare to stop cost-based reimbursement using instead cost caps which result in a financial gap that health centers often have to write off, incurring a loss. Approximately fifteen percent of health center patients are covered by Medicare but the insurance program only provides seven percent of annual revenues for center, clearly indicating the costs that health centers must absorb.¹²

Another fifteen percent of health insurance patients are covered by private insurance, which have the lowest levels of reimbursement for costs. As noted, patients covered by private insurance generally seek out community health centers because of the high levels of costs sharing that apply with general medical centers. Unable to deny care, community health centers provide care and absorb the loss that they incur because of low reimbursement or client inability to pay. Although fifteen percent of privately insured patients receive care at CHCs, only six percent of center revenues came from private insurance companies, indicative of the sizeable loss incurred. State laws prevent eligible patients from obtaining dual public and private coverage, which would allow the public coverage (Medicaid) to cover costs not covered by private insurance and provide cost based reimbursement to health centers.

The loss in revenue from treating Medicare and privately insured patients has noteworthy financial consequences for community health centers. Funds that are set aside for indigent care must be used to cover overall costs of the center, leaving less money available for services provided to the poor. According to the Kaiser Commission on the Uninsured, “if Medicare and private insurance paid health centers at the Medicaid level of reimbursement in 2004, an additional 200,000 patients could have been served,” indicating that community centers sustain

¹² NPHF, 6

considerable losses by treating Medicare and privately insured patients.¹³ This statement also indicates that some health centers stop treating the uninsured once grant revenues are gone.

The financial health of community health centers is also threatened by the state of the economy on the national, state, and local level. Grants from the government, particularly at the state and local level, are used to fund ancillary services such as transportation and translation services, which are important to the culturally and financially sensitive values of the community health center movement. During budget crises, funds for these services are often cut immediately. Increased state flexibility in regards to reimbursement rates for Medicare and Medicaid also lead to reduced revenues during budget crises. According to the National Health Policy Forum (NHPF), many states approve Medicaid benefit and eligibility cuts in efforts to balance the state budget. They also consider Medicaid demonstration waivers that allow the state to experiment with cost-containment measures such as “capping enrollment, creating waiting lists, and reducing benefits.”¹⁴ Community health centers are forced to adjust to fluctuating costs and revenues, which generally decrease the number of uninsured individuals that can be serviced at the various centers if the center attempts to remain financially solvent.

What services are provided by Community Health Centers?

One of the goals of community health centers is to connect patients with medical and non-medical services to improve their quality of life. “About one in twenty U.S primary care visits occur at CHCs.”¹⁵ In regards to medical services, there is a high demand for obstetric/gynecologic, family practice, and pediatric services. This demand is correlated to the

¹³ Kaiser Commission on Medicaid and the Uninsured. “Health Centers: An Overview and Analysis of their Experiences with Private Health Insurance.” January 2008, p2.

¹⁴ NPHF, 26.

¹⁵ O’Malley, Forrest, Politzer, Wulu, and Shi. “Health Center Trends, 1994-2001: What do They Portend for the Federal Growth Initiative?” Health Affairs, 24(2), p 465.

large number of women and children served within health centers. As twenty-nine percent of women served in centers are of childbearing age, family planning and obstetric services are very important.

Health centers are often the sole provider of dental, mental health, and substance abuse services for medically underserved individuals and families. Community health centers average four encounters per patient per year, providing mostly primary medical care services.¹⁶ Approximately seventy-five percent of CHCs provide preventative dental services. Another seventy percent provide mental health treatment and counseling, and close to fifty percent provide substance abuse treatment and counseling services.¹⁷ In 1998, only five percent of CHC encounters were of mental health services or substance abuse prevention of treatment.¹⁸

Located in areas in which access to medical services are limited, health centers host several medical services within the same facility or have access to a network of other medical professionals that treat patients at little to no cost. When services are offered off site, health centers make referrals and in some cases, are allowed to cover some or all of the costs associated for care. Due to shortages of physicians in various areas across the nation as well as a lack of insurance coverage, certain services and access to providers of dental and mental health care may be unavailable to the uninsured and underserved. In particular, uninsured adults have significantly worse access to substance abuse and mental health services secured through referrals than Medicaid and privately insured patients.¹⁹

¹⁶ GAO. Community Health Centers: Adapting to Changing Healthcare Environment Key to Continued Success.” March 2000, p. 13.

¹⁷ NPHF, 9.

¹⁸ GAO, 13.

