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Health Care Reform and Primary Care — The Growing Importance of the Community Health Center

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During the debate over U.S. health care reform, relatively little attention was paid to the long-established network of community health centers (CHCs) in the United States. And yet this unique national asset constitutes a critical element of any reform intent on expanding access to health care through a primary care portal. With an eye toward meeting the primary care needs of an estimated 32 million newly insured Americans, the recently passed Patient Protection and Affordable Care Act underwrites the CHCs and enables them to serve nearly 20 million new patients while adding an estimated 15,000 providers to their staffs by 2015. The "new" CHCs have arrived.

Launched in 1965 by the Office of Economic Opportunity as a component of President Lyndon Johnson's War on Poverty, the very first CHCs — in urban Columbia Point (Boston) and rural Mound Bayou (Mississippi) — were designed to reduce or eliminate health disparities that affected racial and ethnic minority groups, the poor, and the uninsured. The CHCs were to constitute a key component of the national public safety net, focused simultaneously on the care of individual patients and on the health status of their overall target populations. With their host communities involved in their governance, the centers were to be "of the people, by the people, for the people."

Now operating at more than 8000 sites, both urban and rural, in every state and territory (see Fig. 1), run by about 1200 CHC grantees, the centers are the medical home to 20 million Americans, 5% of the current U.S. population (see Fig. 2). Federally funded under the authority of the Public Health Service Act, the nonprofit CHCs are administered by the U.S. Health Resources and Services Administration. Support from federal (and frequently state, county, and city) grants notwithstanding, CHCs must meet budget requirements through fees for services rendered to insured patients and "pay-as-you-can" (sliding-scale) collections from the uninsured (who account for 40% of patients served). No one is turned away, regardless of ability to pay. The CHCs are dedicated to the delivery of primary medical, dental, behavioral, and social services to medically underserved populations in medically underserved areas. Marked by a substantial representation of young women and children, the characteristic patient mix includes geographically isolated, migrant, and urban (including homeless) constituencies that are often estranged by linguistic and cultural barriers. Seven of 10 CHC patients live in poverty, and well over half are members of minority groups; the CHC is often the sole health care provider available to these patients.

Beyond their commitment to the uninsured, the CHCs have always welcomed the insured in need of high-quality primary care. At present, 35% of CHC patients are beneficiaries of Medicaid, and 25% are beneficiaries of Medicare or enrollees in private health plans. With the advent of health care reform, the percentage of insured people frequenting CHCs will undoubtedly grow: the impending expansion of Medicaid and the establishment of health insurance exchanges will see to that. The CHCs are thus likely to further cement their role as the bedrock of primary care for all while remaining the provider of last resort for the uninsured.

Ever since their inception, CHCs have received substantial legislative attention, in a remarkable display of bipartisan harmony. In the face of a national crisis in primary care, sequential legislative initiatives have sought to expand and strengthen the CHC paradigm. The need for such expansion has always been clear. As recently as 2009, the Government Accountability Office reported that 43% of medically underserved areas continue to lack a CHC site.[1] Intent on doubling the number of CHCs, Congress and President George W. Bush doubled the annual appropriation to $2.1 billion by fiscal year 2008. More recently,

