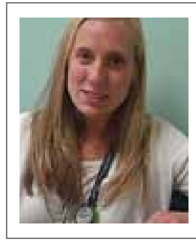
NATIONAL ASSOCIATION OF
Community Health Centers

ACCESS ENDANGERED:
Profiles of the Medically Disenfranchised

August 8, 2011



"The economic recession has greatly affected the type of background our patients have. Prior to the recession, a lot of patients had insurance through their jobs so we mostly saw patients with low-incomes. Now we have so many patients who lost their jobs, lost their insurance, so now we see patients from all over the community and from all economic backgrounds who come here for health care."

— Kathryn Beesley, Nurse Practitioner at Matthew Walker Comprehensive Health Center, Nashville, TN

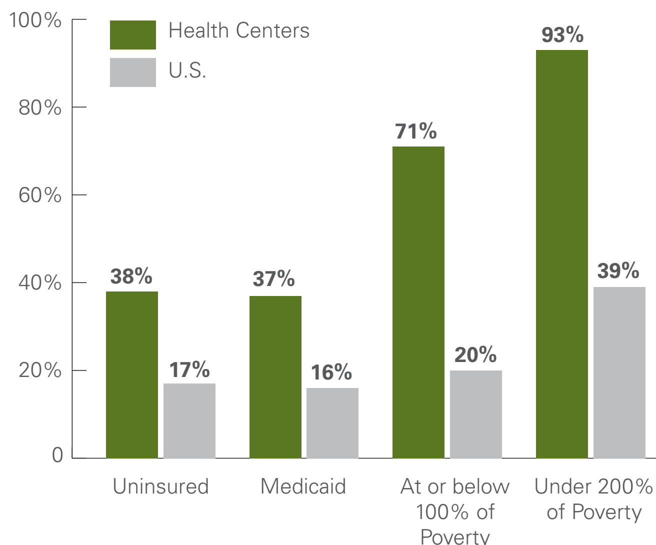
INTRODUCTION

As the nation struggles to recover from one of the worst economic crises since the Great Depression, Congressional and state lawmakers are debating budget cuts and programmatic changes that could have profound and far-reaching effects on the health of people and communities. In this difficult climate, the Community Health Centers program could find itself among the safety net programs facing funding cuts, even as more Americans – including the millions of recently jobless and uninsured – turn to them for care.

Community Health Centers operate in more than 8,000 locations and serve more than 20 million patients.[1] They provide **one-quarter of all primary care visits for the nation's low-income population,**[2] thereby **making up a substantial share of the nation's primary care infrastructure**. In disproportionately serving Medicaid, uninsured, and other high-risk patients compared to other providers,[3] health centers present a unique and comprehensive approach to health care that has been repeatedly found to propel system-wide cost savings and improve patient health. Over the past 10 years, health centers have doubled the number of patients served and extended their reach into twice as many underserved communities. With their expansion came improved access to care and patient outcomes, as well as jobs and resources for impoverished communities and health system efficiencies.

Fig. 1

HEALTH CENTER PATIENTS ARE DISPROPORTIONATELY POOR, UNINSURED, AND PUBLICLY-INSURED VS. THE U.S. POPULATION, 2009



Today, the successes that come with health center expansion are in danger as the nation attempts to put its fiscal house in order. Congress and state governments are proposing or even passing significant programmatic cuts on several fronts, which could constrain or reverse health centers' reach. Reductions in health center investment from federal and state governments, as well as dramatic changes to the Medicaid program, threaten their ability to expand health center services to more communities at a time when **60 million Americans do not have access to primary care because of shortages of such providers**.[4] Many of these individuals actually have insurance. As we've noted in previous reports, these individuals have been labeled the "medically disenfranchised," but this count does not adequately capture the many others who otherwise confront daunting barriers to care in the current economic environment – barriers such as cost, transportation and language. **The medically disenfranchised come from all economic backgrounds and live anywhere in America, but they all share one common feature: they are without a regular and continuous source of primary care**, and are often forced to seek costlier health care services in hospital emergency rooms.

This report highlights a small sample of health center patients who are the most at risk of losing access to care. It also profiles the individuals and communities who remain without access to primary and preventive care, even today. While each patient's story is unique, together their stories paint a larger picture of what's at stake for individuals and families struggling to make ends meet in communities that suffer from widespread unemployment and poverty.

SHRINKING HEALTH CENTER CAPACITY IN A TIME OF RISING DEMAND

Congress recently reduced their investment in the Health Centers Program halfway through Fiscal Year 2011. **This reduced investment scaled back health center efforts to expand into more underserved communities and grow their capacity at existing sites. Because every $1 million cut from federal funding reduces health centers' capacity to serve over 8,000 patients, a $600 million reduced investment means 5 million additional patients could not be served**. At the same time, state governments have cut their health center funding to the lowest levels since its peak in 2005.[5]

A proposal to block grant the Medicaid program has the potential to bring even further reductions in patients served. Such a drastic change to Medicaid **endangers access to care for more than 1.7 million current health center Medicaid patients**.[6] This conservative estimate only takes into account reductions in federal and state Medicaid spending as a result of the block grant and does not account for any policy changes after the block grant implementation that may disproportionately impact health centers.

Over the past 5 years, Community Health Centers have expanded access to care in numerous communities to serve 5 million more patients. Cuts to health centers would jeopardize access to primary and preventive health care for the millions currently without care, and even threaten access to care for those who rely on health centers as their only available source of primary care. The cuts disproportionately hurt working families, people insured by Medicaid/CHIP, or people who lack any insurance coverage.

