

The Future Role of Community Health Centers in a Changing Health Care Landscape

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Abstract: The Affordable Care Act provides an opportunity to reinvent the health care delivery system to make it more accessible, patient-centered, and comprehensive, with an emphasis on prevention and primary care. This article explores how community health centers are well positioned to implement the Act's provisions, by expanding access to high-quality, affordable care to millions.

Key words: *affordable care act, community health centers, primary care*

THE history of the Community Health Centers program dates back to 1965, when teachers working at early childhood learning centers in Mississippi and Alabama funded by the then-new Head Start program, the first and still-enduring effort of President Johnson's "War on Poverty" initiative, realized that they had a problem. They could not begin to provide education services to their students, they told federal program managers in Washington, District of Columbia, until the students' profound, untreated health care needs were met. As Dr Jack Geiger, a founder of the first Community Health Center, tells it, when the War on Poverty leaders such as Dr Julius Richmond and OEO Director Sargent Shriver suggested that the Head Start teachers use some of their grant funds to purchase health care from local physicians, they were shocked to learn that the mostly white med-

ical establishment in those states would not treat the mostly black students at any price. It was then that they realized a whole new system of care would be needed if America's poor, minority, and disenfranchised were to ever have a chance at realizing the American dream.

Just as the health centers program was born at a time of social reform, health centers will now play a major role in a post-health reform landscape. The enacted health reform legislation, the Affordable Care Act (ACA), seeks to alter the fragmented American health care system to provide access to affordable quality health care, by expanding insurance coverage and by experimenting with initiatives to integrate and improve care. The ACA, a catalyst driving toward a more integrated delivery system, positions health centers to play a critical role in America's future health care system. As they considered the changes needed to reform health care, legislators saw the unique value health centers have embodied over 45 years, and decided it was a worthy place to invest new resources to help meet the primary care needs of the nation. The ACA provides new resources that will allow health centers to serve up to an additional 20 million people

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over the next 5 years, and also provides funds for additional primary care providers to stem the primary care provider shortage.

HISTORY OF COMMUNITY HEALTH CENTERS

America's health centers owe their existence to a remarkable turn of events in US history, and to a number of determined community health and civil rights activists who fought more than 45 years ago to improve the lives of Americans living in deep poverty and in desperate need of health care. Acting on the opportunity presented by President Johnson's War on Poverty effort, Dr Geiger and other health care pioneers submitted proposals to the federal Office of Economic Opportunity to establish health centers in medically underserved inner-city and rural areas of the country based on a unique model of health care that Geiger had studied in South Africa (Davis & Schoen, 1978; Lefkowitz, 2007).

While local clinics in many communities predated this new effort, they generally were not linked together with one another and were typically stymied both by the limits of local funding sources and by often-powerful political opposition; organized medicine, for example, strenuously resisted any attempts to allow these clinics to furnish anything beyond basic preventive health care.

By contrast, the new health center model combined the resources of local communities with federal funds to establish local community-based health care systems in both rural and urban areas all across America. It has proven to be a formula that not only empowers communities to establish and direct health services at the local level via consumer-majority governing boards but also demonstrates that affordable and accessible health care can produce significant, tangible benefits.

Today, health centers serve as the medical and health care home for 20 million people nationally—a number that is quickly growing. Health center patients are among the nation's most vulnerable populations—people who, even if insured, would nonetheless remain iso-

lated from traditional forms of medical care because of where they live, who they are, the language they speak, and their higher levels of complex health care needs. As a result, patients are disproportionately low-income, uninsured or publicly insured, and minority.

Nearly all patients are low-income, with 70% of health center patients having family incomes at or below the official Federal Poverty Level. Patients also tend to be members of racial and ethnic minority groups. At the same time, 38% of health center patients are uninsured, and another 37% depend on Medicaid or the Children's Health Insurance Program. In addition, about half of health center patients reside in rural areas, while the other half tend to live in economically depressed inner-city communities (Bureau of Primary Health Care, 2009).

