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COMMUNITY HEALTH CENTERS

Adapting to Changing Health Care Environment Key to Continued Success

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Contents

Abbreviations

BBA	Balanced Budget Act
C/MHC	community and migrant health center
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MCO	managed care organization
MGMA	Medical Group Management Association
OBRA	Omnibus Budget Reconciliation Act
PCER	Primary Care Effectiveness Review
SCHIP	State Children's Health Insurance Program
UDS	Uniform Data System

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United States General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

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March 10, 2000

The Honorable James M. Jeffords
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Bill Frist
Chairman
Subcommittee on Public Health
Committee on Health, Education, Labor and Pensions
United States Senate

About 35 years ago, federal community and migrant health centers (C/MHC) were established to increase the availability of primary and preventive health care services for low-income people living in medically underserved areas. C/MHCs have been an important safety net provider for Medicaid beneficiaries, minorities, and uninsured families. In some communities, they may be the only primary care provider available to these vulnerable populations. C/MHCs rely on funding from a wide variety of public and private sources, including federal, state, and local governments; foundation grants; and payments for services from Medicaid, Medicare, private insurance, and patients. Fiscal year 2000 appropriations for the Consolidated Health Centers program totaled over $1 billion.[1]

Recent developments in the health care environment—such as the steady growth in the number of uninsured, a dramatic increase in the use of managed care by Medicaid, and increased competition and consolidation among health care providers—have presented new challenges for C/MHCs. In light of these developments, you asked us to examine how C/MHCs are evolving to meet the needs of the nation's vulnerable populations. Specifically, you asked us to (1) describe the current status of C/MHCs, the populations they serve, the types of services they provide, and their primary sources of revenue; (2) describe changes in Medicaid that have had an effect on C/MHCs; (3) discuss how C/MHCs have responded to these and

[1]The Health Centers Consolidation Act of 1996 (P.L. 104-299, 110 Stat. 3626) combined programs for community health centers, migrant health centers, health care for the homeless, and primary care for residents of public housing into one.

other changes in the health care environment; and (4) assess the Department of Health and Human Services' (HHS) actions to monitor C/MHC performance and help them improve operations.

To conduct our work, we analyzed national data from C/MHCs that receive federal grants and interviewed federal officials, representatives of state and national C/MHC membership organizations, and primary care experts. We also conducted case studies of eight C/MHCs in urban and rural areas of Colorado, Florida, and Maryland and met with state public health and Medicaid officials and C/MHC membership organizations in those states. To assess HHS' oversight activities and obtain views about C/MHCs nationwide, we interviewed headquarters and field office officials in HHS' Health Resources and Services Administration (HRSA), which administers the grants to centers, and reviewed documents they provided. Financial and demographic data on C/MHCs come from HRSA's Uniform Data System (UDS), an administrative database of self-reported information from C/MHCs. (For more detail on our methodology, see app. I.) Our work was conducted from September 1998 to January 2000 in accordance with generally accepted government auditing standards.

Results in Brief

The number of C/MHCs remained stable from 1996 to 1998, at a little over 600 grantees. In 1998, centers on average served more patients and provided care at a greater number of locations than they did in 1996. Nevertheless, HRSA estimates that about half of the C/MHCs have some operational or financial problems and about 10 percent are struggling to maintain operations. While approximately 2 percent lost federal grant funding each of the last 3 years, about the same number of grantees entered the program. C/MHCs primarily serve children, low-income individuals, and minority populations. A high—and increasing—proportion of the centers' patient population is uninsured and a significant proportion is enrolled in Medicaid. In addition to primary care, C/MHCs provide ancillary services, such as transportation, but at times have had to curtail these services because of declining revenues. While federal grant funding for the C/MHC program increased significantly in recent years, from about $825 million in fiscal year 1998 to about $1.02 billion for fiscal year 2000, the program's major source of funding since the 1980s has been Medicaid payments.

Recent legislative and programmatic changes, including the growing use of managed care by Medicaid, can affect the number of Medicaid beneficiaries that C/MHCs treat and, in some cases, reduce centers' Medicaid revenues. In implementing mandatory Medicaid managed care programs, some states

discontinued cost-based reimbursement for C/MHCs and some health centers in these states experienced declines in Medicaid reimbursements. The Balanced Budget Act of 1997 (BBA) allowed all states to gradually reduce reimbursement levels. BBA also required states to make supplemental payments to centers participating in Medicaid managed care to cover differences between the managed care organizations' payments and the minimum reimbursement level established by BBA. However, some states have been slow in giving centers these required payments, resulting in reduced Medicaid reimbursements at some centers.

Most C/MHCs have adapted to recent changes in Medicaid and the overall health care environment. We found that C/MHCs that have formed partnerships and networks and are participating in managed care are more likely to be successful. Typically, the management teams at such centers demonstrate both strong business skills and a dedication to carrying out the C/MHC mission, and their boards actively perform their policy and oversight roles. Attracting patients with diverse payment sources and pursuing other revenue sources—such as foundation grants—have also contributed to better C/MHC financial performance. C/MHCs that have not adjusted to the changes in Medicaid and the health care market and whose management and board have not paid sufficient attention to their financial operations are more likely to have problems.