HEALTH CENTERS HAVE EXPANDED IN NUMEROUS COMMUNITIES

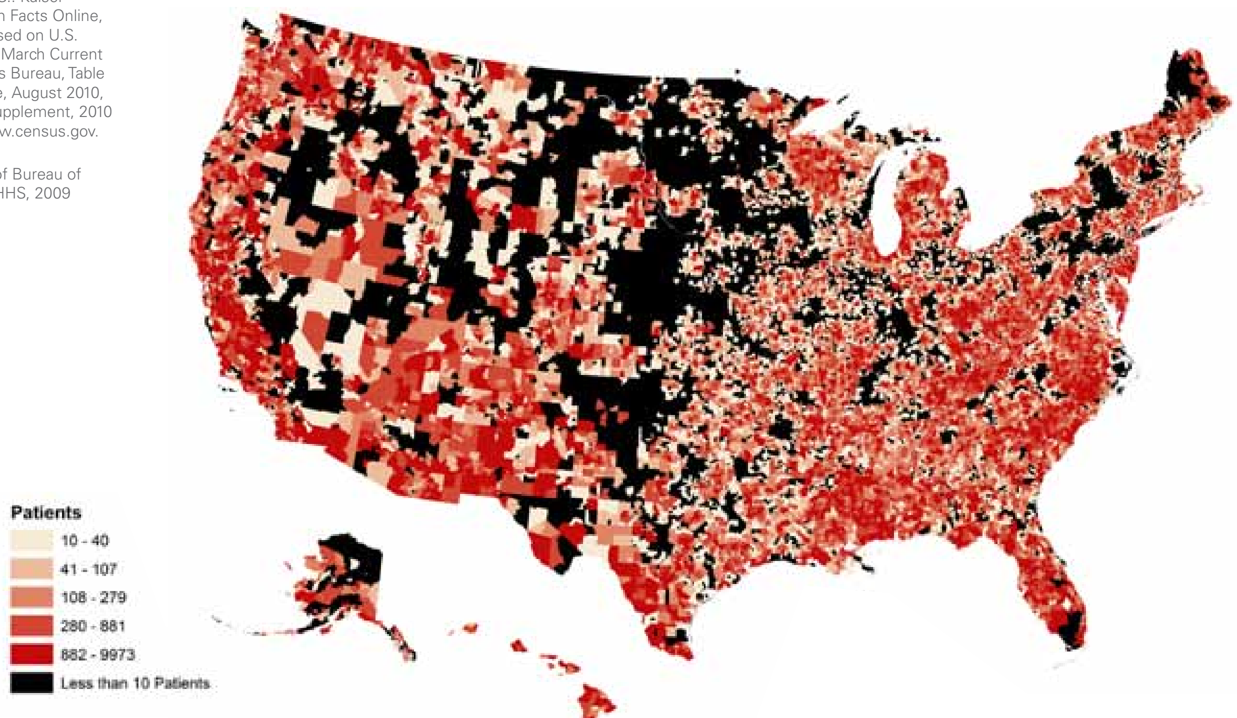


Fig. 1 Sources: Health Center: Based on Bureau of Primary Health Care, HRSA, DHHS, 2009 Uniform Data System. U.S.: Kaiser Family Foundation, State Health Facts Online, www.statehealthfacts.org. Based on U.S. Census Bureau 2009 and 2010 March Current Population Survey. U.S. Census Bureau, Table POV46. Poverty Status by State, August 2010, Annual Social and Economic Supplement, 2010 Current Population Survey. www.census.gov.

Map Source: NACHC analysis of Bureau of Primary Health Care, HRSA, DHHS, 2009 Uniform Data System (UDS).

Courtesy of Direct Relief International, photography by Rob Wang, robwang.com

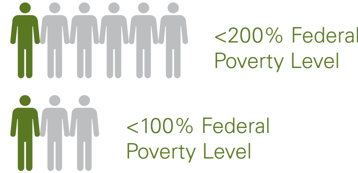
WHO ARE THE MEDICALLY DISENFRANCHISED?

The medically disenfranchised are often low-income, or what we know as "the working poor" – people employed with jobs that do not provide insurance. The medically disenfranchised are also on Medicaid or uninsured, unemployed, and suffering from chronic conditions that, as these patient profiles demonstrate, can go untreated as they attempt to navigate an increasingly fragmented health care system. They also live in communities with too few health care resources and must travel long distances to access care. Consequently, the medically disenfranchised often go without needed primary and preventive care because they are unable to negotiate barriers of distance, time, and cost to find primary and preventive care services outside of their communities.

When access to care is impaired, the evidence suggests we all pay in some measure. People without a usual source of health care are more likely to have unmet needs for care, more hospitalizations, and higher costs of care while receiving fewer preventive care services.[7] Barriers to care reach past the insurance card; in many cases, office-based physicians limit the number of patients they will see or choose not to practice in areas with too little health care resources. Navigating these complex and compounding barriers also requires an enhanced level of services beyond medical care to address social and environmental determinants of sickness and poverty, such as language proficiency, care management, and social supports that health centers are able to offer their patients. And in doing so, health centers generate better health outcomes, reduced disparities, and reduced costs for all payers.