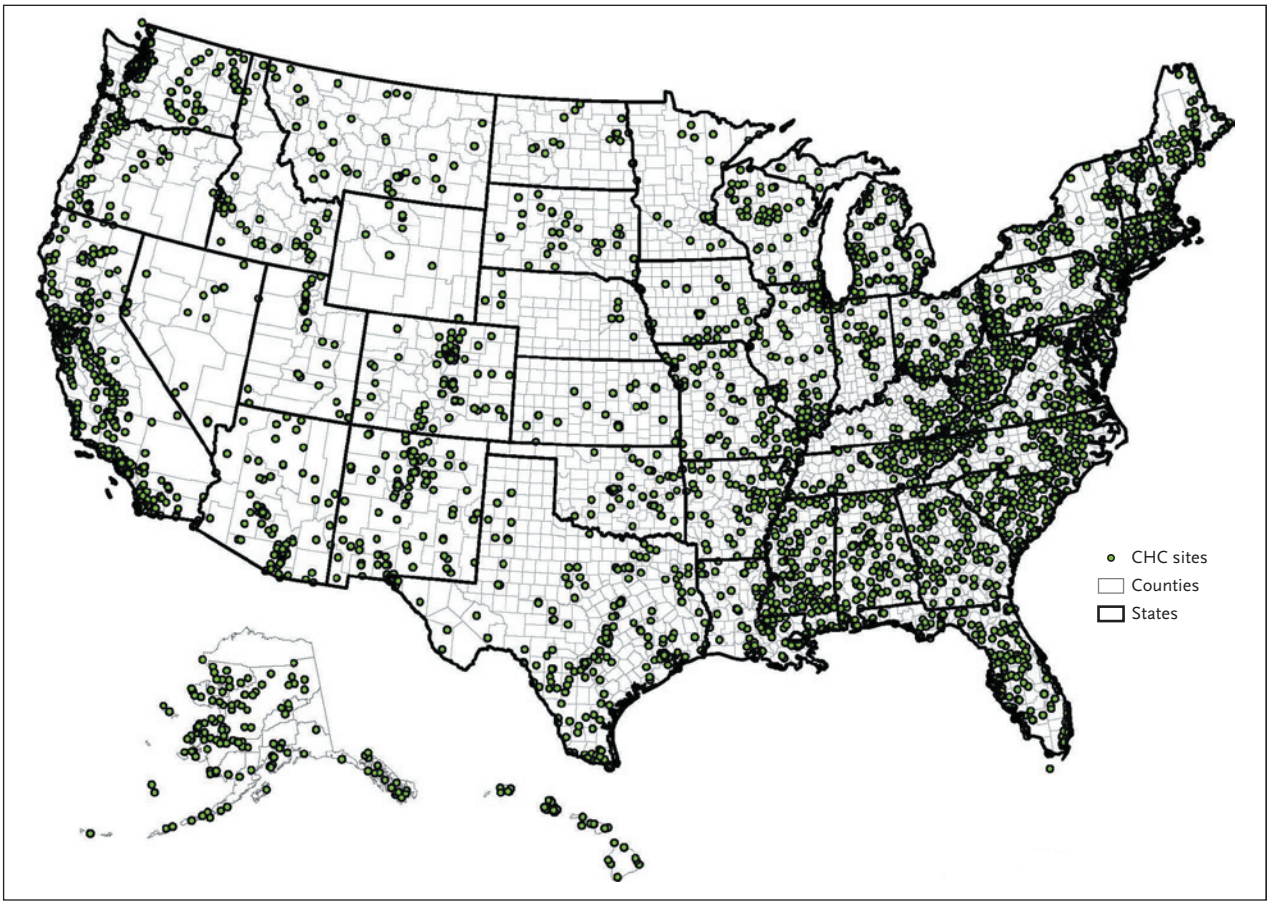

Figure 1. Nationwide Distribution of Community Health Center Sites, 2008.

Data are from the 2008 Uniform Data System, prepared by the Robert Graham Center, April 2010.

Congress and President Barack Obama, by way of the American Recovery and Reinvestment Act of 2009 (ARRA), directed an additional one-time appropriation of $2 billion to the CHCs. Commensurate support ($300 million) has been extended to the National Health Services Corps (NHSC), an indispensable CHC partner responsible for recruiting and placing health care professionals in "health professional shortage areas" (HPSAs). An additional $47.6 million has been dedicated to primary care training programs for residents, medical students, physician assistants, and dentists. Most important, the recently passed health care reform law appropriated $12.5 billion for the expansion of the CHCs and the NHSC over 5 years, beginning in 2011. In their new steady state, with 15,000 additional primary care providers in HPSAs, the CHCs may well be entrusted with the primary health care of 40 million Americans — thereby ensuring that most medically disenfranchised Americans receive care. Finally, the health care reform law established a new Title III grant program ($230 million over 5 years) for community-based teaching programs and authorized a new Title VII grant program for the development of primary care residency training programs in CHCs.

