

medicaid
and the **uninsured**

February 2000

**Health Centers' Role as Safety Net Providers
for Medicaid Patients and the Uninsured****Introduction**

In their nearly 35 years of existence, the community health centers, migrant health centers, and clinics that make up the federal health centers program have served as a vital link to health care for the most medically underserved areas of the nation. These centers care for the inner city and rural poor, migrant and seasonal farmworker families, homeless persons, and the uninsured, and are a critical component of service delivery in the Medicaid program. By law, health centers provide a broad range of primary and preventive health services at low or no cost to patients. Numerous studies have also found that, in addition to providing low-cost care, health centers provide high quality care—increasing preventive care, decreasing preventable hospitalization, and maintaining high patient satisfaction.¹

Federal grants help support the development of health centers and subsidize the cost of the health care they furnish to low income and uninsured patients. However, recent trends in the marketplace and in financing may undermine health centers' ability to continue to furnish care for both the uninsured and the Medicaid populations. For example, stagnant federal grant levels, Medicaid revenue losses, and a disproportionate share of patients with serious illnesses and disabilities all threaten the viability of the health center program.

In order to understand the role of health centers as safety net providers, as well as the potential impact of these trends, this issue paper provides an in-depth examination of federally-funded health centers. Using data from the Uniform Data System (UDS), a government-maintained system that collects extensive patient, revenue, and service data on a calendar-year basis from health centers that receive federal grants,² this issue paper profiles federally-funded health centers. It presents information on health center patients and revenue sources and analyzes similarities and differences both between health centers and private practices and among health centers.³ Health centers perform a unique role in the American health care system as nearly 85 percent of their patients are low-income and more than a third of their revenue comes from the Medicaid program, compared with less than 10 percent for most physician practices. The paper also reviews trends in health center patients and funding and concludes with an assessment of current challenges facing health centers.

Background

Program Evolution

The federal health centers program was established as a demonstration program by the Office of Economic Opportunity (OEO) in 1965. Initially called the Neighborhood Health Centers Program, it was conceived when other OEO programs encountered serious health problems and poor access to care among communities targeted for aid.⁴ Many of the founding principles of the program in 1965 remain as defining elements of the program today: programs used public funds to establish and operate comprehensive medical practices and social services in underserved areas and were governed by community staff. After early success, the pilot program was expanded in 1966 with the belief that grants and Medicaid and Medicare payments would sustain the centers.

Though the next decade saw some restrictions in the health center program (such as limiting services only to the poor), it was formally adopted as a program of the Public Health Service in 1975. The idea that the centers could rely on public insurance programs to cover their costs was mistaken, however, and most centers struggled financially. In response, in 1989 Congress enacted the Federally-Qualified Health Center (FQHC) Act. This Act required States to pay federally-funded health centers, "look-alike" health centers funded with state and local funds, urban Indian clinics, and clinics operated by Indian Tribal Organizations the full cost of providing care to Medicaid patients, thereby reducing the need of health centers to divert grants meant for the uninsured to cross-subsidize the cost of care for Medicaid patients.

With the passage of the Balanced Budget Act of 1997 (BBA), health centers are facing a return to pre-1989 financing issues, as the Act calls for the reasonable cost payment requirement to be phased out by 2003.⁵ In the wake of opposition from health centers and advocates, Congress recently passed a proposal to delay the phase-out by continuing cost-based reimbursement until 2005. Though postponed, the change in financing, as well as other funding trends, creates an uncertain financial future for health centers.

Program Administration

The health centers program is administered by the Bureau of Primary Health Care in the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services. The federal government designates geographic areas as "underserved" (and thus determines where health centers may be located), sets requirements for the services a center must provide, and establishes a public schedule of charges that is adjusted based on family size and income.

To qualify as a FQHC, a clinic must demonstrate that the community meets the need standards set by HHS, must be governed by a non-physician community board, and must deliver the entire range of services set by the federal government (from preventive and diagnostic health and laboratory services and dental care to case management and health education). In meeting these requirements, health centers also provide links to other assistance programs, such as WIC and Head Start, and serve as a source of employment in the community.

Profiles of Federally-Funded Health Centers

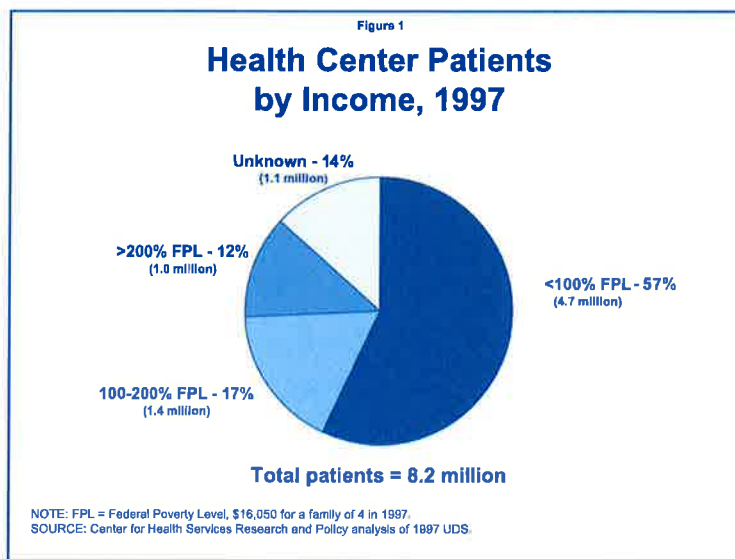
The health centers program has grown into an expansive network of centers that reaches out to medically underserved children and adults across the nation. In 1997, the 671 reporting federally-funded health center grantees⁶ served 8.2 million patients at 2,899 service sites across the nation.⁷ In addition, 134 health centers supported with state and local funds and certified as meeting all of the requirements of the federal health centers program furnished health care to an additional estimated 1.5 million patients.⁸

Centers are located in all 50 states, the District of Columbia, and the Commonwealth and Trust Territories, though the distribution of centers across states varies. While health centers are often thought of as urban facilities, health centers actually serve both urban and rural populations. In 1997, 54 percent of all federally-funded health center patients (or 4.4 million) were served by rural health centers.