Fig. 2

HEALTH CENTERS SERVE 1 IN 3 AMERICANS BELOW POVERTY



THE LOW-INCOME

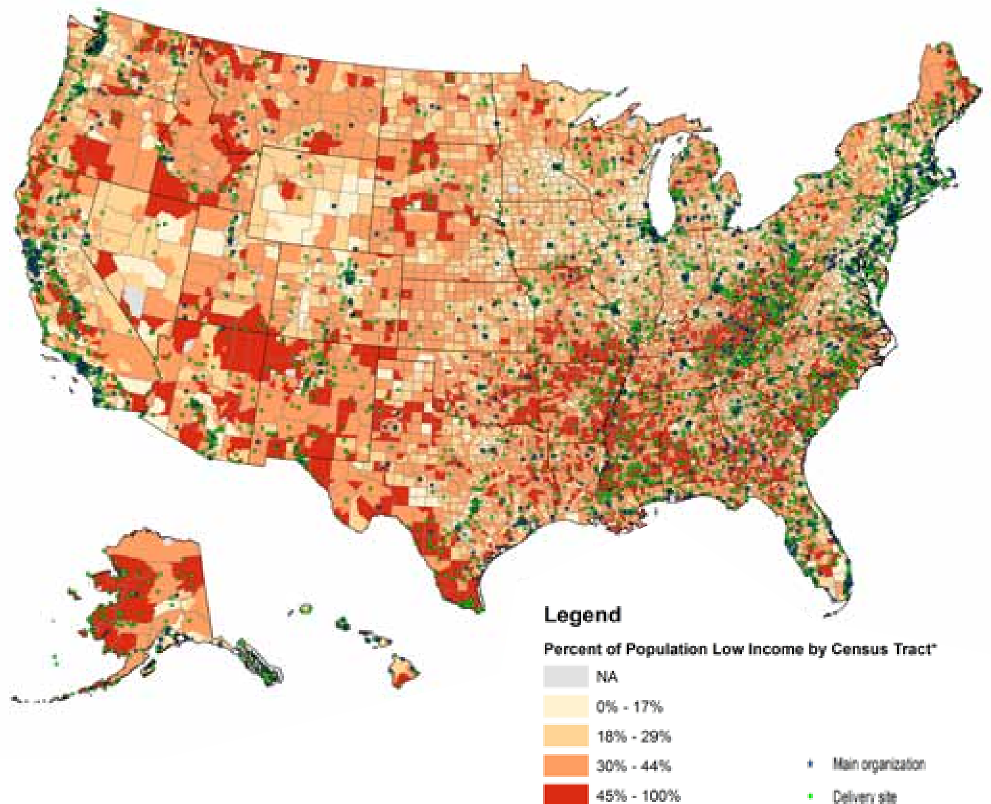
Nearly 1 in 3 low-income adults does not have a usual source of care.[8] More than 10 million working families in the United States live with incomes less than 200 percent of the Federal Poverty Level ($44,700 for a family of four in 2011) and nearly a third of working families are struggling to meet basic needs despite their hard work.[9]

Health centers are the provider of choice for many working individuals and families who are priced out of the health care market. Health centers have seen the number of low-income patients served (those with incomes under 200 percent of poverty) almost double over the last ten years, now reaching more than 19 million[10] **– 1 out of every 6 low-income Americans**. Health centers also reach **1 out of every 3 individuals living in poverty**. They provide care on a sliding fee scale to make care affordable to people with low-incomes. Health center patients are much more likely than patients of office-based physician practices to live in communities with higher concentrations of poverty. [11]

The low-income are often employed in jobs that form the backbone of our economy. They are people like Mark Cushman, 54, a health center patient in Medford, OR, who works part-time at a car dealership after getting laid off from his job selling ads for a newspaper. Cushman recently told a Washington Post columnist in an interview that he goes to his health center for blood work and to refill his prescription for a statin drug to keep his cholesterol in check. The bill for his recent the office visit was $28, the prescription was $4, and the blood work a few dollars more.

— Andrew, M. (2011, April 12). Health Overhaul Could Double Community Health Centers' Caseload. Kaiser Health News "Health Overhaul Could Double Community Health Centers' Caseload" by Michelle Andrews, April 12, 2011

HEALTH CENTERS ARE LOCATED IN AREAS WITH A HIGH CONCENTRATION OF LOW-INCOME FAMILIES



Sources: Health Center and Look-Alike Locations: HRSA Data Warehouse, June 2, 2011. Low-Income and Population Data: U.S. Census Bureau's American Community Survey, 5 Year (2005-2009) Estimates.

Fig. 3

HEALTH CENTERS SERVE 1 IN 7 MEDICAID BENEFICIARIES

MEDICAID BENEFICIARIES

Medicaid provides 50 million low-income and disabled people with health insurance. However, Medicaid beneficiaries still experience barriers to care as office-based physicians cut back on their participation in Medicaid, largely because of low payment rates.[12] Nearly 1 out of 8 Medicaid beneficiaries has no usual source of care.[8]

Health centers are more likely than other providers to accept new Medicaid patients, as Figure 4 illustrates. The number of Medicaid health center patients continues to increase, growing more than twice as fast as the number of Medicaid beneficiaries nationally (116 percent vs. 49 percent between 2000 and 2009).[13] Because of this, health centers serve 1 in 7 Medicaid beneficiaries today.[14] More than 15 percent of all Medicaid children depend on a health center to receive care.[15] Health centers also disproportionately serve the so-called dual eligibles, those over age 65 and enrolled in both Medicaid and Medicare, compared to other providers.[16]

Fig. 4

HEALTH CENTERS ARE MORE LIKELY TO ACCEPT NEW PATIENTS REGARDLESS OF INSURANCE COVERAGE

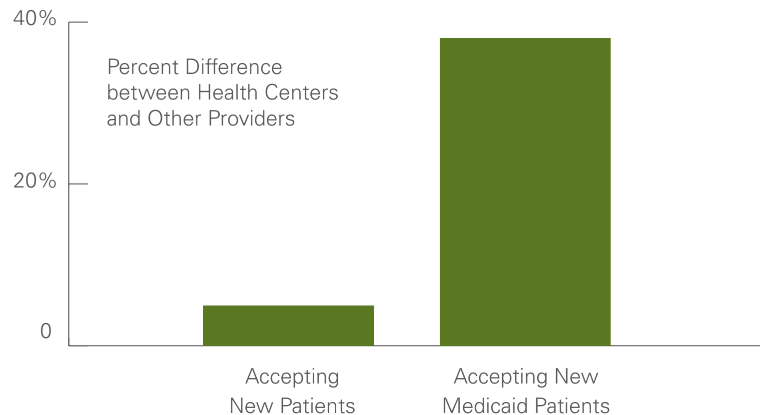


Fig. 5

OVER TWO-THIRDS OF HEALTH CENTER PATIENTS ARE UNINSURED OR PUBLICLY INSURED

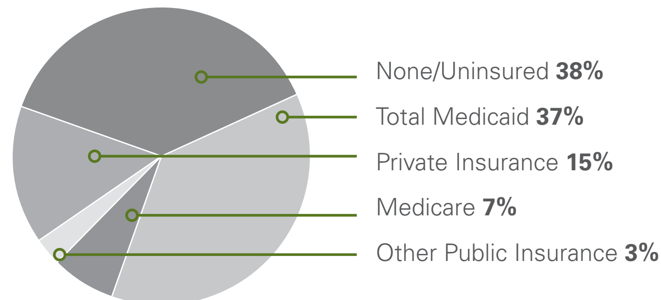


Fig. 3 Source: Hing E, Hooker RS, Ashman JJ. Primary Health Care in Community Health Centers and Comparison with Office-Based Practice. *J Community Health*. 2010 Nov 3 epublished.

