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Implementing Health Care Reform: Building on New Hampshire's Primary Care Foundation New Hampshire's Community Health Centers and Medicaid Expansion

Purpose

To provide information about the unique role of the Community Health Centers and the positive impact Medicaid expansion would have on access to health care in New Hampshire. Bi-State Primary Care Association and the New Hampshire Community Health Centers support the Medicaid expansion under the Affordable Care Act and encourage restoration of $4 million to the primary care contracts that support Community Health Centers.

Medicaid Expansion to Cover the Uninsured

Bi-State Primary Care Association and NH Community Health Centers support the expansion of Medicaid to eligible uninsured populations under the Affordable Care Act. In a recent study done by the Kaiser Foundation, nearly 20,000 children and 127,000 non-elderly adults in NH were uninsured. The Lewin Group estimated there will be 170,000 people uninsured by 2014. In addition, there are over 37,500 individuals living below 100 percent of the Federal Poverty Level without health insurance coverage, and 13,400 individuals with incomes between 100 and 139 percent poverty level. The expansion of Medicaid to individuals living at 138 percent of the poverty level will have a drastic positive impact on our uninsured population. In its first report prepared for the NH Department of Health and Human Services, the Lewin Group estimated that more than 62,000 people will be eligible for coverage if Medicaid is expanded. We understand that a percentage of the State's population will remain without health insurance even after the implementation of the Affordable Care Act, and therefore, a percentage of the cost of serving those patients will remain uncompensated.

The Lewin Group estimates the federal government will give NH $2.5 billion in federal matching funds by 2020, while the cost to the state is approximately $85.5 million over the same time period. The people of NH depend on Community Health Centers for access to primary and preventive care, regardless of their insurance coverage or ability to pay.

Federally Qualified Health Centers: NH's Safety Net Providers

Federally Qualified Health Centers are nonprofit health centers providing primary and preventive care in underserved urban and rural communities through a comprehensive, patient-centered model of care.

As safety net providers, FQHCs are required to provide primary health care services, which include, but are not limited to, diagnostic laboratory and radiological services, preventive dental services, preventive health services, cancer screenings, well-child checkups, immunizations, emergency medical services, pharmaceutical services, patient case management services,

outreach, transportation, interpretation, and educational services.[1] In order to qualify as an FQHC, the organization must demonstrate that there is a shortage of personal health services in its service area, and each FQHC must provide services unique to the community they serve.[2] Additional services may include behavioral health services, recuperative care services, or environmental health services.[3]

FQHCs maintain staffing levels of physicians, dentists, pharmacists, clinical social workers, physician assistants, nurse practitioners, nurses, medical assistants, and other professional and clinical staff to provide team-based "primary, preventive, enabling health services and additional health services as appropriate and necessary" to underserved populations.[4] An FQHC is required to maintain business hours and locations that assure accessibility and meet the needs of its patient population and coverage for medical emergencies.[5]

FQHCs provide a community-based approach to health care. Each FQHC must have a governing board with a majority of the positions filled by patients of the FQHC.[6] The composition of the board must be representative of the demographics of patients served by the FQHC.[7] The remaining board members may not earn more than 10 percent of their income from the health care industry.[8]

Not only do FQHCs provide comprehensive primary and preventive health care in communities throughout the state, they also provide jobs that result in direct and indirect economic impact. A 2009 Capital Link report demonstrated that eight FQHCs in New Hampshire generated an economic impact of $84.5 million and created 1,116 full-time jobs.

17 Community Health Centers in New Hampshire

Of the 17 Community Health Centers in NH, 11 are Federally Qualified Health Centers (a subset of Community Health Centers) operating 19 health center sites, and one is an FQHC Look-Alike operating two health centers.

Federally Qualified Health Centers:

1. Ammonoosuc Community Health Services in Franconia, Littleton, Warren, Whitefield, and Woodsville;
2. Charlestown Family Medicine in Charlestown;
3. Coos County Family Health Services in Berlin and Gorham;
4. Families First Health and Support Center in Portsmouth;
5. Goodwin Community Health in Somersworth;
6. Harbor Care Clinic serves the homeless in greater Nashua;
7. Health Care for the Homeless Program serves the homeless in greater Manchester;
8. Health First Family Care Center in Franklin and Laconia;

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[1] *Id*. at §254b(b)(1)(A)
[2] 42 USCS §254b(k)(2); 42 USCS §254b(a)(1)(B)
[3] *Id*. at §254b(b)(2)
[4] http://bphc.hrsa.gov/about/requirements/index.html#services1; 42 USCS §242b(k)(3)(I)
[5] 42 USCS §242b(k)(3)(A)
[6] http://bphc.hrsa.gov/policiesregulations/governance/index.html
[7] *Id*.
[8] *Id*.