PREVIOUS INVESTMENT IN HEALTH CENTERS

Health centers received a \$2 billion investment from the American Recovery and Reinvestment Act of 2009 (ARRA), to cover the costs of caring for new patients and the capital expenditures required to meet that need. This historic level of funding included \$500 million to expand health center services, while the remaining \$1.5 billion was allocated for facility construction and renovation, equipment, and the acquisition of health information technology. This infusion has enabled health centers to meet increased demand for patient services in a variety of ways, including extended hours of operation, hiring more staff, adding new services, and even opening new locations and acquiring needed quality improvement tools.

With the new ARRA funding, health centers have rapidly expanded access to care and generated economic benefits for the low-income communities they serve. By the end of June 2010, 15 months after receiving the new funds, health centers are serving an additional 2.7 million patients—93% of their 2-year target. In that same time period, health centers have served more than 1.5 million uninsured individuals, which include existing health center patients who have lost their

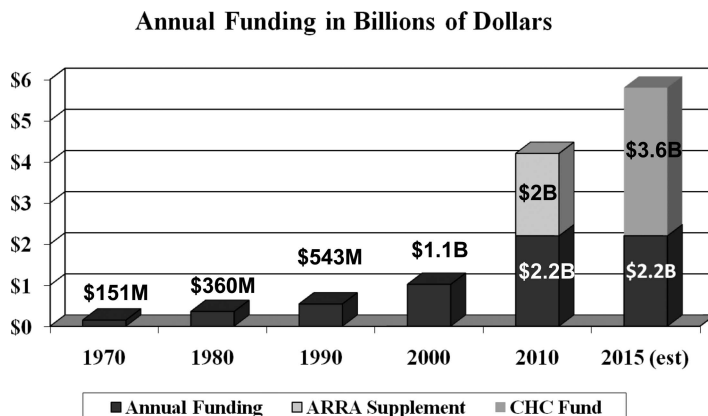


Figure 1. Growth of health centers: 1970–2015.

insurance coverage and new patients who are uninsured or have become uninsured. They were quick to create or save more than 8000 jobs in their economically hard-pressed communities over that period (Bureau of Primary Health Care, 2010).

HEALTH CENTERS AND HEALTH REFORM

The ACA establishes a Community Health Center Trust Fund of \$11 billion over a 5-year period providing funding for health centers as they continue to expand access to communities. The Act will transform the health landscape for Community Health Centers and for the patients they serve. The sweeping reform law is focused on 2 major challenges: reshaping the system of insurance coverage, and reinventing the health care delivery system.

Medicaid

Insurance coverage reform will change the way people obtain coverage. Most importantly, the ACA expands Medicaid to all individuals younger than 65 years with incomes up to 133% of the Federal Poverty Level, or \$24 352 for a family of 3 in 2010, without categorical restrictions. This expansion is expected to insure an additional 16 million people. States are required to maintain their current Medicaid and Children's Health Insurance Program eligibility levels for chil-

dren until 2019 and their current Medicaid eligibility rules for adults until new health insurance exchanges are fully operational in 2014.

Today, more than two-fifths of the patients served at health centers are uninsured; many of them will soon gain Medicaid coverage. We estimate that the percentage of uninsured served in CHCs will decrease from 38 to 22 in the next 5 years, while the proportion of patients with Medicaid coverage will rise from 34% to 45%. If recent trends in declining charity care among private practice physicians and hospitals continue, those who remain uninsured will likely have fewer places to turn for care and are expected to seek care at health centers in even greater numbers.