¹⁹ Cook, Hicks, O’Malley, Keegan, Guadagnoll, and Landon. “Access to Specialty Care and Medical Service in Community Health Centers.” Health Affairs Sep/Oct 2007. 26 (5), p. 1465.

Some health centers also operate as pharmacies or have a contractual agreement with a local pharmacy to provide prescriptions at a discounted rate to patients. Studies indicate that uninsured or low-income individuals are more likely to go without prescriptions because of cost, negatively impacting their health status. While only one-third of health centers across the nation have pharmacies in-house, patients are provided with easy access to prescriptions and medical providers are able to monitor patient behavior regarding prescriptions more effectively. A federal prescription drug program (340B) and a mandate to pharmaceutical companies with ties to Medicaid have enabled many centers and local contracted pharmacists to provide deeply discounted drugs to health center patients. Unfortunately, only half of eligible centers take advantage of the prescription program due to lack of knowledge, effectively robbing millions of low income and uninsured patients of access to necessary drugs.

Health centers are also responsible for providing “enabling services” or services that allow patients to consume health care and other services more effectively. Most centers offer “case management, translation, transportation, outreach, eligibility assistance, and health education.”²⁰ These services, while not directly connected to medical services, allow health centers to treat patients more holistically and to connect them with available and necessary services. These enabling services remove barriers to access to medical care for disadvantaged Americans and provide a minimum level of protection of patient rights.

How are Community Health Centers staffed?

Staff at community health centers consists of “primary care physicians, nurse practitioners, physician’s assistants, nurses, substance abuse and mental health specialists,

²⁰ NPHF, 8

dentists, hygienists, and other health professionals.”²¹ Due to the nature of the work and location of community health centers, there is considerable difficulty in recruiting and retaining qualified staff. Two issues that detract from the position include the location of areas that do not attract medical providers, hence they are medically underserved, and the lack of financial resources to offer competitive salaries. Consequently, physician recruitment for community health centers is heavily dependent upon scholarships for medical costs and loan repayment programs provided through the National Health Service Corps (NHSC) and the recruitment of foreign medical school graduates.

Created in 1970 by the Emergency Health Personnel Act, the National Health Services Corp provides scholarships and loan repayments to health professionals in exchange for commitment to practice in Health Professional Shortage Area (HPSA) area, which is determined based on physician to population ratio. Specifically, the area must have at least a population-to-full-time equivalent primary care physician ratio of 3,500:1.²² Corps scholarship recipients receive tuition and fees, books, supplies, equipment, and monthly stipend for up to four years. Corps members are contracted to serve one year for every year of financial support received, with a two year service minimum. Over the long run, the National Health Service Corps scholarship program has the potential to increase the number of available physicians to Health Professional Shortage Areas, and increase access to health care for the more than 56 million Americans who have limited healthcare options due to their location. However, current expansion of health centers and the need to fill the hundreds of vacancies in centers across the nation have expanded the loan repayment option of the National Health Services Corps, which seeks to recruit already trained professionals to needy areas. Health professional in fields such as

²¹ NPHF, p 10.

²² NPHF, 11

dentistry, psychology, social work, and general medicine are targeted for recruitment and offered loan assistance and tax assistance payments in return for years of service in community health centers. Shortages for community health centers lie primarily with dentists, family physicians, and gynecologists and can be attributed to low salaries and high costs of insurance, including malpractice. As another incentive to serve as a corps member in community health centers, the federal government created the Health Center Judgement Fund which shifts medical liability from centers and physicians to the federal government and provides special malpractice coverage.²³

The NHSC has been extremely successful in engaging medical practitioners in needy areas nationwide. To meet current and future demand, however, recruitment efforts and financial assistance will have to increase. According to studies of the NHSC, barriers to recruitment include low salaries, cultural isolation, poor quality schools and housing, and lack of spousal job opportunities.²⁴ To meet some of the excess demand, the federal government has allowed states to issue H1B visas to foreign medical school graduates who agree to serve three years in a HPSA. Specifically, visa requirements for foreign medical students require them to return home immediately after graduation for two years before being able to practice medicine in the United States. However, the current shortage of available medical practitioners to areas across the nation has inspired the government to provide an alternative option to those graduates, allowing them to remain in the United States and practice medicine and increasing access of insured and uninsured patients to medical providers. Despite the increasing need for more providers, however, a state can only issue a certain number of medical provider visas due to caps set by the federal government.