9. Indian Stream Health Center in Colebrook
10. Lamprey Health Care in Newmarket, Raymond, and Nashua;
11. Manchester Community Health Center in Manchester; and
12. Mid-State Health Center (FQHC Look-Alike) in Bristol and Plymouth.

The following five Community Health Centers (non-FQHCs), also members of Bi-State Primary Care Association, provide primary and preventive care services to insured and uninsured populations in 13 communities around the state:

1. Child Health Services in Manchester serves at-risk children from low-income families in the greater Manchester area;
2. Concord Hospital Family Health Centers serves vulnerable residents in Merrimack and Hillsborough counties with sites in Concord and Hillsboro-Deering;
3. Planned Parenthood of Northern New England provides primary and reproductive health care services for women and men in Claremont, Derry, Exeter, Keene, Manchester and West Lebanon;
4. Weeks Medical Center's Rural Health Clinic serves portions of Coos and Grafton counties with sites in Lancaster, Groveton, and Whitefield; and,
5. White Mountain Community Health Center in Conway serves residents of Carroll County.

New Hampshire's 17 Community Health Centers provide primary care services to more than 122,000 people in hundreds of towns and cities throughout the state. More than 30 percent of their patients are uninsured.

80 Percent of Patients Live Below 200 Percent of Federal Poverty Level

In 2011, 53 percent of the patients treated by NH FQHCs had incomes at or below 100 percent of the Federal Poverty Level, which is less than $11,000 for a single person. A total of 80 percent of the patients live at or below 200 percent of the poverty level, according to the 2011 Uniform Data System State Rollup Report.

The self-reported data for Community Health Centers that are not designated as FQHCs show similar data; approximately 50 percent of their patients have incomes at or below 100 percent of poverty level, and nearly 80 percent are at or below 200 percent of poverty level.

Approximately 35,000 (29 percent) of the FQHC and Community Health Center patients were uninsured in 2011. Several FQHCs report that 40 or 50 percent of their patients are without health insurance. If the State expanded Medicaid to individuals up to 138 percent of poverty level, the number of uninsured patients treated at Community Health Centers will decrease, however, a large amount of uncompensated care will still need to be provided.

How Federally Qualified Health Centers Are Funded

In 2011, FQHCs reported that less than half (46 percent) of their revenue came from patients, including self-pay, commercial insurance, Medicaid and Medicare payments. The remaining revenue (54 percent) was generated by FQHCs through competitive grant applications for state, federal and foundation grant funds.

To qualify as an FQHC, certain Medicaid and Medicare criteria must be met.[9] If an FQHC meets these criteria, it is then eligible to receive funds pursuant to Section 330 of the Public Health Service Act (PHSA; 42 USCS §254(b)).[10] These funds are commonly called Section 330 grants. FQHCs receive grants pursuant to Section 330 based on the population that an FQHC serves.[11] In 2011, New Hampshire FQHCs received $8.9 million in Section 330 grants. The Secretary of the U.S. Department of Health and Human Services awards competitive grants to support the cost of operations for FQHCs, including purchasing and leasing buildings and equipment and staff training. In 2011, $11 million in competitively awarded one-time American Recovery and Reinvestment Act funds were invested in FQHCs for facility improvement and capital improvement projects.

Three FQHCs in NH are specifically funded to serve homeless populations, including: Health Care for the Homeless Program in Manchester, Families First Health and Support Center in Portsmouth, and Harbor Care Clinic in Nashua. As a condition of funding, FQHCs that serve the homeless are required to provide outreach, comprehensive primary care to homeless children and those at risk of being homeless.[12] These FQHCs must also provide substance abuse services as a condition of receiving Section 330 grant monies.[13] However, the State experienced an unprecedented reduction in public health funding: 17 percent, the second largest cut in the country.[14]

Medicaid Reimbursement Shortfall: $1 Million

In 2011, the Federally Qualified Health Centers billed the Medicaid program for $12.5 million for services rendered to Medicaid patients and they received $11.3 million in payment - leaving approximately $1 million dollars in uncompensated care.

In addition, there are essential services that are not covered by the Medicaid program that are sorely needed by Medicaid patients, including adult dental services, nutrition counseling, and substance abuse counseling. The FQHCs provide these services, but are not reimbursed for the expense.

Currently, the more Medicaid patients an FQHC serves, the more money they lose. Combined with the financial losses associated with a high percentage of uninsured patients, this is not a sustainable situation.

All combined, the Medicaid spend on patients served by FQHCs represents less than 1 percent of NH's Medicaid budget. This small investment in primary care helps to keep the cost of the Medicaid program down by diverting patients from emergency room care to the much more affordable care provided by Community Health Centers.