Exchanges

Health reform establishes health insurance exchanges for individuals and small businesses who do not currently have access to affordable coverage. These exchanges will link individuals and families to insurance coverage for up to 25 million low- and moderate-income people who are not eligible for Medicaid. The ACA sets a minimum benefit package for all plans sold through the exchanges that emphasize coverage of preventive and early primary health care. The law will also require insurers operating in the exchanges to permit full participation by safety-net providers in exchange plans, requiring them to contract with health centers and other

safety net providers. This will ensure that, as uninsured patients gain coverage through the new insurance exchanges, the plans covering them do not exclude low-income communities and individuals most in need of access to care and the providers who serve them. As a result of the exchanges, health centers will serve fewer employer-insured patients and more with coverage from the newly created exchanges. However, these patients will face higher out-of-pocket costs and many will need help paying for their care. The health centers' tradition of discounting regular charges to low-income people to make out-of-pocket costs more affordable will play an essential role in eliminating a crucial barrier to care.

Medicare

While the ACA does not expand Medicare coverage to new populations, it expands Medicare benefits to include new preventive care benefits, and it begins to close the prescription drug coverage gap known as the "donut hole." It also revises many Medicare payment policies and will launch demonstrations to lower costs and improve the value of care.

With an aging population, health centers can expect their Medicare patient population to grow significantly in the coming years. Both those just younger than 65 years and patients with chronic conditions are the fastest growing groups of health center patients (NACHC, 2009c). Since 1996, the number of pre-Medicare patients served by health centers has grown 13 times faster than the national low-income pre-Medicare population (NACHC, 2009c). The ACA will expand the scope of services provided at health centers to include all preventive services covered under Medicare, and it revises the Medicare payment system for health centers to improve payment levels.

The Medicaid and private insurance expansions will lead to a surge in demand for primary health care, especially among those living in medically underserved low-income communities, making vitally important the law's investments in expanded service delivery capacity for the newly insured. At the

same time, an estimated 23 million will remain uninsured, even after reform is fully implemented. Many of these individuals, which include undocumented immigrants (one-third of the total) and others who either qualify for an exemption from the mandate on financial grounds or who choose to pay a penalty rather than comply with the mandate, will likely depend on health centers as their principal source of care (Congressional Budget Office, 2010). It should be noted, however, that even after their significant growth under the reform law, health centers are expected to provide care to approximately 8 million uninsured persons, only 1 of every 3 remaining uninsured Americans; thus, it will be vital that other providers continue furnishing uncompensated care to other uninsured individuals.

DELIVERY SYSTEM REFORM

With US health care spending consuming 17% of the national economy and expected to grow (Truffer et al., 2010), health reform provides an opportunity to transform the delivery system to promote quality and stimulate cost savings. The law includes new programs and demonstration projects to promote patient-centered, quality, primary care delivery in a medical home setting, with the potential to impact the organization, structure, and function of the health care delivery system. Many of these new programs could benefit health center patients and health centers that are able and willing to participate. Several major demonstration programs have the potential to integrate care and provide better care coordination, including medical homes and accountable care organizations.

Medical Homes

A medical home is a patient- and family-centered source of care that offers regular, continuous primary and preventive care for the people it serves. Medical homes have been shown to benefit patients by preventing sickness, managing chronic illness, mitigating disparities, and reducing the need for avoidable, costlier care such as

emergency department visits and hospitalizations (Rosenthal, 2008; Starfield & Shi, 2004).

There are several ways the ACA attempts to integrate the medical home concept in the system, from grants to demonstration programs. Two grant programs seek to promote better coordination of services: first, a grant for medication management services to assist pharmacists treating patients with multiple chronic diseases and those who take several, or high-risk, prescribed medications; and second, grants to establish community health teams that collaborate with providers in the community to support patient-centered primary care. It also creates a Medicaid State Plan Option with enhanced Federal matching funds to promote health homes and integrated care. Under this option, enrollees with 2 or more chronic conditions may designate a qualified provider as their health home. Teams of qualified providers can include community health centers and other provider groups. The law also establishes a Medicare demonstration program to test a model of care that uses physician and nurse practitioner directed home-based primary care teams.