²³ NPHF, 12.

²⁴ Rosenblatt, Adrilla, Curtin, and Hart. "Shortages of Medical Personnel at Community Health Centers." JAMA. March 2006, 295 (9), p 1046.

Overall, the community health centers fill a particular niche in the health care market and are the primary source of primary and preventative care for uninsured and publicly insured Americans. The centers typically provide care to everyone regardless of ability to pay, which can lead to substantial losses for the center, and are located in areas in which individuals often lack access to insurance coverage and medical practitioners. As recipients of millions in dollars of grants from the federal, state, and local government, several studies have been done to measure the effectiveness of CHCs and the role they play in medically servicing the poor.

How effective are Community Health Centers?

There is substantial evidence of “disparities in preventive services use by race, socioeconomic status, and insurance status. However, among CHC patients, such disparities are greatly reduced.”²⁵ Health centers have been widely recognized for the quality of care and services they provide to indigent Americans. There is documented impact “on reducing racial and ethnic health disparities, as measured by infant mortality, tuberculosis, and death rates, and lack of access to prenatal care.”²⁶ Health centers have been particularly successful in the reduction of low weight babies, hospitalizations for patients with chronic conditions, and the increase in the provision of preventative women’s health services among the uninsured.²⁷ National data shows that the rate of low-weight babies to African American women in urban (10.3%) and rural CHCs (8.5%) is lower than the national average, 13.1% and 13% respectively.

²⁵ O’Malley et al, 470.

²⁶Kaiser Commission on Medicaid and the Uninsured. “Health Centers: An Overview and Analysis of their Experiences with Private Health Insurance.” January 2008, p17.

²⁷ NPHF, 18.

According to the General Accounting Office Report in community health centers, Medicaid beneficiaries who use the centers have on average a twenty-two percent lower rate of hospitalization than Medicaid beneficiaries who rely on other sources of primary care. Also,

“uninsured users were more likely than other uninsured people to have a regular source of care and have more frequent contact with physicians... Women who use CHCs receive more up-to-date Pap tests, mammograms, and clinical breast examinations than low-income and minority women in the general population.”²⁸

CHCs have improved access to appropriate and timely health care services for underserved populations. Health centers provide a regular source of primary and preventative care services, which dramatically reduces emergency room use and avoidable hospitalizations and ensures quality care at lower costs.²⁹

What are the difficulties and threats faced by Community Health Centers?

Despite the success of CHCs in providing preventative indigent care, they face considerable difficulty in ensuring access to specialty care and diagnostic tests for the uninsured and underinsured. Eligibility for federal funding requires community health centers to establish formal referral networks for specialty care, diagnostic services, nonemergency hospitalizations, and other services. Unfortunately, the lack of insurance by many CHC patients greatly impedes the formation of such relationships. A survey of twenty health center directors from ten states reveals that specialty referrals for insured patients could be obtained with relative ease. For the uninsured however, only 59% of the directors could obtain referrals for specialty services “frequently” or “very frequently.”³⁰ Specialty care referrals are needed for a very small proportion of overall community health center patients (7%) but difficulty in the referral process

²⁸ GAO, 14.

²⁹ Kaiser Commission on Medicaid and the Uninsured. “Health Centers: An Overview and Analysis of their Experiences with Private Health Insurance.” January 2008, p17

³⁰ NPHF, 19.

is prevalent for that population. Another study of specialty care access in five diverse cities demonstrates that capacity for specialty services for the uninsured is strained and that waiting times for services had to be measured in months. Hospitals in the cities either provided outpatient specialty care on a sliding fee scale or denied uninsured patients access to care unless they could pay in full prior to treatment.³¹ Thus, insurance status maintains a prominent barrier in access to care for the indigent, even with the existence and use of CHCs.

Community Health Centers also face significant shortages of medical personnel. According to a 2004 study reported by the American Medical Association (AMA), there are vacancies for 13.3% of family physician positions, 20.8% of obstetrician/gynecologist positions, and 22.6% of psychiatrist positions.³² These shortages are higher in rural community health centers, which have longer term vacancies and greater proportional difficulty in attracting and retaining staff than urban centers. CHCs also face significant barriers to filling dentist vacancies, most of which remain open for seven or more months in both urban and rural areas. The study reveals that CHCs in rural areas particularly are heavily dependent upon international medical graduates for their staffing needs. Approximately 37.6% of rural community health centers have current staff composed of international graduates.³³ The J-1 waiver is not available to dentists, which limits the number of dentists available for practice in CHCs, particularly in rural areas which face the most significant shortage.