Fig. 4 Source: NACHC analysis of Bureau of Primary Health Care, HRSA, DHHS, 2006, 2007, 2008, and 2009 Uniform Data System (UDS).

Fig. 5 Source: NACHC estimates based on Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2009 Uniform Data System. Kaiser Family Foundation. www.statehealthfacts.org. Data Source: Compiled by the Health Management Associates from state Medicaid enrollment reports, for the Kaiser Commission on Medicaid and the Uninsured, 2010. For more details on the December 2009 enrollment data, please see Medicaid Enrollment: December 2009 Data Snapshot, availableat http://www.kff.org/medicaid/enrollmentreports.cfm.

Fig. 6

HEALTH CENTERS SERVE 1 IN 6 UNINSURED AMERICANS

THE UNINSURED

More than half of the uninsured have no usual source of care,[8] and rising rates of unemployment exacerbate this problem. High unemployment in a sluggish economy has diminished the pool of affordable health care options for families and individuals now finding themselves uninsured. Nearly one-quarter (24 percent) of working-age adults – an estimated 43 million – reported that they and/or their spouse had lost their job within the past two years, according to a recent Commonwealth Fund survey, and nearly half of those reporting recent unemployment lost their health insurance.[17] The uninsured – who now number around 50 million – are more likely than those with health coverage to live in a household that is having difficulty paying basic monthly expenses such as rent, food, and utilities. They are also significantly more likely to have an unmet health care need and delay seeking care due to cost.[18] Delaying care increases the risk of more complicated conditions and leads to an increased use of avoidable expensive services such as emergency departments.

"I lost my insurance when I stopped working to care for my father who was sick… For the last year I was walking around without an immune system. I had a big rash on my chest and breast. I had the same primary care doctor for years so I went to see him and he sent me to a dermatologist. The dermatologist said it was a fungus and gave me samples of a cream (I was not able to pay the $100 for the cream). For a whole year after that I had been putting on the cream and wondering if the rash was going to go away. I kept wondering if it was my clothes, or a reaction to the lotions I was using. Then a friend of mine who is a Registered Nurse was visiting and I showed her my rash. She said I needed to get in to see a doctor and she told me about the Community Health Center. I called them at 8:00 a.m. and they asked if I could be there at 9:20 a.m. that same day. I showed the nurse my rash and she said she was going to give me a blood test. I asked, "Why a blood test?" And she said she didn't like the way it looked. On Wednesday she called me with the test results. I have leukemia. People should know who Community Health Centers are and how they are helping people who don't have insurance without worrying about how they are getting paid if the person is uninsured."

— Diana Thomas, 55, former homecare nurse, patient at Family Practice & Counseling Network, Philadelphia, PA

Fig. 6 Source: NACHC estimates based on Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2009 Uniform Data System. Kaiser Family Foundation. www.statehealthfacts.org. Data Source:Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).

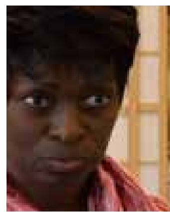
Health centers serve as a regular source of care for their uninsured patients, and now **care for 1 out of every 6 uninsured Americans**.[19] Uninsured health center patients are half as likely as other uninsured to delay care because of cost, go without needed care, or be unable to refill a prescription. They are also more likely to receive important preventive screenings, such as mammograms, pap smears, and health promotion counseling than their national counterparts.[20]

Community Health Centers are a more affordable option for the working poor. Indeed, 1 in 4 adults who are low-income, employed, and uninsured has turned to them for care.[21] A NACHC survey found that total health center visits increased 14 percent between June 2008 and June 2009, the beginning of the economic crisis. This was more than double the increase in visits between calendar years 2007 and 2008. About two-thirds (68 percent) of health centers reported that at least 10 percent of their patients have recently been affected by unemployment. One in five health centers (19 percent) put the proportion at 30 percent or higher.[22]

"Wake Health Services Rock Quarry Health Center has helped me greatly. I am a colon cancer survivor. If it were not for the health center I would probably be sick and depressed. I had been sick and trying to work, and I kept putting off care because I had to work to pay the bills. I went to the emergency room, and they diagnosed me with cancer. I didn't leave the hospital for a month. After I left the hospital, Rock Quarry offered to provide me with services. They check me for cancer. They write prescriptions. I would have nowhere to go for care if it wasn't for Rock Quarry Road. I would go to the hospital for services but they don't have a clinic anymore. I have no health insurance. My job used to offer health insurance, and then they stopped and then the company moved to another city."

— Joanne Feaster, 56, former telephone operator, patient at Wake Health Services, Raleigh, NC

"So my thing was, an apple a day will keep the doctor away. So I will eat my apple. But, no insurance will also keep the doctor away. So, that was my thing, I can't go to the doctor, cause I had no insurance, I can't afford a test, I couldn't go see what was wrong with my heart. I had an abscess, I couldn't afford to extract a tooth, that was $285. I couldn't afford to do that. The basic things, your blood tests, I couldn't afford to. I campaigned, made sure people took HIV tests, encouraged the young people to do that, but I talked, but couldn't walk, I couldn't afford to. And when I came here, I told [the nurse], she gave me my dignity back, cause we did the forms, I got to see the doctor, I got to see the dentist, I got to extract my tooth, got to go to a heart specialist, got to take my EKG, my echogram, and ladies, the mammogram, and all the things had fallen back in place"



— Florentina Richardson, patient at Community Health Center, Inc., Middletown, CT.