The Citizen's Health Initiative, Patient-Centered Medical Home pilot project recently released preliminary results that demonstrate cost-effective results when patients were served by a

[9] http://bphc.hrsa.gov/about/index.html
[10] http://bphc.hrsa.gov/about/index.html
[11] 42 USCS §254b(e)(1)(C)
[12] *Id*. at §254b(h)(1)
[13] *Id*. at §254b(h)(2)
[14] Robert Wood Johnson Foundation, "Ready or Not? Protecting the Public's Health from Diseases, Disasters, and Bioterrorism 2012," 16 (2012).

Federally Qualified Health Center. NH Community Health Centers provide the cost-effective, comprehensive, high-quality care needed for a healthy New Hampshire.

State Primary Care Contracts: $4 Million Budget Cut

The NH Community Health Centers, including all of the Federally Qualified Health Centers, contract with the NH Department of Health and Human Services, Division of Public Health Services, to provide office-based primary care services to populations in need within their service area. The contract scope of services requires the Community Health Centers to provide primary care, breast and cervical cancer screening, reproductive health services, child and adolescent care, screening and treatment of sexually transmitted infections, substance abuse services, immunizations, and prenatal genetic screening.

In addition, Community Health Centers must coordinate wherever possible with other organizations to provide services that enable their patients to access health care, such as transportation assistance and interpretation. Community Health Centers are encouraged to integrate mental and behavioral health care, as well as oral health care, within their primary care setting. Pursuing national accreditation, such as Patient-Centered Medical Home designation, is also encouraged.

In SFY 13, approximately $2.5 million in primary care contracts was awarded to the 17 Community Health Centers in New Hampshire; a $4 million (42 percent) reduction in funding for fiscal years 2012 and 2013. This reduction impacted the Community Health Centers' ability to deliver patient services because they were unable to hire additional primary care providers to meet the demand from new patients; patient "wait times" increased and same-day appointments were more difficult to schedule; staff had to be reduced; and services such as nutrition counseling, case management, home care, and substance abuse counseling were cut back or eliminated.

When access to primary and preventive care is limited, patients turn to hospital emergency rooms for primary care issues and thus cost the Medicaid system much more than it would if patients were seen in a primary care setting. In order to accommodate the increased demand as a result of Medicaid expansion and health care reform, the state primary care contracts must be restored to ensure adequate access to cost effective, comprehensive, quality primary and preventive care.

Hospital Community Benefit Contributions Declined by $1.7 Million

Some Federally Qualified Health Centers receive community benefit contributions from their local community hospital(s) to support the services they provide within the community. In State Fiscal Year 2012-13, the budget reduced funding for the hospitals and that, in turn, resulted in a significant cut in community benefit contributions to FQHCs. To-date, the FQHCs have reported $1.7 million in reduced community benefit contributions.

Patient Sliding Fee Discounts and Bad Debt: $8.5 Million

Unlike other primary care practices, Federally Qualified Health Centers are prohibited from refusing a patient access to care based on an inability to pay for services.[15] If a patient is not insured by commercial insurance, Medicaid or Medicare, an FQHC must provide a sliding fee discount to the patient.[16] Charges are reduced on an income-based sliding fee scale, if the patient's income is less than 200 percent of the Federal Poverty Level. In 2011, NH FQHCs provided approximately $7 million in discounted care for uninsured patients. [17]

In 2011, NH FQHCs' wrote off in excess of $1.5 million in bad debt from uninsured and self-paying patients. Bad debt write-off may occur due to the inability to locate a person with outstanding debt, a patient's refusal to pay, or a patient's inability to pay even after a sliding fee discount has been applied. This has a negative impact on the financial health of the FQHCS and adds to the overall level of uncompensated care.

Financial Position Declines: 24 Days of Cash on Hand

The balance sheet indicators of the FQHCs in NH provide clear evidence of their financial vulnerability and the challenges they face in meeting anticipated increased demand with full implementation of the Affordable Care Act. The FQHCs recently reported the number of days of cash on hand declined to a new average low of just 24 days. This represents an amount that could cover approximately two payrolls, with half of the FQHCs only having enough cash to cover one payroll or less. This is in stark contrast to the Federal guidelines recommending FQHCs have 60-90 days cash on hand. The aggregate net margin for the FQHCs declined in 2011 to -1.31 percent.

The $4 million reduction to the primary care contracts, combined with $1.7 million reduction in community benefit contributions, $8.5 million in discounts and bad debt, and $1 million in unreimbursed Medicaid payments has resulted in a fragile primary and preventive care system in NH, as evidenced by the extremely low number of days of cash on hand.

Conclusion

With the financial constraints that Community Health Centers currently operate under, not only does the State need to address Medicaid expansion, it is also necessary to restore the primary care contracts. This would allow the Community Health Centers to serve the increase in patient populations expected with the implementation of the Patient Protection and Affordable Care Act.

[15] *Id*. at §254b(k)(3)(G)(iii)(1)
[16] *Id*. at §254b(k)(3)(G)(iii)(2)
[17] 2011 Uniform Data System (UDS)