Accountable Care Organizations

Under the law, groups of providers who voluntarily meet certain criteria, including quality measurements, may form Accountable Care Organizations (ACOs) and share in the cost savings they achieve for the Medicare and Medicaid programs. An ACO is a provider-led organization whose members engage in joint decision-making, and which manages the full continuum of care and is held accountable for the overall costs and quality of care for a defined population. ACOs come in many forms and sizes—from large, integrated delivery systems to physician-hospital groups, multispecialty practice groups, group physician practices, and health center networks. These groups are held accountable to achieve measured quality improvements and reductions in the spending growth rate (Shortell & Casalino, 2008). ACOs will require a strong primary care core foundation to succeed in redirecting the US delivery system toward reduced cost growth and improved quality

(Rittenhouse et al., 2009). Community Health Centers will be able to play a prominent role, serving as the foundation upon which ACOs need to be grounded to achieve the goal of cost-effective care, as they do today in model systems such as Denver Health in Colorado and the Marshfield Clinic in Wisconsin.

WORKFORCE

To give the primary care system the tools needed to respond to the insurance expansions identified earlier, the health reform package strengthens the pipeline of primary care professionals by expanding training opportunities and placement incentives for locating in underserved areas. One key provision provides \$1.5 billion in new, dedicated funding for the National Health Service Corps over 5 years in addition to that program's existing discretionary funding. The new funding, in combination with the prior investment from ARRA, will place an estimated 16 000 primary care providers in provider-short areas by 2015, over and above the 4000 clinicians placed by the NHSC prior to the new funding, and who will continue to receive NHSC support (U.S. Department of Health and Human Services, 2010).

In addition, the ACA creates 2 new programs designed to sustain and further develop teaching health centers (defined as community-based, ambulatory care centers that operate a primary care residency program), for which health centers and other ambulatory care providers can apply. The first is a Title VII grant program authorized at \$25 million in 2010, \$50 million in 2011, and \$50 million in 2012. If funded by Congress, this new program would provide awards of up to \$500 000 for each teaching health center for up to 3 years. The second is a Title III program that funds payments to teaching health centers for their direct and indirect teaching costs; that provision is directly appropriated at \$230 million for FY2011-FY2015 and is available for health centers that sponsor or hold an accreditation certificate for the residency program (direct appropriation means the funding is guaranteed; authorized funding

is subject to the vagaries of the appropriations process).

Also important will be new and expanded training of nonphysician providers such as nurse practitioners, nurse midwives, and physician assistants. Health and Human Services Secretary Sebelius has demonstrated recognition of this fact recently by dedicating key preventive and public health funding toward expanded training of these provider types. Today, health centers utilize nearly 6000 such providers, in addition to the 9000 physicians they employ.

THE FUTURE ROLE OF HEALTH CENTERS

Today's Community Health Centers stand as a proven primary care model. Both the Institute of Medicine (IOM) and the Government Accountability Office (GAO) have recognized health centers for their effective and efficient delivery of primary care (GAO, 2003; IOM, 2003). Under one roof, health centers provide comprehensive patient-centered health care and enabling services, and they engage in quality improvement initiatives and regular community-wide needs assessments. They embrace a team-based approach to preventive and primary care that has improved screening rates and outcomes for their patients and reduced health care disparities (Chin et al., 2007; Landon et al., 2007). Moreover, evidence shows that health centers provide care of equal or superior quality compared with other primary care providers (Eisert et al., 2008; Hicks et al., 2006; Shin et al., 2008).

Health centers can transform the delivery system because they operate at the crossroads of medical care and public health. Health centers improve access to timely screening and preventive services for patients who would not otherwise have access to them. For example, health center patients do not experience disparities by race, ethnicity, or insurance status in receiving preventive services (O'Malley et al., 2005). Hispanic and African American health center women needing mammograms and pap smears are more likely to receive them than their counterparts nationally (Politzer et al., 2001; Shi & Stevens 2007).

Care received at health centers is ranked among the most cost-effective anywhere. Health centers' average annual total cost of care is \$600 per patient (Bureau of Primary Health Care, 2009) or about \$1.64 a day per patient served, even though health centers include an array of enabling services such as case management, transportation, translation, and health education not provided in most other primary care settings. Total medical care expenses for health center patients are 24% lower (\$1093 per person) compared with patients seen elsewhere (Ku et al., 2010). Most health centers also provide dental, behavioral health, and pharmacy services.