President Bush's current expansion of community health centers requires a fifty percent increase in the health center workforce. To be more specific, approximately 44,000 additional medical professionals would be needed for health centers alone to meet the goals set forth in his

³¹ Felt-Hisk, McHugh, and Howell. "Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity?" *Health Affairs* 21(5), p 278.

³² Rosenblatt, Andrilla, Curtin, and Hart, 1042.

³³ Rosenblatt et al, 1046.

expansion program. Without changes to the recruitment and reward process for health center staff, the shortage of medical providers to the medically underserved will continue to increase.

Another threat to community health centers is the loss of government funding due to financial performance. According to the General Accounting Office report on community health centers, ten percent of centers struggle to survive and face major financial problems. Some of these financial difficulties can be attributed to poor management by health center directors. However, some of the difficulties can be traced to the low reimbursement to centers for the care of privately insured and Medicare patients. These losses are absorbed by the center and result in deficits that threaten the federal funding available. Furthermore, most centers continue to serve the indigent even after federal grant funds have been completely used. Unwilling to turn patients away, centers face financial repercussions for continuing to serve the most medically needy population. Of the two percent of CHCs that lose their funding each year, sixty-one percent are located in rural areas.³⁴

A recent threat to the financial solvency of community health centers can be found in the Deficit Reduction Act of 2005, which increased state flexibility regarding Medicaid benefits and expenditures. New changes to cost-sharing requirements and benefits designs could increase the number of uninsured patients and decrease Medicaid revenues currently received by community health centers. The act imposes new citizenship verification standards, creates new lower “benchmark coverage” plans for beneficiaries excluding specific populations such as pregnant women and disabled individuals, or the minimum benefits package Medicaid has to offer, and allows states to impose premiums on low-income families and individuals, increasing cost-sharing obligations which medical studies show negatively impact access to and utilization of

³⁴ GAO, 8.

medical services.³⁵ As noted, Medicaid revenues provide a substantial portion of CHC revenues and provide the financial security needed for centers to provide care to the uninsured. Medicaid beneficiaries disproportionately rely on health centers for primary care, thus any decrease in Medicaid revenues due to fewer patients or services covered would negatively impact the scope and delivery of services from community health centers.

What is the role of insurance in access to health care: Universal Health Care v. Expansion of Community Health Centers?

In general, there are two strategies that are used to increase access to care for the poor and uninsured: increasing the number of people who have health insurance and increasing the availability of services at little to no cost to disadvantaged populations. While both have proved effective in increasing access to care for the poor and indigent, the two methods have distinctly different targets.

“Insurance coverage expansions are targeted directly at uninsured people and attempt to increase access by removing financial barriers. By contrast, expansion of CHCs... is usually not targeted at uninsured people, but rather at specific geographic areas that are considered to be medically underserved.”³⁶

The implication of the first strategy is that CHCs only attempt to increase access to medical services for everyone in the medically underserved area, insured and uninsured. They generally succeed in the provision of primary and preventative services but barriers remain in regards to access to specialty care because providers are unwilling to take patients without insurance. The implication of the second strategy is that insurance coverage does not guarantee access to medical providers and that coverage expansion may be an inefficient way to provide access.

³⁵ Kaiser Commission on Medicaid and the Uninsured. “Health Centers: An Overview and Analysis of their Experiences with Private Health Insurance.” January 2008, p 15.

³⁶ Cunningham and Hadley. “Expanding Care Versus Expanding Coverage: How to Improve Access to Care.” Health Affairs 23(4), p 234.

However, the strategies should not be viewed in competition with one another, but instead as complements of the same goal: improved access for disadvantaged populations. In a study conducted by Cunningham and Hadley, which measured the effectiveness of expanded insurance coverage and access to community health centers on health outcomes, results indicate that the strategies work best together rather than apart.

According to the study, the highest levels of access to care were found in communities with the presence of both strong insurance and strong community health centers. “Low income people in these communities had highest observed levels of health care use among all groups and the lowest level of perceived difficulty getting care among all low-income people studied.”³⁷ The study also found that while health insurance coverage provides more access to care than just the existence of community health centers, particularly in regards to access to specialty care, access to care with insurance is better in communities with a strong CHC presence than those without one.