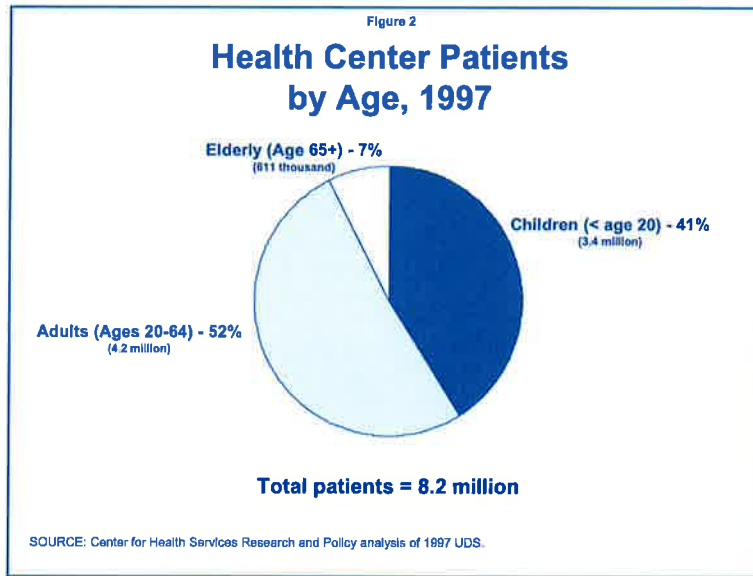
Health Center Patient Characteristics

While the patient population served by health centers varies from community to community, certain patient characteristics are common across the majority of federally-funded health centers. Analysis of data on health center patients reveals that the majority are low-income, non-elderly, members of racial and ethnic minorities, and either uninsured or covered by Medicaid.

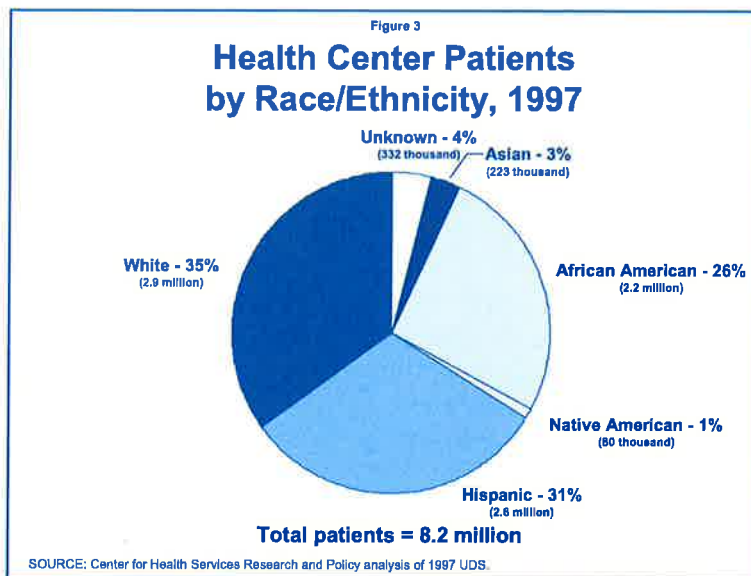
Income: Health center patients are overwhelmingly low income (Figure 1). In 1997, three quarters of all health center patients had family incomes at or below twice the federal poverty level (\$32,100 for a family of four in 1997). Assuming that the income level of the 1.1 million patients whose incomes were unknown approximates that for known patients, approximately 85 percent of all patients served in 1997 – 6.9 million out of the total 8.2 million patients served – had family incomes at or below 200 percent of the federal poverty level.



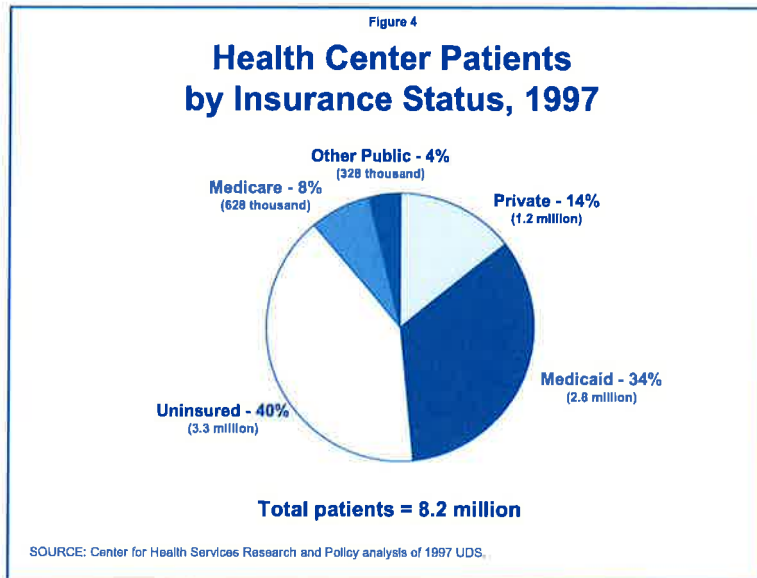
Age: Most health center patients are under the age of 65. Elderly patients comprised just seven percent of all health center patients. In 1997, infants, children and adolescents represented 41 percent of all federally-funded health center patients, while non-elderly adults represented another 52 percent of health center patients (Figure 2). The high number of non-elderly adults in part reflects the importance of health centers as a source of prenatal and pregnancy care: 254,000 pregnant women — approximately one in ten low-income pregnant women — were served by health centers in 1997.