Health center per patient costs grow more slowly than national per capita health expenditures. A George Washington University study concluded that an \$11 billion investment in additional federal grants for nonprofit community health centers from 2011 to 2015 will reduce total expected national medical costs by more than \$122 billion over the next 5 years, including savings of more than \$55 billion in federal Medicaid spending and more than \$30 billion in reduced state Medicaid expenditures (Ku et al., 2010).

Quality improvement has long been championed in community health centers. Since 1998, nearly 90% of community health centers have participated in a federal initiative known as the Health Disparities Collaborative, focused on improving care for individuals with chronic medical conditions and using a chronic care model that identifies and tracks which patients need care for each different health condition, applies the most current clinical knowledge and practice guidelines, and actively involves patients in their own care, helping them learn about their condition and setting goals for their health improvement (Chin, 2010). By sharing best practices, they have narrowed disparities in asthma and diabetes care. The collaborations provide health centers with learning experiences to apply best practices to adapt, share, and generate knowledge about what works and what does not, and to spread change throughout their health centers and to others.

Health centers meet or exceed national practice standards for chronic condition treatment. They provide a wealth of knowledge regarding improving care for medically underserved patients. In fact, the IOM and the GAO have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV (GAO, 2003; IOM, 2003). For example, health centers have dramatically lowered cholesterol levels in their patients (Huang et al., 2007). Health centers' efforts have led to improved health outcomes for their patients, reducing health gaps for racial and ethnic minorities, while lowering the cost of treating chronically ill patients.

Health centers are also credited with reducing hospitalizations, inpatient days, and emergency department use, generating significant returns on investment while improving community health. Their Medicaid beneficiaries were 11% less likely to be hospitalized and 19% less likely to use the emergency department for preventive conditions than Medicaid beneficiaries seen by other providers (Falik et al., 2006).

Health centers have the experience to rapidly use funds and create jobs in their community. They are an economic catalyst causing a "ripple effect" in their communities. Health centers employ people in their communities and purchase goods and services from local businesses spurring additional economic activity in their communities. Their employees purchase household and other goods further triggering economic activity.

Last year, health centers' total economic impact was \$20 billion. Beyond fueling economic activity, they also produced 189,158 jobs in the nation's most economically challenged neighborhoods. By 2015, health centers will generate \$53.9 billion in total economic activity and create more than 284,323 additional full-time equivalent jobs due to the ACA. This means that every \$1 million in federal funding for health center operations yields \$1.73 million in return (NACHC & Capital Link, 2010).

CHALLENGES

Health reform creates investments in health centers that enhance their role in the health care delivery care system. However, they need additional tools to continue expanding access to care for medically underserved patients. Those tools include sustainable federal funding, adequate Medicaid payments, continued state investment, continued investment in the primary care workforce, capital infrastructure, as well as additional specialty care and electronic record-keeping capabilities.

First, sustainable federal funding is essential to increase access. The ACA creates a \$11 billion trust fund over 5 years, \$9.5 billion of which to enable health centers to expand their operational capacity to serve 40 million patients and to enhance their medical, oral, and behavioral health services by 2015. At that point, health centers will serve 1 of 3 uninsured individuals and 2 of 3 individuals living in poverty (NACHC, 2010). Yet, even before enactment of health reform, 60 million persons were considered "medically disenfranchised" because of local physician shortages that prevented adequate access to primary care (NACHC, 2009a). With sustainable funding, health centers will continue expanding access to care for more medically disenfranchised individuals. While health reform attempts to secure health centers' operational margins, third party payments from both public and private payers do not always keep up with the rise in costs. Payment shortfalls divert health centers' resources away from the uninsured who will have fewer places to seek care. Sustainable funding is essential to allow health centers to focus on direct patient care.