The CHCs have demonstrated their ability to deliver affordable, comprehensive, coordinated, patient-centered care in facilities physically proximate to the patients who need it.[2] CHCs pride themselves equally on providing community-accountable and culturally competent care aimed at reducing health disparities associated with poverty, race, language, and culture. Indeed, CHCs offer translation, interpretation, and transportation services as well as assistance to patients eligible to apply for Medicaid or the Children's Health Insurance Program (CHIP). With multidisciplinary teams replete with primary care providers, behavioral health professionals, dentists and dental hygienists, pharmacists, and health and nutrition educators, as well as social workers, CHCs are well equipped to address acute care challenges as well as a broad

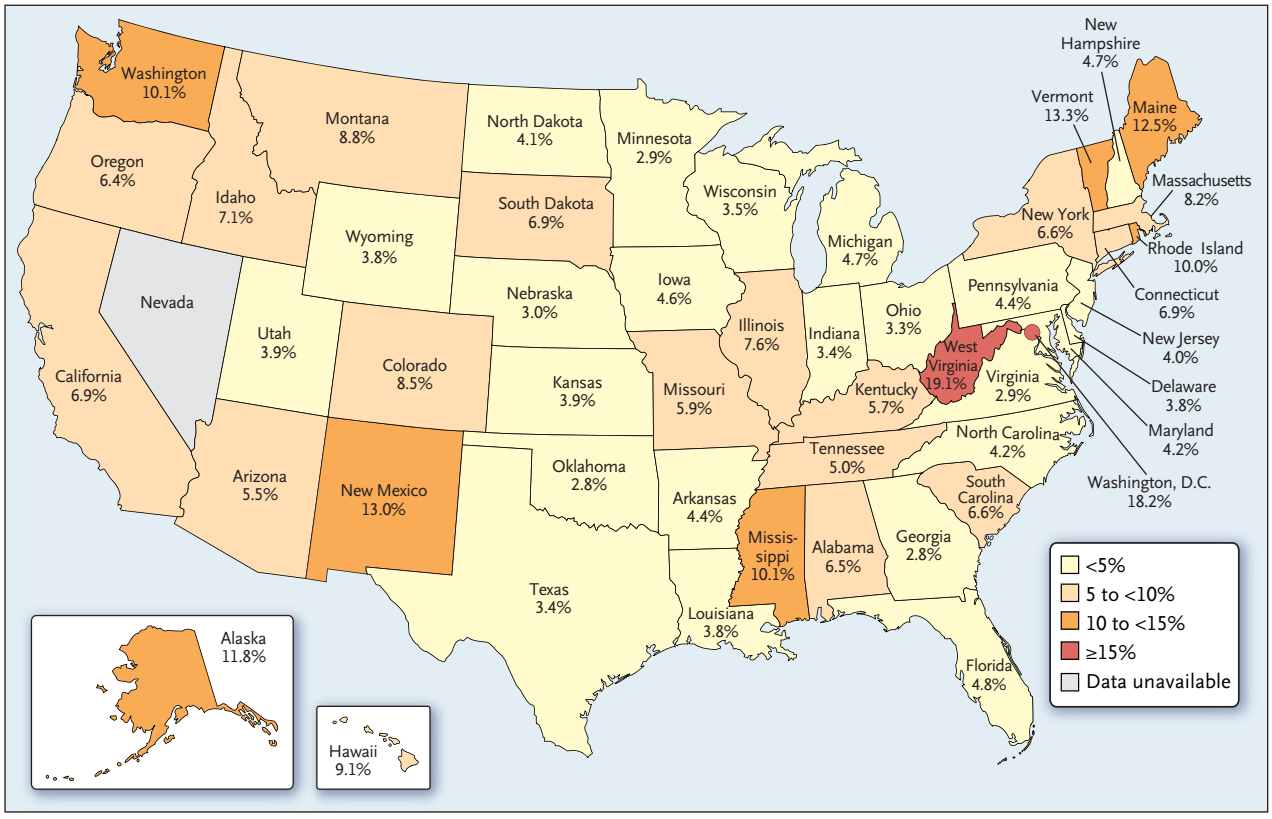

Figure 2. Percentage of the Population of Each State Served by Community Health Centers, 2008.

