Financing Community Health Centers

Trends in Health Care and the Role of Community Health Centers in Low-Income Communities

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Overview

- This module will cover:
  - Where federally qualified health centers (FQHCs) fit into the overall American health care system
  - The broad market forces driving health care reform
  - The role of FQHCs within these changes and their importance in solving access to affordable health care in the United States
  - The broader role of FQHCs in low-income communities

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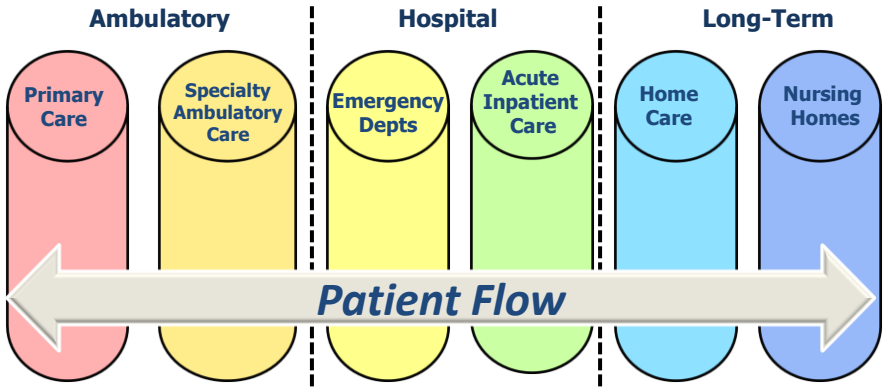
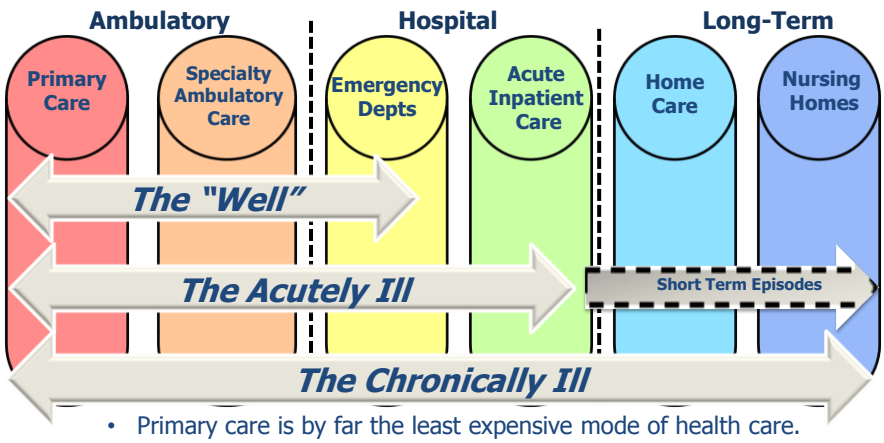
The Health Care Delivery Spectrum



- FQHCs provide primary care, plus some specialties, in underserved communities.
- What is primary care? Think in terms of your family doctor.

Use of the System Across the Spectrum



- Primary care is by far the least expensive mode of health care.
- Advances in medicine enable prevention and optimal treatment of even more conditions in low-cost primary care settings such as FQHCs.

Primary Care Providers in Low-Income Communities

In addition to FQHCs, the following organizations:

- Hospital out-patient departments (OPDs) & satellites
- Hospital emergency rooms
- Private doctors
- Freestanding clinics
- Free clinics
- Rural health centers
- In-store clinics
- Special needs providers:
  - Developmentally Disabled
  - Frail Elderly (Program of All-inclusive Care for the Elderly, or PACE)
  - Substance Abuse / HIV+ / Homeless

What is Driving Healthcare Reform?

- The US healthcare system – often called an "inverted pyramid" -- is oriented towards treatment -- specialty care and institutional (i.e., hospital and nursing home) interventions, rather than prevention.
- This contributes to more healthcare spending, with poor results in the US relative to other industrialized countries.
- Reform efforts, aimed at quality improvement and cost containment, are pushing more services into primary care and prevention.
- Reform efforts are system-wide and driven by private market forces as well as federal legislation.

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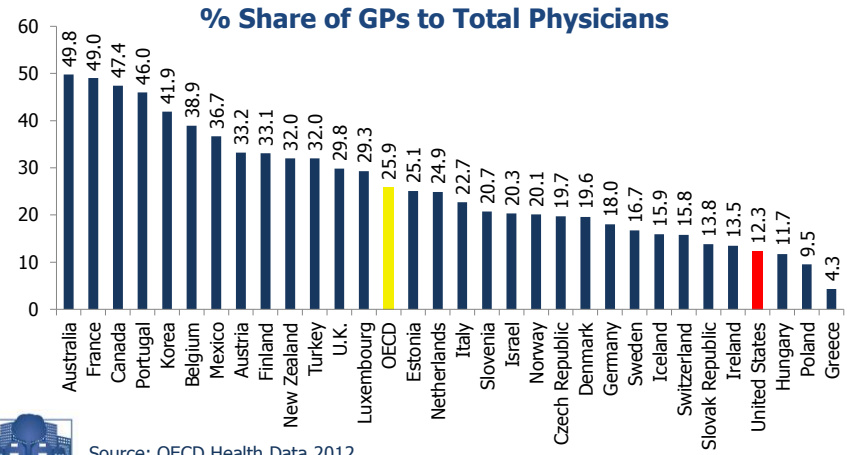
Hallmarks of our "inverted" system include:

1. Reliance on specialty care rather than primary care.



Source: OECD Health Data 2012

Hallmarks of our "inverted" system include:

2. Heavy investment in after-the-fact intervention, not in prevention.

Medicare Example

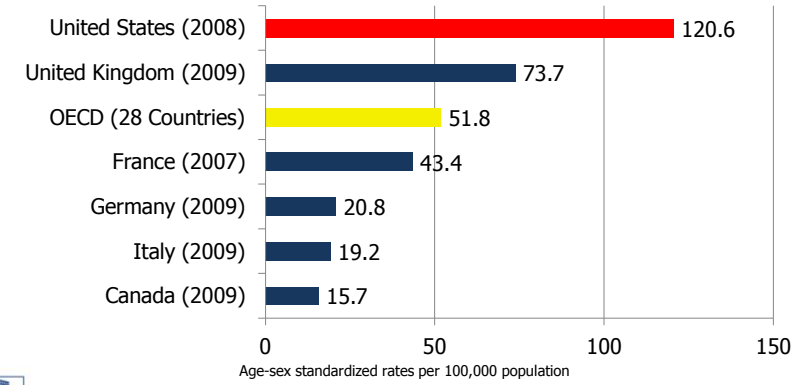
Payments to healthcare providers:

- Office visit to manage high blood pressure → **$69.51**
- Hospitalization for stroke due to high blood pressure → **$10,518**

Hallmarks of our "inverted" system include:

3. High incidence of preventable hospitalizations.

Example: Asthma-Related Hospital Admissions

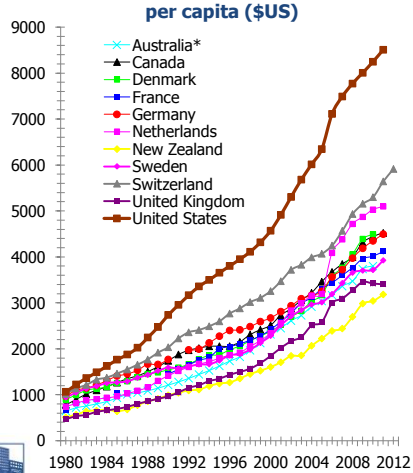


Source: OECD Health Data 2012

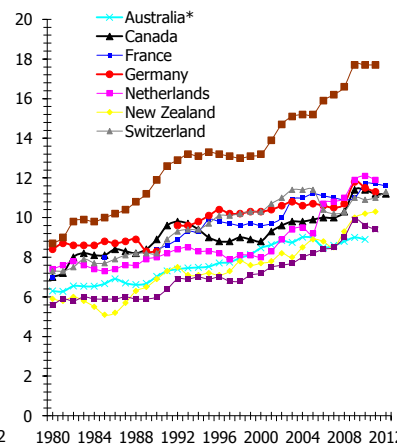
Hallmarks of our "inverted" system include:

4. The US far outspending its peers on health care.

Average spending on health per capita ($US)



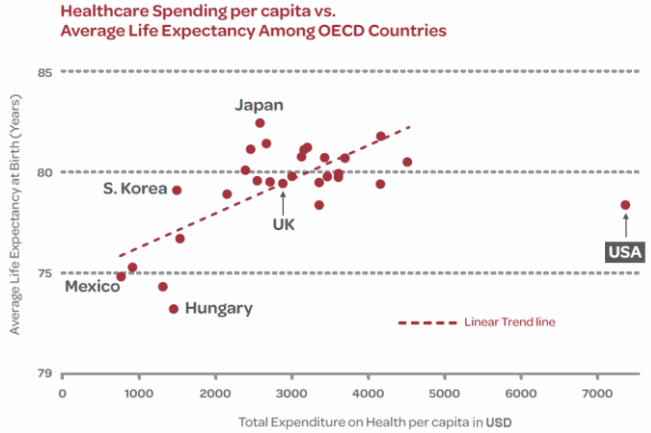
Total expenditures on health as percent of GDP



Source: OECD Health Data 2012

Hallmarks of our "inverted" system include:

5. Lack of quality relative to health care expenditures.



Average life expectancy & annual expenditures per adult; industrialized countries.