THE CHRONICALLY ILL

Chronic disease is one of the largest burdens on the U.S. health care system because of its increasing prevalence and continuous demand for care and management.[23] **Health centers have a higher proportion of patients with chronic conditions than other providers**.[24] Hypertension and diabetes are currently the leading diagnoses for patients visiting health centers. Over the past 10 years, the number of patients with certain chronic diseases has doubled. In 2009, approximately 15 million health center visits were for patients with chronic disease – including depression and other behavioral health conditions – who depend on health centers for their care.[25]

Research shows that Community Health Centers provide more effective chronic management than other providers for many chronic conditions[26] even though their patients are poorer and more at risk for adverse outcomes than other providers. Health centers significantly reduce the expected lifetime incidence of diabetes complications, including blindness, kidney failure, and certain forms of heart disease.[26] Their chronic care management activities have significantly improved clinical processes of care in just one to two years and clinical outcomes in two to four years.[24]

Fig. 7

HEALTH CENTER PATIENTS ARE MORE LIKELY TO HAVE SERIOUS CHRONIC CONDITIONS THAN PATIENTS OF OTHER PROVIDERS

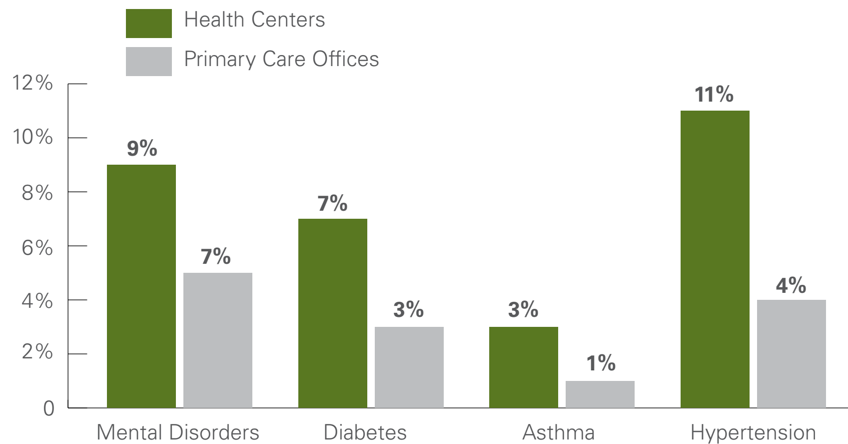
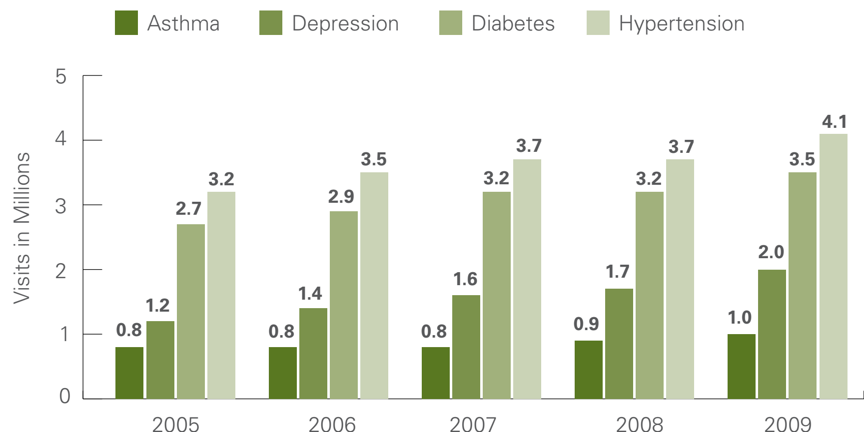


Fig. 8

THE NUMBER OF CHRONIC CONDITION VISITS AT HEALTH CENTERS HAS INCREASED, 2005-2009



Note: Only includes visits by primary diagnosis and therefore likely underestimates the true volume of care provided by condition.

Fig. 7 Source: Kaiser Family Foundation. Community Health Centers: Opportunities and Challenges of Health Reform. August 2010. Available at http://www.kff.org/uninsured/upload/8098.pdf. Based on Private Physicians from 2006 NAMCS (CDC National Center for Health Statistics, 2008). Health Centers from UDS, 2006.

Fig. 8 Source: NACHC analysis of Bureau of Primary Health Care, HRSA, DHHS, 2006, 2007, 2008, and 2009 Uniform Data System (UDS).

Fig. 9

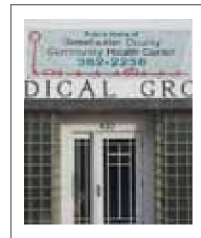
HEALTH CENTERS SERVE 1 IN 7 PEOPLE LIVING IN RURAL COMMUNITIES

RURAL COMMUNITIES

About 1 in 5 Americans lives in a rural area.[28] Compared with their urban counterparts, rural residents are more likely to be older, poor, and in fair or poor health with chronic conditions.[29] Rural residents are less likely than their urban counterparts to receive recommended preventive services and, on average, report fewer visits to health care providers.[30] Transportation needs are more pronounced among rural residents, who must travel longer distances to access care. Nearly 1 in 5 Americans living in rural areas does not have a usual source of care.[20]

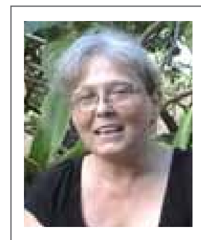
Health centers serve 1 in 7 rural residents.[31] Just like other Community Health Centers, health centers in rural areas also provide "enabling services" that facilitate access by either bringing the patients to care or care to the patients. Fifty-five percent provide transportation services to overcome geographic and transportation barriers and 75 percent have on-site pharmacies so patients do not have to drive to other locations. Without a health center in these communities, many residents would have to travel great distances to receive medical or dental care. Research has shown that rural counties without a health center have 25 percent more hospital emergency department visits that could have been treated in a primary care setting,[32] and 55 percent more pediatric preventable hospitalizations.[33]

"There are no medical or dental providers in [Sweetwater County] that are accepting new Medicare or Medicaid Patients. It is estimated that over 31,000 patient visits are not being met because of the lack of providers.