Race and ethnicity: The UDS reveals extraordinary diversity among health center patients (Figure 3). In 1997, 61 percent of health center patients were non-White: 26 percent were African American, 31 percent were Hispanic, three percent were Asian, and one percent were Native American. Thirty-five percent of all health center patients were White.



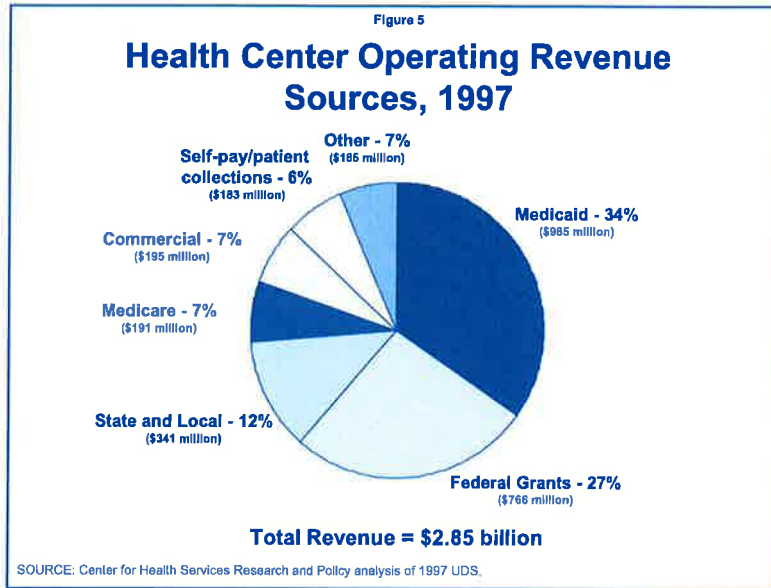
Insurance status: Data on the insurance status of health center patients reflect the centers' mission to provide care to medically underserved populations. In 1997, 40 percent of health center patients (3.3 million) lacked any health insurance, and 34 percent (2.8 million) were covered by Medicaid (Figure 4). These figures also demonstrate the importance of health centers as safety net providers: federally-funded health centers served nearly 8 percent of the uninsured and over 8 percent of Medicaid enrollees nationally.



Health Center Financing

While all the health centers in the sample receive federal funding, these grants are not their only source of revenue. Rather, health centers' revenue comes from a variety of public sources and some private payers as well.

In 1997, Medicaid revenues comprised 34 percent of federally-funded health centers' total operating revenue of \$2.85 billion (Figure 5). Medicaid revenues as a proportion of total operating revenues thus paralleled Medicaid patients as a percentage of all patients. However, federal grant revenues as a percentage of total operating revenues (27 percent) fell significantly below the proportion of health center patients who were uninsured that year (40 percent). State and local governments contributed another 12 percent to total health center operations for uninsured patients, helping to close this gap. Finally, patients themselves contributed six percent directly to health centers' total operating budgets, reflecting the fact that most uninsured health center patients have low family incomes and cannot afford to pay for care.



Health Center Participation in Managed Care

As health centers derive much of their patient base and revenue from Medicaid patients, the movement to delivering Medicaid services through managed care contracts has significant implications for these providers. Managed care may, for example, affect health centers' financial stability and patients' ability to continue to receive care at these sites, should health centers be excluded from provider networks.

In 1997, 347 federally-funded health centers – over half of all health centers – took part in some form of Medicaid managed care, including both discounted fee-for-service and risk-based managed care. Figure 6 and Table 1 show that federally-funded health centers in nearly all states participate in managed care – 29 states show a participation rate of 50 percent or greater among health centers.