Data on total numbers of CHC patients in each state are from the National Association of Community Health Centers, which based these numbers on the 2008 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services; data on the population in each state are from the U.S. Census Bureau.

swath of needs for coordinated disease prevention and health maintenance. Perhaps most important, CHCs offer high-quality health care, as assessed against that provided in other health care settings and national benchmarks.[3]

Challenges abound, of course. The recent economic downturn has resulted in a further swelling of the ranks of the uninsured. Belt tightening in state Medicaid and CHIP programs is placing ever-growing pressures on CHCs' financial sufficiency. Other challenges include ongoing needs for infrastructure capital and reimbursement policies that undervalue primary care services. Perennial challenges in recruiting and retaining providers, resulting in part from outdated noncompetitive compensation schemes, continue to hinder optimal staffing of CHCs with primary care practitioners. Equally unrelenting is the difficulty of securing specialty referrals in the face of geographic isolation and increases in the numbers of specialty providers who choose not to care for the uninsured or not to participate in Medicaid- or Medicare-sponsored health plans.[4] In addition, many CHCs have yet to broadly embrace health information technology. Going forward, the health care reform law and the ARRA are expected to ameliorate some of these challenges by reducing the rolls of the uninsured, offering capital for the renewal and expansion of the CHC infrastructure, enhancing the compensation of primary care providers, and underwriting and facilitating the adoption of information technology.

Yet as the United States seeks to optimize primary care, in part by advancing the concept of the "patient-centered medical home" (PCMH), some of the key values of the CHC model — a whole-person orientation, accessibility, affordability, high quality, and accountability — could well inform tomorrow's primary care paradigm for all Americans. Despite the challenges they face, the CHCs are already built on a premise resembling that of the PCMH, a holistic concept encompassing highly accessible, coordinated, and continuous team-driven delivery of primary care that relies on the use of decision-support tools and ongoing quality measurement and improvement. The compatibility

between the CHC and PCMH approaches was not lost on the Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute when they decided to sponsor a demonstration project called the Safety Net Medical Home Initiative, which seeks to help primary care safety-net clinics qualify as high-performing PCMHs.[5] If successful, this demonstration project may well yield a replicable national model for implementing the PCMH that could have an impact far beyond that of the extant CHC network.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp1003729) was published on April 28, 2010, at NEJM.org.

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The Cost Implications of Health Care Reform

Jonathan Gruber, Ph.D.

On March 23, 2010, President Barack Obama signed into law the most significant piece of U.S. social policy legislation in almost 50 years. There is little disagreement over the premise that the Patient Protection and Affordable Care Act (ACA) will dramatically expand health insurance coverage. But there is concern about its implications for health care costs. These concerns have been heightened by a recent report from the actuary at the Centers for Medicare and Medicaid Services (CMS), which shows that health care reform will cause an expansion of national health care expenditures.

The ACA includes a major investment in the affordability of health insurance for low-income families: under the law, all individuals with family incomes below 133% of the poverty line (i.e., below about $30,000 for a family of four) are eligible for free public insurance, and there are tax credits to help make health insurance affordable for families with incomes of up to 400% of the poverty level. At the same time, the ACA incorporates a number of fund-raising mechanisms, including a reduction in the overpayment to Medicare Advantage insurers, a reduction in the update factor for Medicare hospital reimbursement, an increase in the Medicare tax (and extension to unearned income) for high-income families, an assessment on employers whose employees use subsidies rather than employer-sponsored insurance, and the "Cadillac tax" (an assessment on the highest-cost insurance plans). The Congressional Budget Office estimates that these revenue increases will exceed the new spending, reducing the federal deficit by more than $100 billion in the first decade and more than $1 trillion in the second decade.[1]

Some have questioned the likelihood of this deficit reduction, claiming, for example, that the numbers are "front loaded" because some of the revenue-raising mechanisms begin before 2014, whereas the majority of spending doesn't start until after 2014. But the trend under the law will actually be toward larger deficit reduction over time; indeed, the reduction in the deficit is expected to increase in the last 2 years of the budget window. The cuts in spending and increases in taxes are actually "back-loaded," with the revenue increases rising faster over time than the spending increases, so that this legislation improves our nation's fiscal health more and more over time.[1]

Others have raised the possibility that the cuts that provide much of this financing will never take place, and they point to the physician-payment cuts required by the Balanced Budget Act of 1997, which have been repeatedly delayed by Congress. But as Van de Water and Horney have highlighted,[2] Congress has passed many Medicare cuts during the past 20 years, and the physician-payment cut is the only one that has not taken effect.

With U.S. health care spending already accounting for 17% of the gross domestic product (GDP) and growing, there is also concern about policies that increase this spending. And, as the CMS actuary points out, the ACA will increase national health care expenditures. At the peak of its effect on spending, in 2016, the law will increase health care expenditures by about 2%; by 2019,