Second, Medicaid will become a larger player in health reform. As the largest insurer of health center patients, adequate Medicaid payments are critical to their financial well-being. Medicaid represents 37% of total revenue for health centers—the largest of any single source—and is proportional to the percentage of patients with Medicaid coverage (Bureau of Primary Health Care, 2009). Medicaid reimburses health centers on a per-visit basis that ensures that grant revenues can be

dedicated to care for the uninsured rather than subsidizing care for Medicaid patients. As a result, health centers have been able to more than double the number of uninsured patients they serve over the past 10 years (NACHC and Capital Link, 2010). Given the relationship between health centers and Medicaid, changes in one of those programs profoundly impact the other.

Third, states play an important role in sustaining health centers and must continue to invest in them. Unfortunately, many states are slashing funding for health programs in the face of budget shortfalls, and some have relied on federal stimulus and health reform funding to justify cuts that thwart health centers' expansion efforts and threaten capacity (NACHC, 2009b).

Fourth, continued investment in the primary care workforce is crucial. While health reform provides funds to expand the NHSC and to develop and operate teaching health centers, multifaceted national and state initiatives are needed to strengthen the pipeline of primary care professionals, even before they begin formal medical education, to expand training opportunities and placement incentives for locating in underserved areas, and to ensure adequate reimbursement for primary care services. Policies also need to be developed to provide short-term solutions to shortages while the primary care pipeline is developed.

Fifth, health centers need additional financing to invest in capital infrastructure. Health centers will need \$10.5 billion between now and 2015 to sustain, renovate, or upgrade existing facilities (NACHC, 2008). Health centers are unable to invest in capital infrastructure, given slim operating margins, low cash reserves, complex and diverse funding streams, and lack of endowments making them difficult credit customers for conventional private lenders. Health centers must leverage other financing sources to obtain loans and mortgages. Of the \$11 billion trust fund to health centers, \$1.5 billion is dedicated for capital financing. These resources must remain available to leverage the private sector to ensure that health centers have the human and tech-

nological capacity to reach the millions who live without access to high-quality primary care today.

Finally, health centers are the epitome of patient-centered medical homes. Many health centers possess capacity in key medical home domains identified by the National Committee for Quality Assurance—patient tracking and registry functions, test tracking, referral tracking, enhanced access and communication, and performance reporting. Nearly 90% of surveyed health centers possess at least 3 of the 5 domains.

Still, there are deficiencies in care coordination and adoption of advanced HIT systems. Nearly all health centers reported difficulty securing specialty care for their uninsured patients, and 71% and 49%, respectively, reported having difficulty finding specialty care for their Medicaid and Medicare patients (Doty et al., 2010). In addition, nearly 40% of health centers have electronic medical records, which parallels the use by private-practice primary care physician (Doty et al., 2010). Achieving the capacity for more advanced HIT—electronic ordering prescriptions and tests, creating and maintaining patient registries, tracking patients and tests, and providing alerts or prompts—remains highly variable. On the other hand, significant progress has been achieved since 2006, when only 25% showed electronic health record capacity (Shields et al., 2007).

CONCLUSION

Health centers have 45 years of experience providing high-quality, cost-effective primary care to underserved communities. Health centers were able to quickly, efficiently, and successfully target their services where needed, as demonstrated with ARRA. Health center expansion will magnify their contributions to improve access and community health, while generating significant economic returns to local, state, and national health care delivery systems.

Over the next decade, the US health care system will experience a thorough transformation, from the current costly and

fragmented system to one that promotes patient-centered and integrated, cost-effective care. The ACA jump-started this process by expanding access to affordable health insurance coverage and quality care for millions more Americans. The new law's investment in health centers primes them to be national leaders in comprehensive, community-based,

and cost-effective quality health care. Just as health centers constituted a key answer to the country's healthcare dilemmas of the past and have proved to be a central part of addressing our most pressing problems of today, it is clear that health centers will remain at the core of America's essential response to the most crucial healthcare needs in its future as well.

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