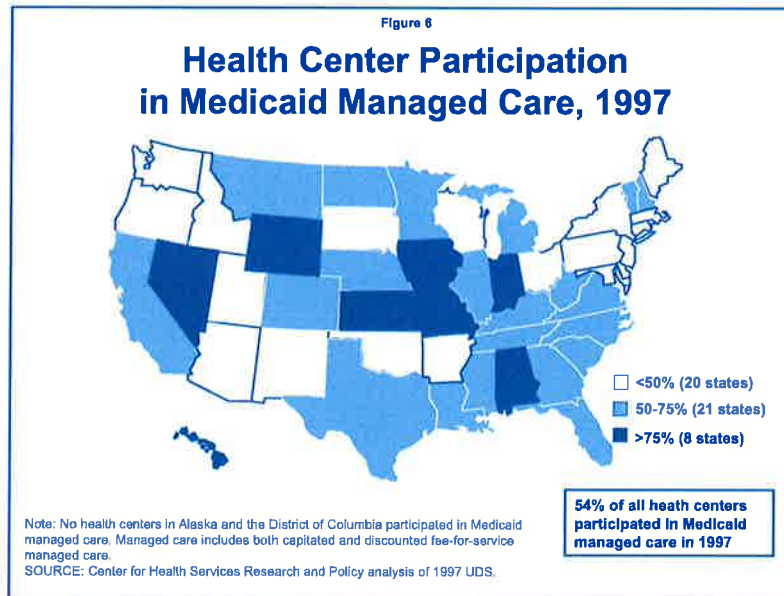


Table 1: State Health Center Participation in Managed Care, 1997

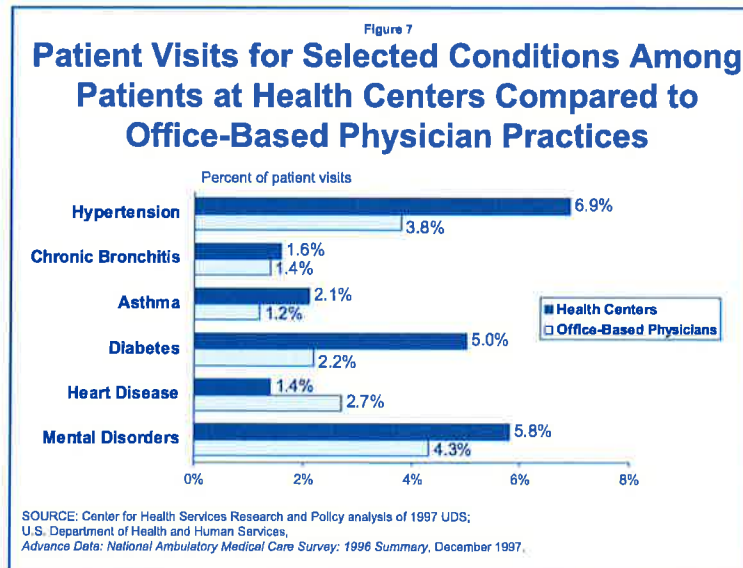
State	Number of Centers in Each State	% Participating in Managed Care	State	Number of Centers in Each State	% Participating in Managed Care
Alabama	15	80%	Montana	6	67%
Alaska	2	0%	Nebraska	3	67%
Arizona	9	44%	Nevada	3	100%
Arkansas	9	44%	New Hampshire	5	60%
California	46	74%	New Jersey	10	30%
Colorado	15	67%	New Mexico	10	40%
Connecticut	8	13%	New York	39	26%
Delaware	3	33%	North Carolina	20	70%
District of Columbia	1	0%	North Dakota	2	50%
Florida	28	71%	Ohio	16	44%
Georgia	20	70%	Oklahoma	4	25%
Hawaii	4	100%	Oregon	9	44%
Idaho	7	14%	Pennsylvania	28	39%
Illinois	18	56%	Rhode Island	5	40%
Indiana	4	100%	South Carolina	18	50%
Iowa	5	100%	South Dakota	8	25%
Kansas	5	80%	Tennessee	19	63%
Kentucky	9	56%	Texas	31	52%
Louisiana	11	73%	Utah	7	29%
Maine	9	44%	Vermont	2	50%
Maryland	10	30%	Virginia	18	50%
Massachusetts	24	33%	Washington	22	41%
Michigan	26	58%	West Virginia	19	58%
Minnesota	8	63%	Wisconsin	12	42%
Mississippi	20	70%	Wyoming	2	100%
Missouri	12	83%	U.S. Total	646	54%

Source: Center for Health Services Research and Policy analysis of 1997 UDS.
 Note: Managed care includes both capitated and discounted fee-for-service managed care.

Health Centers vs. Private Physician Practices

The role of health centers in caring for vulnerable populations, as well as the importance of various funding sources, is highlighted by a comparison to private physician practice characteristics. Health centers treat a higher percentage of patients with complex chronic diseases than most physician practices and are also more dependent on Medicaid to pay for services.

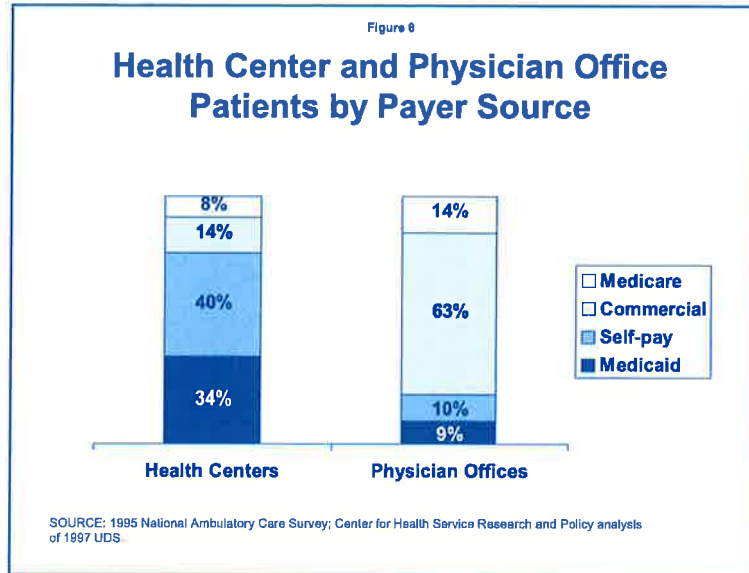
Patient health problems: Compared to private physicians, health centers see a greater percentage of patients with chronic diseases (Figure 7). Comparison of patient visits for selected diagnoses shows that a higher portion of health center visits are for diagnoses associated with additional care costs and greater levels of mortality and morbidity, including hypertension, chronic bronchitis, asthma, diabetes, and mental disorders. Health centers have fewer patient encounters for heart disease, which may be due to the fact that patients in health centers are generally non-elderly.



Patient insurance coverage: Health centers are much more dependent on Medicaid as a revenue source than private physician practices (Figure 8). While Medicaid patients comprise 34 percent of health center practices, only nine percent of physician practice patients have Medicaid coverage. Private physicians rely more heavily on private insurance as a revenue source: commercially insured patients comprise two-thirds of all physician practices but represent only 14 percent of all health center patients.

Self-pay patients represent 40 percent of all health center patients but only ten percent of physician practices. Moreover, the characteristics of self-pay patients in the two types of settings are likely to be very different. In the case of health center patients, these patients are likely to be the low-income uninsured (based on income and insurance data presented in the earlier figures), whereas self-pay patients in physician offices are likely to have higher family incomes and able to pay a higher proportion of uncovered medical care bills.

These comparative data underscore the challenge that health centers face in serving a population with complex health needs and reveals the importance of Medicaid payment rates for health centers. As with other core safety net providers, such as public hospitals and clinics operated by state and local public health agencies, health centers can be expected to be highly sensitive to changes in Medicaid financing policy, such as declining payment rates and mandatory price discounting as a condition of participation in managed care. Given health centers' patient population, they may have more difficulty absorbing these changes than other providers do.