In a simulation of the impact of universal health care on access to medical services for the uninsured, Cunningham and Hadley conclude that insurance coverage expansions lead to larger increases in access to care than if an equivalent level of funding was spent on expanding community health centers alone. Expansion of centers alone would lead to greater access to primary health care while expansion of insurance coverage would lead to access to more medical services overall. If the premise is that most people cannot afford health services, increasing insurance coverage solves the problem. However, there are several pitfalls with just expanding health insurance coverage for the poor.

Since insurance coverage is voluntary, many may choose not to enroll which still leaves them without access to medical services. Though subsidies could be offered in the universal

³⁷ Cunningham and Hadley, 239.

health care plan, cost-sharing requirements and premiums may remain a barrier for low-income families and impede service use. Administrative requirements such as asset tests, reapplication and reenrollment periods, and long applications can also inhibit people from participating in the universal coverage plan.³⁸

In regards to access to health care providers, universal insurance coverage does not guarantee service. “Adequate incentives (reimbursement rates) must be offered to physicians to take on newly insured patients.”³⁹ Research currently shows that many medical providers have stopped accepting Medicaid patients due to low reimbursement rates and universal coverage without adequate reimbursement will continue the same trend. Thus, while universal coverage will lower most financial barriers to care, the poor can still face substantial barriers to care and need to continue to rely on safety net providers in community health centers.

The 2007 report by the National Association of Community Health Centers (NACHC) indicates that access to medical providers is a substantial barrier to nearly sixty million people, both insured and uninsured, in the United States, supporting the premise that increased insurance coverage and access to providers are complementary solutions to the health care crisis for the underserved. Community Health Centers provide “enabling” services such as transportation and language translation to indigent populations and remain the “preferred or sole source of care for services such as reproductive health, mental health, and substance abuse services.”⁴⁰ They also redistribute medical care providers so that Americans around the nation receive the care they need. In sum, even with insurance coverage expansion, difficulties remain in regards to care for vulnerable populations and those in underserved areas. Community health centers play an

³⁸ Cunningham and Hadley, 242.

³⁹ Cunningham and Hadley, 242

⁴⁰ Cunningham and Hadley, 243.

important role in servicing these gaps, remaining an important and viable policy option to ensure access to primary care.⁴¹

What is the future of Community Health Centers: Policy Proposals and Strategies?

According to the research consulted for this paper, community health centers are and will remain a vital component of the health care system for the uninsured and underserved. Even if the United States moved to a system of universal health care coverage, community health centers would be necessary to cover the most vulnerable populations within society. CHCs provide cost effective care to millions of Americans across the nation but there are steps that can be taken to improve the community health center system. They include changes in regards to measuring accessibility of care, the need for universal health insurance coverage, recommended changes for improving recruitment of staff, and the adoption of the Wisconsin public insurance “wrap-around” for the eligible privately insured as well as proposed solutions to the threats to community centers identified earlier.

A. Accessibility of care.

Physician to population ratios provide a superficial measurement of access to care for the indigent and publicly insured populations. The measure should also take into account “provider willingness” to serve the uninsured and Medicaid patients, which would require surveys of medical providers in the area as well.⁴² Provider willingness to serve these populations vary and have decreased dramatically in the last decade as reimbursement rates for services continue to decline, causing the provider to absorb greater losses. Surveying provider willingness would provide a more concrete estimation of access to care for the medically underserved and

⁴¹ Shi and Stevens. “The Role of Community Health Centers in Delivering Primary Care to the Underserved.” *Journal of Ambulatory Care Management*, 30 (2). p 168.

⁴² NPHF, 24.

disadvantaged. This would most likely lead to more areas being designated as MUAs but it would also provide more information that could be used in the creation of solutions.

B. Expansion of the Federal Prescription Drug Program (340B)

Health centers are eligible to receive significant discounts on prescription drugs through the federal prescription drug program, 340B. Drug manufacturers have to participate in the program and the federal government negotiates significant discounts in prices for medicines that are intended for entities such as CHCs. As noted, only one-half of health centers in the nation take advantage of the program. Increasing the participation rate of CHCs in the program could notably increase access of center patients to the prescription drugs they require at a much lower price. In order to expand the program, the Health Resources and Services Administration, which administers the CHC program, should promote the 340B service to centers across the nation, encouraging them to contract with local pharmacists to provide necessary drugs.