When we put the banner on our medical building announcing that we would be opening soon, an average of seven patients a day called asking for an appointment."

—Tiona Linkenauger, CEO of Sweetwater County Community Health Center, Rock Springs, WY [The center is awaiting federal funding to become an FQHC.]



"[My husband] Roy had a minor health problem and we came to the health center. We were uninsured, but they helped us. They paid for his biopsy. Within two months he was in treatment, and by February he was cancer free. I firmly believe that if the health center had not been there for us, I'd probably be a widow today. Next year we will be celebrating our 30th anniversary and I strongly believe that the health center is responsible for that… To give back I've become a board member of the Waimanalo health center, and beside being one of the most rewarding things I've ever done, I've learned how important they are in these communities, and my wish is that every community would have a health center, because when you have a problem, you're not insured or you're under insured, they'll help you.

— Kathy Conner, patient and board member at Waimānalo Health Center, Waimānalo, HI

Fig. 9 Source: NACHC estimates based on Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2009 Uniform Data System. Kaiser Family Foundation. www.statehealthfacts.org. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).

Courtesy of Direct Relief International, photography by Margaret Molloy

THE HEALTH CARE SYSTEM AT RISK

Without a health center, these populations would be forced to turn to other medical providers, putting pressure on an already strained and limited primary care infrastructure. As demand exceeds the supply of care, the result could be increased waiting times and access barriers for most or all people. Patients who cannot get timely primary care in health centers or physicians' offices may spill over into more expensive emergency rooms or experience delays that result in otherwise avoidable hospitalizations for conditions that could be treated in ambulatory care settings.

Further cuts to the Community Health Center program would therefore have a ripple effect on the health care delivery system and in communities that are very slowly recovering from unemployment and a sluggish economy. Such a trend would increase the costs in an already fragile health care system and strain under-resourced communities.

DIMINISHING COST SAVINGS

Currently, health centers generate $24 billion in annual savings, including $6 billion in savings to federal and state Medicaid programs.[34] These savings could be lost should funding cuts and drastic Medicaid reductions occur. Studies have shown that:

- For every one dollar in health center funding reductions, $11.50 in potential savings is lost.[35]
- Lower health center capacity in communities is associated with higher ED utilization among low-income populations.[36]

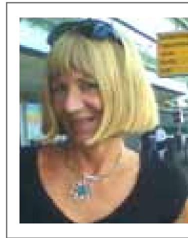
REDUCED ECONOMIC ACTIVITY

Health centers generate nearly 190,000 jobs and $20 billion in annual economic activity through the purchase of goods and services from local businesses in poor rural and urban communities. **For every million dollar cut in federal funding, communities would lose $1.73 million in economic activity**.[37]

DETERIORATING HEALTH OUTCOMES

Health centers not only produce cost benefits, but they also improve access to needed services and improve health outcomes. They improve rates of important screening services, offer prenatal services that improve birth outcomes, narrow gaps in health disparities through routine screenings,[37] and boost the health outcomes for the chronically ill while reducing costs. Research shows the quality of their care is equal to or better than that of other providers, and 99 percent of patients report being satisfied by the care they receive at health centers.[20]

Another highlighting achievement of health centers is their dedication and record of success in reducing health disparities and improving health outcomes for the most vulnerable populations. Even though health center patients often live in poverty and are at higher risk for chronic health conditions, research has shown that health centers narrow or even eliminate health disparities among their patients because they reduce barriers and provide high quality care.[20] And despite accounting for 1 in 6 of all low-income births, their patients are consistently below the national average for low birth weight. For example, without health centers, there would be 17,000 more African American low birth weight infants annually.[38]



"For years, I worked full-time in the pharmaceutical industry, which provided a great salary and insurance coverage for myself and my daughter. Unfortunately, as the recession grew, I joined the growing ranks of unemployed when management laid off nearly half of its experienced, well-paid employees. I was left without any coverage, paying for basic care from my dwindling savings and whatever work I could find, while trying to support my daughter in college.

Last spring, I began experiencing very bizarre symptoms: severe pain that traveled to odd areas of my arms and legs, bouts of Bell's Palsey, and extreme fatigue that made it difficult to function at a normal level. Being a strong, athletic person, this was making no sense. I was supposed to travel to Sweden to visit family, a trip planned 6 months prior. As the symptoms increased, I was frantic for medical help, but with no insurance it seemed hopeless. I saw an ad for the Open Door Family Medical Centers and called right away. A very professional and caring staff member answered and listened as I explained my situation. I'll never forget her response: 'Can you come in today? We go on a sliding scale basis, so please don't worry, we will accommodate you.' I nearly cried with relief!

That day I was privileged to meet Dr. Margaret (Marge) Statile, with whom I felt an instant rapport. She did an extensive history and exam. Over the next two weeks, as symptoms worsened, I considered canceling my trip, when she decided to do a Lyme titer, putting it on rush. She called first thing in the morning with great news. "Don't cancel that trip! You have Lyme Disease and we caught it early. I'll prescribe antibiotics; you'll feel fine in a few days." She was right."

— Barbara Beals, patient at Open Door Family Medial Centers, Ossining, NY

Courtesy of Direct Relief International, photography by Margaret Molloy

WHY HEALTH CENTERS MATTER

There are many reasons why 20 million-plus otherwise medically disenfranchised people go to health centers to receive their care. Health centers have over 45 years of experience providing high-quality, cost-effective primary care to underserved communities. With recent projections showing that national health spending will double by the year 2020, partially due to the lingering effects of the economic recession but also due to the increase in demand for health care,[39] Community Health Centers can effectively address the heart of this challenge, serving patients in tough economic situations, patients who might otherwise drive up the overall costs of care if not for health centers.