Variation Among Health Centers

While it is useful to compare health centers to other providers to better understand their role in the health care system, it is also instructive to examine differences among health centers. One characteristic that is of particular interest in looking at variation within health centers is the percent of the patient population that is uninsured. Analysis of this issue not only shows differences among patient populations served, but also indicates how different subgroups of health centers are affected by financing trends.

This section classifies centers into quartiles by percentage of uninsured patients. In the top quartile, at least 54.1 percent of patients were uninsured in 1997, whereas in the bottom quartile, no more than 27.3 percent of patients were uninsured. On average, 40 percent of health center patients were uninsured in 1997.

Table 2 presents health center information by uninsured quartiles, showing what percentage of the total health center population falls into the top and bottom quartiles. Not surprisingly, centers in the top quartile cared for most uninsured patients seen in health centers (over 37 percent), even though they only served about 22 percent of all patients. In addition, these centers served the majority of migrant/seasonal and homeless patients cared for in health centers, two groups that are highly likely to be uninsured.

Table 2: Comparison of Health Centers by Percentage of Uninsured Patients Served

	All Health Centers	Centers with High Percentage of Uninsured Patients (Top Quartile)	Centers with Low Percentage of Uninsured Patients (Bottom Quartile)
Number of Centers	671	168	168
Patients by selected characteristics			
	Number of patients	Percentage of Patients Seen by Top Quartile	Percentage of Patients Seen by Bottom Quartile
Medicaid patients	2,796,826	12.6%	38.3%
Uninsured patients	3,298,083	37.4%	12.0%
Migrant/seasonal patients	536,297	28.2%	23.7%
Homeless patients	467,909	57.3%	6.5%
Income < 200% FPL	6,118,330	24.1%	27.5%
All patients	8,228,670	21.9%	27.9%
Visits by Selected Diagnoses			
	Number of visits	Percentage of Visits Occurring in Top Quartile	Percentage of Visits Occurring in Bottom Quartile
HIV/AIDS	209,045	24.8%	35.6%
Tuberculosis	32,377	27.1%	20.5%
STDs	80,807	26.9%	23.4%
Asthma	536,619	15.5%	42.6%
Chronic bronchitis/Emphysema	400,889	16.8%	33.3%
Diabetes	1,274,831	19.1%	32.0%
Hypertension	1,775,832	19.8%	31.2%
Heart disease	366,772	14.1%	35.4%
Perinatal conditions	34,723	24.5%	31.4%
Alcohol dependence	176,985	25.0%	31.7%
Drug dependence	217,725	23.1%	39.3%
Mental disorders	1,081,876	21.3%	33.9%
Revenue by Source			
	Percentage of Total Revenue	Percentage of Total Revenue	Percentage of Total Revenue
Federal Grants	26.9%	38.3%	18.8%
State/Local	12.0%	16.8%	8.9%
Medicaid	34.6%	23.5%	43.2%
Medicare	6.7%	3.8%	9.1%
Commercial	6.9%	2.6%	9.8%
Self-pay	6.4%	6.8%	5.0%
Other	6.5%	8.1%	5.2%

SOURCE: Center for Health Services Research and Policy, analysis of 1997 UDS.

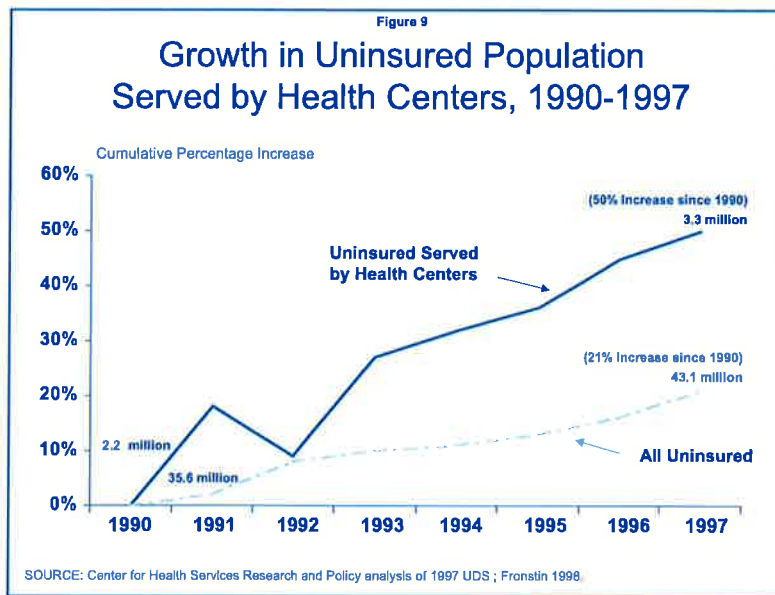
Data on the health status of the patients served (represented here by diagnosis per patient visit) reveal an interesting trend among centers in the bottom quartile. These centers, which serve a large percentage of Medicaid patients seen in health centers (over 38 percent), also care for the majority of patients with serious chronic health conditions. Those centers serving the lowest number of uninsured patients (and greatest percentage of Medicaid patients) handled over 30 percent of health center patient visits for HIV/AIDS, asthma, chronic bronchitis/emphysema, diabetes, hypertension, heart disease, perinatal conditions, alcohol and drug dependence, and mental disorders. This trend may be attributed to several factors, such as the poor health status of the Medicaid population, an increased likelihood of enrolling a chronic (repeat) patient into Medicaid, and an increased chance that a person with a chronic problem (i.e. HIV/AIDS through the SSI program, or asthma, common in children) may be eligible for Medicaid coverage.

Data on both the top and bottom quartiles also show vulnerabilities to financing trends. Centers in the top quartile are caring for a disproportionate share of uninsured patients, which means they are particularly dependent on grants to cover costs. Centers in the bottom quartile treat a substantial portion of health center patients with ongoing, serious health needs; these centers rely on Medicaid financing to treat these patients and may struggle in the face of declining federal reimbursement.