C. Reduce State Flexibility with Medicaid Benefits

The Deficit Reduction Act of 2005 is another attempt by the federal government to reduce national costs by cutting benefits and services to Medicaid patients. The provisions within this act could reduce the number of people eligible for Medicaid which will in turn impact the revenues available to community health centers. Due to the population served by the centers, they are heavily dependent on public insurance revenues to remain financially solvent and to provide no-cost or considerably decreased cost care to the uninsured. The act specifically allows states to experiment with benefit packages and reimbursement rates, which also affect the number of providers willing to provide care at all to publicly insured patients. Thus, reduction in Medicaid benefits could also reduce access to care for the poor. Instead of increased state

flexibility, Medicaid reimbursement rates should remain cost-based. This will allow for the maximum level of medical choice for the poor and publicly insured.

D. Universal Health Insurance.

Executive directors of CHCs across the nation continue to stress the importance of national health insurance to the services available to the poor and medically underserved, especially in regards to the receipt of specialty care. According to the study conducted by Cunningham and Hadley on the impact of insurance coverage and access to health services for the poor, health insurance coverage is powerful determinant of health status and outcomes. The study also shows that those with the best health outcomes have insurance and live in communities with a strong community health center presence, thus lowering physical and financial barriers to access to health services.

E. Improved Recruitment Strategies for Medical Staff.

The 2004 survey on CHC staffing needs indicates that staffing for centers could be improved by increasing salaries, creating more National Health Service Corps loan repayment slots, and promoting centers as desirable options for training placement.⁴³ Other options include consideration of geographic background (urban v. rural) and willingness to return to the medically underserved area after training in the medical school application process, and provision of retention bonuses for physicians that remain in MUAs. . Past studies show that “one of the most effective ways to attract rural health professional is to train people from rural backgrounds in programs with a rural emphasis.”⁴⁴ By considering geographical background as a factor in admission, medical schools can ensure that there is a subset of graduates with expressed intention to return to disadvantaged areas to serve the poor and medically underserved.

⁴³ Rosenblatt et al , 1046.

⁴⁴ Rosenblatt et al, 1047.

Retention bonuses can also be employed to retain quality staff in community health centers. Physicians in CHCs receive lower salaries than those in private practice and the bonuses raise yearly salaries for CHC staff and reward them for their service to disadvantaged Americans.

A study on staffing for community health centers conducted by NHSC indicates that there are many qualified American graduates that are turned away from medical education because there are 2.5 applicants for every medical school position and that minority students are vastly underrepresented in medicine. The need for “physicians with cultural competency and identity to work with these same populations are acute” and the system needs to be improved to address these problems.⁴⁵ Improvement in both the number of physicians available to CHCs and those with cultural competency because of their background would decrease the medical professional shortage now faced by centers.

Another option is the extension of J-1 waivers to international medical graduates of dental schools. Studies show that CHCs face considerable shortages of dentists. The use of J-1 waivers for other types of medical providers has filled many vacancies in the centers, particularly in rural areas. If the waiver is extended to dental school graduates as well, the potential pool of dentists for CHCs would increase.

F. Medicaid “wrap-around” coverage for the eligible privately insured.

One of the financial issues facing health care centers is the lack of cost-based reimbursement from privately insured and Medicare patients. These patients cause CHCs to absorb potentially substantial losses and contain the amount of care that can be provided to the poor and uninsured. Most states have laws that prevent patients from using both public and private insurance together to cover health care costs, a solution that could decrease the

⁴⁵ Mullan. “The Muscular Samaritan: The National Health Service Corps in the New Century.” Health Affairs 18 (2), p. 170.

amount of financial loss absorbed by the CHC. Following the example set by Wisconsin, states should allow “privately insured health center patients who are also eligible for Medicaid to obtain coverage from both sources.”⁴⁶ This allows Medicaid to “wrap-around” private insurance and cover services not included in the private policy and provide cost payment to health centers. Most importantly, the policy lessens the losses CHCs incur from treating privately insured individuals.

Conclusion

Community health centers are a powerful component of the health care safety net for the poor and uninsured and must remain intact. Recent expansion of community health centers nationwide has increased the number of uninsured and underinsured Americans served but a careful examination of literature regarding CHCs indicates that expansion of insurance coverage is needed as well. CHCs in general have proven themselves effective but there are many opportunities for improvement. The reliance of millions of Americans upon the services provided by community health centers demands the continued exploration of ways in which to expand and improve the program.

⁴⁶Kaiser Commission on Medicaid and the Uninsured. “Health Centers: An Overview and Analysis of their Experiences with Private Health Insurance.” January 2008, p11.

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