The testimonials of health center patients and staff illustrate that a growing and diverse medically disenfranchised population is more reliant on health centers than ever before. Community Health Centers can play a vital role in the delivery of health care, but cuts in health center funding and drastic changes to Medicaid severely limit their ability to serve the disenfranchised. This in turn begins a downward cycle of higher costs to the entire health care system. **Although reducing health center funding may lower the budget in the short term, the long term consequences would be devastating for individuals, communities, and the broader health care system.**

[1] NACHC, 2011. Includes all patients of federally funded health centers as reported through the Uniform Data System, as well as NACHC data on non-federally funded health centers, and expected growth through 2011.

[2] NACHC analysis of Bureau of Primary Health Care, HRSA, DHHS, 2009 Uniform Data System (UDS) and AHRQ Medical Expenditures Panel Survey, 2008 Tables of Expenditures by Health Care Services. Low-income is defined by 200% of Federal Poverty Level.

[3] Hing, E., & Uddin, S. (2010). Visits to Primary Care Delivery Sites: United States, 2008. *NCHS Data Brief, (47)*(47), 1-8.

[4] NACHC. (2010). Primary Care Access: An Essential Building Block of Health Reform. Retrieved July 25, 2011 from http://www.nachc.com/access-reports.cfm.

[5] NACHC. (2010). Entering the Era of Reform: The Future of State Funding for Health Centers. State Policy Report 33, October 2010. Retrieved July 25, 2011 from http://www.nachc.com/client/State%20Funding%20Report-%20Final.pdf.

[6] NACHC analysis is based on Center for Budget and Policy Priorities, *What if Ryan's Medicaid Block Grant Had Taken Effect in 2000? Federal Medicaid Funds Would Have Fallen over 25% in Most States, Over 40% in Some, by 2009.* To estimate the total Medicaid spending levels by state using Kaiser Family Foundation. HYPERLINK "http://www.statehealthfacts.org/" www.statehealthfacts.org. Data Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from Centers for Medicare and Medicaid Services HCFA-64 reports, 2011. This analysis assumes state spending reductions would be proportional to their current matching assistance percentage and understands that CBPP does not account for federal reductions to increases in 2009 Medicaid spending. Thus, producing a conservative estimate. NACHC used Bureau of Primary Health Care, HRSA, DHHS, 2009 Uniform Data System (UDS) to estimate Medicaid patients under a block grant and compared 2009 Medicaid patients caseloads.

[7] Starfield, B., & Shi, L. (2004). The Medical Home, Access to Care, and Insurance: A Review of Evidence. *Pediatrics, 113*(5 Suppl), 1493-1498.

[8] National Center for Health Statistics. Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011.

[9] Roberts B, Povich D, Mather M. Great Recession Hits Hard At America's Working Poor: Nearly 1 in 3 Working Families in United State Are Low-Income. The *Working Poor Families Project. Policy Brief. Winter 2010-2011*. http://www.workingpoorfamilies.org/pdfs/policybrief-winter2011.pdf.

[10] NACHC, 2011. Includes all patients of federally funded health centers as reported through the Uniform Data System, as well as NACHC data on non-federally funded health centers, and expected growth through 2011.

[11] Shi, L., Lebrun, L. A., Tsai, J., & Zhu, J. (2010). Characteristics of Ambulatory Care Patients and Services: A Comparison of Community Health Centers and Physicians' Offices. *Journal of Health Care for the Poor and Underserved, 21*(4), 1169-1183. doi:10.1353/hpu.2010.0928.

[12] Cunningham, P. J., & Hadley, J. (2008). Effects of Changes in Incomes and Practice Circumstances on Physicians' Decisions to Treat Charity and Medicaid Patients. *The Milbank Quarterly, 86*(1), 91-123. doi:10.1111/j.1468-0009.2007.00514.x

[13] Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2000 and 2009 Uniform Data System. Kaiser Commission on Medicaid and the Uninsured. Medicaid Enrollment: December 2009 Snapshot. September 2010. Retrieved July 25, 2011 from http://www.kff.org/medicaid/upload/8050-02.pdf.

[14] NACHC estimates based on Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2009 Uniform Data System. Kaiser Family Foundation. www.statehealthfacts.org. Data Source: Compiled by the Health Management Associates from state Medicaid enrollment reports, for the Kaiser Commission on Medicaid and the Uninsured, 2010. For more details on the December 2009 enrollment data, please see Medicaid Enrollment: December 2009 Data Snapshot, available at http://www.kff.org/medicaid/enrollmentreports.cfm.

[15] Kaiser Commission of Medicaid and the Uninsured. (2010). Medicaid: A Primer. June 2010. Retrieved July 25, 2011 from http://www.kff.org/medicaid/upload/7334-04.pdf.

[16] Rosenbaum S, Shin P. Medicare's Accountable Care Organization Regulations: How Will Medicare Beneficiaries who Reside in Medically Underserved Communities Fare? Geiger Gibson /RCHN Community Health Foundation Research Collaborative. *Policy Brief #23 April 20, 2011*. Retrieved July 25, 2011 from http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_6EFAAA15-5056-9D20-3DBE579D20C06F05.pdf.

[17] Collins, S.R, Doty, M.M., Robertson R., Garber, T. Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief (2011), March 16th, 2011, The Commonwealth Fund. Retrieved July 25, 2011 from http://www.commonwealthfund.org/~/media/Files/Surveys/2011/1486_Collins_help_on_the_horizon_2010_biennial_survey_report_FINAL_31611.pdf.

[18] Kaiser Commission on Medicaid and the Uninsured. (2010). The Uninsured: A Primer. December 2010. Retrieved July 25, 2011 from http://www.kff.org/uninsured/upload/7451-06.pdf

[19] NACHC estimates based on Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2009 Uniform Data System. Kaiser Family Foundation. www.statehealthfacts.org. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).