Trends in Health Center Patients and Revenues

Growth in the Number of Uninsured Health Center Patients

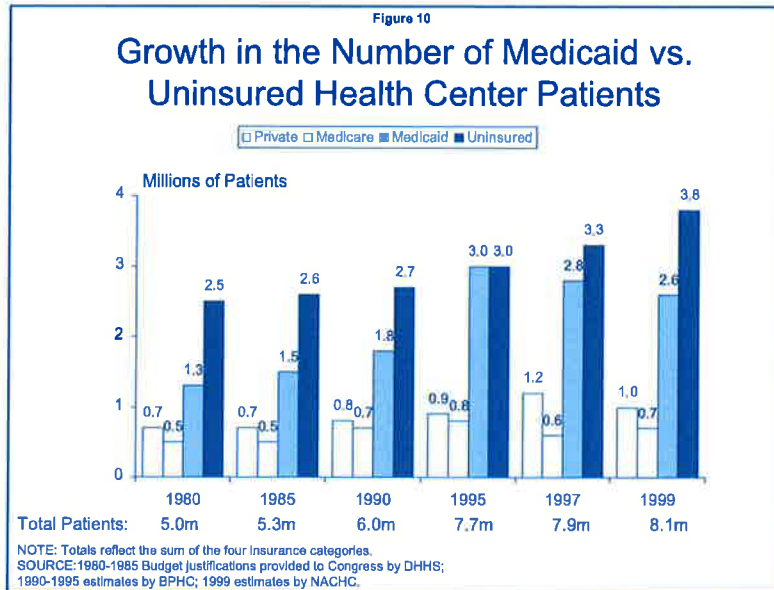
The number of uninsured patients served by health centers has grown significantly since 1990 and at a rate far exceeding the overall growth in the uninsured population. Figure 9 shows that while the nation's uninsured population grew by 21 percent between 1990 and 1997, health centers' uninsured caseload increased by 50 percent.



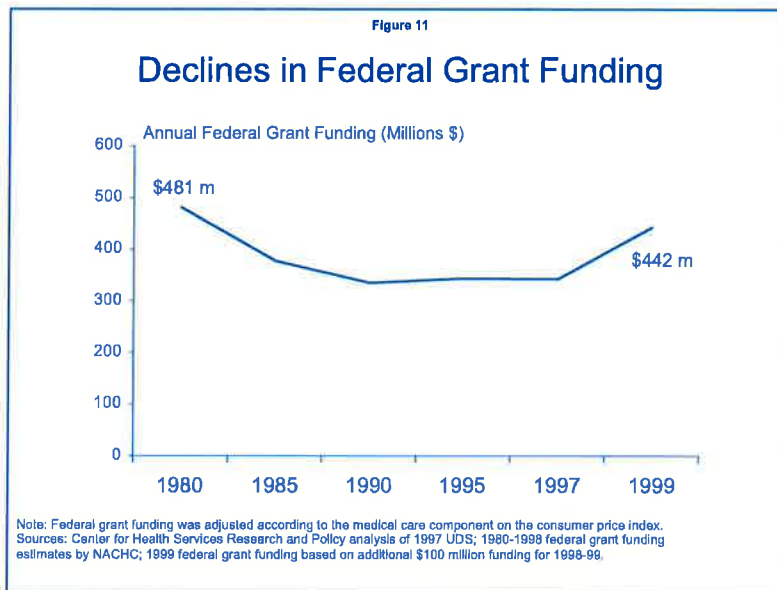
Growth in the Number of Medicaid Health Center Patients

Figure 10 shows the growth in both uninsured and Medicaid patients served by federally-funded health centers from 1980 to 1999. Over this time period the number of Medicaid patients served by federal health centers doubled, paralleling significant expansions in Medicaid eligibility over the same period.

The number of uninsured patients treated by health centers also grew significantly over this time period. However, the greatest proportional growth in the number of uninsured



patients served occurred only after enactment of cost-based reimbursement under the 1989 Federally-Qualified Health Center Act. The implementation of this new payment modality was immediately followed by a very large increase in the number of uninsured patients served by federally-funded health centers. Figure 10 shows that health centers served an additional two-hundred thousand (200,000) uninsured patients between 1980 and 1990 compared to a growth of 1.1 million between 1990 and 1999. This recent rapid growth would suggest that, as payments from public insurance programs increased under cost-based reimbursement, health centers were able to devote more grant resources to the care of the uninsured.



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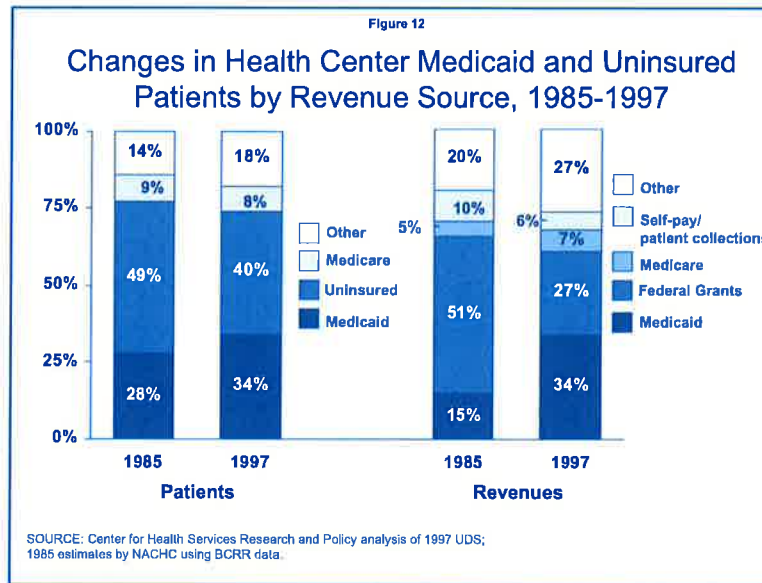
Declining Federal Grant Support for Health Centers

While health centers receive grant support for care of the uninsured from federal, state, and local sources, federal funding remains by far the principal source of health centers' operational subsidies. Figure 11 shows that between

1980 and 1999, adjusted for inflation, federal support has declined in real dollar terms. Between 1980 and 1999 real-dollar funding fell from \$481 million to \$442 million, a ten percent decline, even as the number of uninsured health center patients grew from 2.5 million to 3.8 million – a 50 percent increase.