Sources: Expenditures – OECD , *Frequently Requested Data 2009*
Life Expectancy – OECD, *Frequently Requested Data 2009*

Leading to Pressure for Change

Unsustainable costs and poor outcomes are driving change in the industry. The shift began before the Affordable Care Act (ACA) and will continue from:

- High cost, tertiary, after-the-fact intervention to a **primary and preventive care-based system**
- Paying for units of service (FFS) to **paying for performance and outcomes**
- Fragmentation to **care management and coordination**
- Isolated, individual providers to **integrated networks** able to take responsibility for full care of the patient (capitation)
- Provider-centered to **patient-centered**

The ACA Accelerates Reform and Promotes Primary Care Indirectly

- Expands coverage
  - Medicaid expansion
  - Exchanges – expanded markets for private insurance
  - Impact
    - Newly-insured payments seek personal and family doctors
- Drives health system change via payment reform
  - Global payments via ACOs; non-payment for re-admissions; and other
  - Impacts
    - Creates very strong incentives for prevention and care
    - Drives more services to lowest cost delivery settings
    - Puts extreme financial pressure on weaker hospitals

ACA's Direct Benefits to Primary Care

ACA expands and supports primary care through:

- Expansion of FQHCs -- $11B Trust Fund
- Temporary Medicaid and Medicare physician rate increases
- Training, recruitment, and staff retention
  - National Health Service Corps
  - Scholarships, loans, repayment programs
  - Support for growth of family practice programs
- Center for Medicaid & Medicare Innovation Programs

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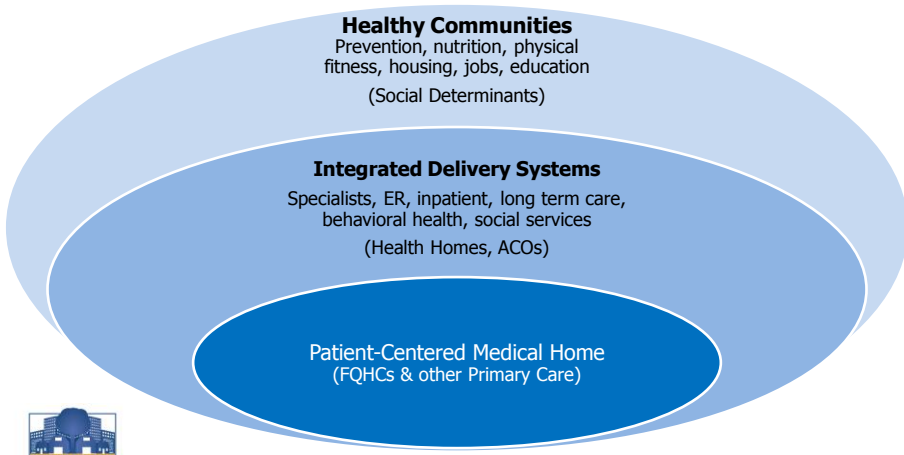
The Health Care Paradigm is Changing

FQHCs are interwoven into a broad set of community resources and services



Products of an Effective Health Care System

An effective health care system focused on primary care will produce:

- Better health
- Lower costs
- Reduced health disparities between socio-economic groups
  - Akin to environmental justice

FQHCs are a Critical Component of any Strategy to Improve Results and Lower Costs

Comparison of Average Cost of Care:

Community Health Center Visit	ER Visit	Hospital Admission
$140	$700 - 1350	$10,000 – 17,000

Studies show FQHC patients experience 11-33% fewer hospital admissions for Ambulatory Care Sensitive (ACS) conditions.

Sources: CHC costs -- HRSA UDS 2011 Data; Hospital costs -- Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey, 2011; Fewer Admissions – Cost Effectiveness of care Provided by Health Centers, NACHC, December 2011

How Can FQHCs Expand if Health Care Spending Must be Cut?

- Expanded primary care is the foundation of most strategies to reduce spending:
  - Chronic conditions account for 75% of US health care spending.
  - Primary care currently covers only approximately 5% of spending.
- FQHCs can manage chronic conditions and reduce the need for ER visits & hospitalizations.

Sources: US Centers for Disease Control (CDC), Healthcare Cost Institute's Healthcare Cost and Utilization Report, 2011

How Can FQHCs Expand if Health Care Spending Must be Cut?

- ACA targets now include 50% growth for FQHCs, an additional 10 million patients, supported via:
  - Expanded operating grants to cover care for uninsured
  - Expanded eligibility for Medicaid coverage
  - Financial support for doctors choosing FQHCs
- But:
  - State strategies can vary
  - Each state makes its own decision on Medicaid expansion
  - Expanded operating grants are not guaranteed past 2016

FQHCs and Community Development

- FQHCs are major employers in low-income communities
  - Offering stable jobs at all skill and educational levels, with career ladders
  - Improving real property
  - Creating economic multipliers
- Primary and preventive care reduce personal bankruptcies
- Healthcare delivery is essential to any *Healthy Communities* strategy
- Healthy kids stay in school and healthy adults stay on the job