[20] Proser, M. (2005). Deserving the Spotlight: Health Centers Provide High-quality and Cost-effective Care. *The Journal of Ambulatory Care Management, 28*(4), 321-330.

[21] Shin, P., Rosenbaum, S. The Role of Community Health Centers in Addressing the Needs of Uninsured Low Income Workers: Implications of Proposed Federal Funding Reductions. Geiger Gibson / RCHN Community Health Foundation Research Collaborative *Policy Research Brief # 22*. March 17, 2011.

[22] NACHC. Recession Brings More Patients to Community Health Centers. September 2009. Retrieved July 25, 2011 from http://www.nachc.com/client/documents/rising_patient_%20demand_093.pdf.

[23] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. (2009). Chronic Diseases and Health Promotion, http://www.cdc.gov/chronicdisease/overview/index.htm and Russo C and Andrews R. The National Hospital Bill: The Most Expensive Conditions, by Payer, 2004. September 2006. Healthcare Cost and Utilization Project, *Statistical Brief No. 13*, Agency for Healthcare Research and Quality.

[24] Hing, E., Hooker, R. S., & Ashman, J. J. (2011). Primary Health Care in Community Health Centers and Comparison with Office-Based Practice. *Journal of Community Health, 36*(3), 406-413. doi:10.1007/s10900-010-9322-x.

[25] NACHC analysis of Bureau of Primary Health Care, HRSA, DHHS, 2009 Uniform Data System (UDS).

[26] Chin, M. H. (2010). Quality Improvement Implementation and Disparities: The Case of the Health Disparities Collaboratives. *Medical Care, 48*(8), 668-675. doi:10.1097/MLR.0b013e3181e3585c . U.S. General Accounting Office. (2003). *Health Care: Approaches to Address Racial and Ethnic Disparities.* Publication No. GAO-03-862R. Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.* Washington, DC: National Academy of Sciences Press: 2003.

[27] Huang, E. S., Zhang, Q., Brown, S. E., Drum, M. L., Meltzer, D. O., & Chin, M. H. (2007). The Cost-effectiveness of Improving Diabetes Care in U.S. Federally Qualified Community Health Centers. *Health Services Research, 42*(6 Pt 1), 2174-93; discussion 2294-323. doi:10.1111/j.1475-6773.2007.00734.x.

[28] Committee on the Future of Rural Health Care, Institute of Medicine. Quality through Collaboration: The Future of Rural Health. Washington, DC: National Academies Press; 2005.

[29] Ziller EC, Coburn AF, Loux SL, et al. Health Insurance Coverage in Rural America. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Retrieved July 14, 2011 from http://www.kff.org/uninsured/4093.cfm and Committee on the Future of Rural Health Care, Institute of Medicine. (2005). Quality through collaboration: the future of rural health. Washington, DC: National Academies Press.

[30] Larson, S. L., & Fleishman, J. A. (2003). Rural-Urban Differences in Usual Source of Care and Ambulatory Service Use: Analyses of National Data Using Urban Influence Codes. *Medical Care, 41*(7 Suppl), III65-III74. doi:10.1097/01.MLR.0000076053.28108.F2.

[31] NACHC estimates based on Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2009 Uniform Data System. Kaiser Family Foundation. www.statehealthfacts.org. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).

[32] Rust, G., Baltrus, P., Ye, J., Daniels, E., Quarshie, A., Boumbulian, P., et al. (2009). Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties. *The Journal of Rural Health : Official Journal of the American Rural Health Association and the National Rural Health Care Association, 25*(1), 8-16. doi:10.1111/j.1748-0361.2009.00193.x.

[33] Garg, A., Probst, J. C., Sease, T., & Samuels, M. E. (2003). Potentially Preventable Care: Ambulatory Care-Sensitive Pediatric Hospitalizations in South Carolina in 1998. *Southern Medical Journal, 96*(9), 850-858.

[34] Ku. L.,Richard, P., Dor, A., et al. (2010). Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform. Geiger Gibson/RCHN Community Health Foundation Collaborative at the George Washington University. June 30 2010. *Policy Research Brief No. 19.* Retrieved July 25, 2011 from http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_895A7FC0-5056-9D20-3DDB8A6567031078.pdf.

[35] Shin, P., Rosenbaum, S. (2011). The Health Care Access and Cost Consequences of Reducing Health Center Funding. Geiger Gibson / RCHN Community Health Foundation Research Collaborative *Policy Research Brief # 21*. March 15, 2011. Retrieved July 25, 2011 from http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_B4FD331D-5056-9D20-3DEFF1D54B246805.pdf.

[36] Cunningham, P. J. (2006). What Accounts for Differences in the Use of Hospital Emergency Departments across U.S. Communities? *Health Affairs (Project Hope), 25*(5), w324-36. doi:10.1377/hlthaff.25.w324.

[37] NACHC, CapitaLink. Community Health Centers Lead the Primary Care Revolution. August 2010. Retrieved July 25, 2011 from http://www.nachc.com/research-factsheets.cfm.

[38] Shi, L., Stevens, G. D., Wulu, J. T.,Jr, Politzer, R. M., & Xu, J. (2004). America's Health Centers: Reducing Racial and Ethnic Disparities in Perinatal Care and Birth Outcomes. *Health Services Research, 39*(6 Pt 1), 1881-1901. doi:10.1111/j.1475-6773.2004.00323.x.

[39] Keehan, S.P., Sisko, A.M., Truffer, C.J., et al. (2011). National Health Spending Projections Through 2020: Economic Recovery and Reform Drive Faster Spending Growth. *Health Affairs, no. (2011): doi:*10.1377/hlthaff.2011.0662.

NATIONAL ASSOCIATION OF
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The National Association of Community Health Centers (NACHC) represents Community, Migrant, and Homeless Health Centers as well as Public Housing Health Centers and other Federally Qualified Health Centers. Founded in 1971, NACHC is a nonprofit organization providing advocacy, education, training, and technical assistance to health centers in support of their mission to provide quality health care to underserved populations.

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