Comparison of Medicaid and Uninsured Patients and Revenues

As the number of Medicaid patients has grown, the amount of Medicaid revenues received by health centers also has risen. Figure 12 indicates the changes in Medicaid revenues as a proportion of total health revenues as the Medicaid patient population served by health centers increased. In 1985, Medicaid patients represented 28 percent of all federally-funded health center patients but only 15 percent of all health center revenues, a level of revenue that was significantly below the proportion of patients served. By 1997, Medicaid patients had risen to 34 percent of all patients, and Medicaid revenues more than kept pace, rising to 34 percent of total revenues and eliminating the shortfalls of the previous decade.



These data on the growth of Medicaid patients and revenues suggest that the effect of the FQHC payment system has been to bring Medicaid revenues into line with Medicaid caseloads, rather than yielding Medicaid revenues in excess of the reasonable cost of care for Medicaid patients. However, even this improved payment rate may overstate the extent to which the FQHC system has improved the relationship between services furnished to Medicaid beneficiaries and Medicaid compensation levels. In a recent study of UDS data conducted for the Bureau of Primary Health Care, the agency which oversees the program, researchers found that 5 percent of the Medicaid revenues received actually were to compensate for Medicaid underpayments in prior years and did not reflect compensation for current year costs.⁹ Thus, even with the advent of the FQHC payment system, Medicaid revenues may still proportionately fall below the proportion of patients served who are Medicaid enrollees.

Challenges Facing Health Centers

The data presented in this policy brief illustrate a variety of challenges facing health centers. First and foremost, health centers face the challenge of maintaining and expanding care for uninsured patients in light of likely decreases in their principal source of revenue – Medicaid payments. Health centers will also continue to be challenged through the provision of care to a patient population with increasingly complex health care needs.

Future Growth in Number of Uninsured and Medicaid Health Center Patients

While the number of uninsured patients served by health centers is projected to climb if national insurance trends continue, the number of low-income persons with Medicaid may continue to decline as a result of welfare reform and the movement of low-income families into jobs that do not carry any – or any affordable – health insurance.¹⁰ Health centers are doubly at risk from these potential trends. As a major source of care for Medicaid enrollees, health centers can and should expect that their patients will turn to them for continued subsidized care in the face of lost Medicaid coverage.

It is too early to tell if the number of health center patients enrolled in Medicaid will decline in the near term. In theory, health centers serve the very population – women and their children – who are most vulnerable to the spillover effects of welfare reform. At the same time, there is also evidence that many health centers are actively engaged in outstationed Medicaid enrollment and CHIP case finding, which may somewhat blunt the loss of coverage.¹¹ Moreover, there is also evidence that the remaining Medicaid population, even if smaller than before, may rely even more heavily on health centers in the years to come. Over the past year considerable attention has been paid to commercial managed care companies' exit from the Medicaid program.¹² If this becomes a broader trend, patients who previously had obtained care from network physicians might turn to health centers in greater numbers, particularly as health centers remain highly active in managed care. Thus, even as the national number of Medicaid patients falls, the number of Medicaid patients cared for by health centers actually could increase.

Impact of Recent Changes in Federal Financing

The impact of recent federal Medicaid payment reforms on health centers' revenues, and therefore, their capacity to serve the uninsured, is less speculative. In 1997 Congress enacted a six-year phase-out of the Medicaid FQHC program as part of the Balanced Budget Act. Between FY 2000 and FY 2004, the cost-based payment system was set to phase out, with final repeal after FY 2003. At the close of the first session of the 106th Congress, the House and Senate passed the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. Under Title VI, Sec. 603 of this act, Congress passed a two-year moratorium on the phase-out of cost-based reimbursement for FQHCs. As signed into Public Law 106-113, payments to FQHCs and Rural Health Clinics will be frozen at 95 percent in FY 2001 and FY 2002, declining to 90 percent in 2003, and 85 percent in 2004. Under the new law, cost-based reimbursement will be repealed in 2005.

Unless alternative support mechanisms are put in place, the reductions and eventual loss of the FQHC payment system will raise major issues for health centers. The FQHC system has ensured that health centers can recover the reasonable cost of covered services furnished to Medicaid patients. Moreover, the FQHC program also provided for supplemental payments to health centers that participate in managed care and must discount their fees below cost in order to contract with state Medicaid agencies.

As the FQHC payment system is phased out, a critical source of support for the care of Medicaid patients may be lost unless states elect to maintain this higher payment level. Health centers would effectively return to the pre-1989 Medicaid scenario shown in Figure 12, in which Medicaid payments as a proportion of total payments fell well below Medicaid patients as a percentage of total patients. While providers for whom Medicaid is a marginal payer might be able to absorb deep cuts in Medicaid funding, the data in this policy brief show that Medicaid is the principal funder of health center operations, eclipsing even federal grants. As a result, deep downward shifts in Medicaid financing have significant implications for the ability of health centers to sustain the level of care for the uninsured that they were able to achieve over this past decade.

Research Agenda for Meeting These Challenges

The financial challenges facing health centers are made more complex by the health status of their patients. The diagnostic-based data suggest the need for special payment arrangements that reflect the poorer overall health status of health center patients compared to those found in typical physician practices. They also suggest the value of developing initiatives aimed at improving the management of such conditions in order to improve the quality of care and contain costs. Data regarding mental illness and addiction disorders, two prominent diagnoses within the health center population, may be of particular interest. Assessing the ability of health centers to secure specialty care for these populations, as well as their capacity to develop more comprehensive forms of treatment, represents an important area for further policy research.

A final issue underscored by the data is the need to examine more closely the subset of health centers with a high share of uninsured patients. The data on these health centers indicate that they can be distinguished from other centers by the very high proportion of uninsured patients they serve and by their greater tendency to serve certain populations at very high risk for lack of coverage, such as migrant farm workers and homeless persons. Little is currently known about the characteristics associated with having a high share of uninsured patients. Are these centers located in particular states? Do they have size, patient mix, service mix or service area characteristics that are different from other centers? Are these centers more financially stressed? Is having a large share of uninsured patients an isolated event confined to one year, or is it an ongoing trend that affects certain centers over time?

Further research is needed to discover whether centers particularly adept at reaching the most isolated and difficult to serve patients are both more financially stressed and serve a disproportionate share of the uninsured. Should this be the case, targeted interventions may be needed to sustain their services beyond the grant support typically provided. If financial stress relates to administrative factors or service inefficiencies, then technical support may be needed to improve these centers' prospects for survival. The need to sustain all existing health centers is underscored by the already high numbers of persons reporting no usual source of care who are at risk for medical underservice. Answers to these questions and innovative responses to these challenges are needed to ensure the future of this important program.

This issue paper was prepared by Sara Rosenbaum, Peter Shin, Anne Markus, and Julie Darnell of the George Washington University's Center for Health Services Research and Policy, with the assistance of Rachel Garfield and David Rousseau of the Kaiser Commission on Medicaid and the Uninsured. The authors wish to thank the Bureau of Primary Health Care and Daniel R. Hawkins at the National Association of Community Health Centers for assistance with data analysis and review of this paper.

Notes

¹ Karen Davis and Cathy Schoen, *Health and the War on Poverty* (Brookings Press, Washington D.C., 1977); Alice Sardell, *The U.S. Social Experiment* (University of Pittsburgh Press, 1992); Daniel Hawkins and Sara Rosenbaum, "The Challenges Facing Health Centers in a Changing Health Care System", in *The Future U.S. Health Care System: Who Will Care for the Poor and Uninsured?* (Health Administration Press, Chicago, IL, 1998).

² The UDS system is maintained by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration, U.S. Department of Health and Human Services. The BPHC makes the data publicly available after health centers have adequately addressed missing or inconsistent information. In 1996, the UDS replaced the Bureau of Common Reporting Requirements (BCRR). The UDS improves on the data available under the predecessor system by collecting information on: (1) patients by payer source; (2) managed care; (3) patient health risks as measured by encounters and by diagnosis; and (4) the use of enabling services. Where the data are the same under the UDS and BCRR systems, we have been able to present trend data; in the case of UDS-only data, snapshot information is presented. Like the BCRR, the UDS treats as health center patients those individuals who record at least one visit to a health center during the year involved.

³ Health centers funded with only state and local sources of financial support do not participate in the UDS system. However, these centers are certified as "look-alike" health centers for purposes of the special Medicare and Medicaid payments for which all certified health centers qualify as "federally-qualified health centers." 42 U.S.C. §§1395x(aa)(3) and 1396d(a)(2)(C). While state and locally supported federally-qualified health centers do not maintain UDS data, data gathered from these clinics by the federal government and the National Association of Community Health Centers indicate that their service and patient characteristics closely resemble those of their federally-funded counterparts.

⁴ Rand E. Rosenblatt, Sylvia A. Law, and Sara Rosenbaum, *Law and the American Health Care System*. Westbury, New York: The Foundation Press, Inc., 1997, p 104-5.

⁵ The phase-out schedule, enacted as part of the Balanced Budget Act of 1997, is as follows: FQHC payments equal 100 percent of reasonable costs (as calculated in accordance with federal regulations) in Fiscal Years 1998 and 1999. Beginning in FY 2000, payments begin to decline, falling to 70 percent of reasonable costs in FY 2003. At this point, the program would be repealed. Because health centers can never be paid their reasonable costs no matter how efficiently they operate, the BBA formula would appear to make cost shifting to their operating grants a necessity.

⁶ The actual number of federal grantees in 1997 was 714. However, some were new centers and were not obligated to provide reports for 1997. A few federal grantees that were obligated to report failed to do so. These small numbers of obligated but non-reporting grantees do not affect the overall reliability of the reported data.

⁷ Data on the number of service sites is based on 656 centers, as fifteen health centers did not report their number of service sites.

⁸ National Association of Community Health Centers, 1999 estimates of non-federally funded health centers.

⁹ MDS Associates and Stickgold Associates. National Summary Data, 1998. Bureau of Primary Health Care Uniform Data System. Prepared for the Bureau of Primary Health Care, June 16, 1999.

¹⁰ Ellen O'Brien and Judy Feder, *How Well Does the Employment Based Health Insurance System Work for Low Income Families?* (Kaiser Commission on Medicaid and the Uninsured, Washington D.C. September, 1998).

¹¹ Sara Rosenbaum, Kathleen A. Maloy, Jennifer Stuber, and Julie Darnell, *Initial Findings From A Nationwide Study Of Outstationed Medicaid Enrollment Programs At Federally Qualified Health Centers.* (George Washington University, Center for Health Policy Research, Washington D.C. February, 1998).

¹² Sue Felt-Lisk, *The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation.* (Kaiser Commission on Medicaid and the Uninsured, Washington D.C. May, 1999).

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