To monitor the performance of C/MHCs, HRSA conducts onsite reviews and collects and analyzes program data. For centers with performance problems, HRSA may provide certain assistance, such as developing a financial recovery plan. While such action has helped some struggling centers, HRSA's monitoring tools—as well as the timeliness of its interventions—could be improved. For example, the information in UDS, HRSA's C/MHC administrative database, is not always complete, accurate, or useful. HRSA has also been encouraging C/MHCs to seek accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a means of improving their quality of care and competitiveness, but it is not clear whether such accreditation will produce the anticipated benefits. While HRSA encourages centers to plan strategically, form partnerships, and participate in managed care, C/MHCs could further benefit if HRSA established a systematic best practices program that would allow centers to share successful strategies and implement proven solutions. We are, therefore, recommending that HRSA take steps to improve its collection and use of monitoring data, evaluate the usefulness of JCAHO accreditation, and facilitate information sharing on best practices among C/MHCs. In addition, we are recommending that

the Health Care Financing Administration (HCFA), the HHS agency responsible for overseeing the Medicaid program, ensure that states comply with federal requirements for reimbursing C/MHCs.

Background

Most C/MHCs are nonprofit community-based organizations.[2] C/MHCs were established in the mid-1960s with federal grant funding in an effort to help low-income individuals gain access to health care. C/MHCs offer primary and preventive health services provided by clinical staff—including physicians, nurses, dentists, and mental health and substance abuse professionals—or through contracts or cooperative arrangements with other providers. A distinguishing feature of centers is that they provide "enabling services" that help patients gain access to health care, such as outreach, translation, and transportation. Most C/MHCs operate facilities at several locations. C/MHCs are typically managed by an executive director, a financial officer, and a clinical director. A C/MHC community board, with a majority of members who are C/MHC patients, provides policy oversight and has the authority to hire and fire the center's executive director.

The C/MHC program is administered by HRSA's Bureau of Primary Health Care. HRSA provides grants to health centers to support the provision of health care and enabling services. As part of its responsibility for overseeing the C/MHC program, HRSA provides technical assistance and training to C/MHCs. The ongoing operations of C/MHCs are reviewed and monitored by HRSA's 10 field offices. These offices use formal monitoring tools and informal communications to determine whether C/MHCs are complying with federal statutes, regulations, and policies. C/MHCs are required to annually report administrative data on their operations through UDS.[3]

HRSA also provides grants to state and regional primary care associations—private, nonprofit membership organizations of C/MHCs and other providers—and has cooperative agreements with primary care offices, federally-supported entities within state health agencies. These statewide organizations aim to develop comprehensive primary health care

[2]Some C/MHCs are public organizations.

[3]Until 1996, these data were captured under the Bureau Common Reporting Requirements system.

services and provide technical assistance to C/MHCs. HRSA coordinates with HCFA, which administers the Medicaid and Medicare programs, on issues concerning C/MHCs. Since Medicaid is a federal-state program, HCFA works with states to provide information and guidance and ensure compliance with federal law.

C/MHCs Have Been a Stable Source of Care for Underserved People in Urban and Rural Areas

The number of operating C/MHCs has remained stable over the past several years. Nevertheless, HRSA estimates about half have some operational or financial problems and a small proportion are either struggling or have lost their federal grant funding. C/MHCs primarily serve children, low-income individuals, and minority populations. A high—and increasing—proportion of the centers' patient population is uninsured, and a significant proportion is enrolled in Medicaid. In addition to primary care, C/MHCs provide ancillary services but, at times, have had to curtail these services due to declining revenues. Since the program's inception, the major source of funding has shifted from federal grants to Medicaid payments. This shift in revenue base was the result of changes in federal Medicaid policy that expanded Medicaid eligibility and payment to centers coupled with marginal increases in the health centers' appropriations for several years.

Most C/MHCs Stay in Business, Operating More Sites and Serving More Patients

Between calendar years 1996 and 1998, the number of C/MHC grantees, as reported in UDS, changed minimally, growing from 608 to 611.[4] (See app. II for information on the number of urban and rural C/MHCs in each state.) During this 3-year period, 44 centers lost their federal grant funding, but a similar number of new centers received funding. The average number of sites each health center operated increased from 4 in 1996 to 5 in 1998. During this period, the number of people served by C/MHCs increased from 7.7 million to 8.3 million, and the average number of patients at each center increased from 12,801 to 13,585. In 1998, approximately 57 percent of health center grantees were located in rural areas,[5] but the number of people served in rural and urban areas in 1998 was approximately the same.

[4]In 1996 and 1998, HRSA reported 631 and 643 grantees, respectively. For our analysis, we excluded C/MHCs that did not report to UDS and those that were migrant voucher programs.

[5]Urban/rural designation is self-reported by C/MHC grantees.

According to HRSA, about 40 percent of all health centers are operating efficiently, maintaining sufficient staff capacity and serving a growing number of patients. About 50 percent are considered viable but are experiencing some operational problems. The remaining 10 percent are struggling to survive, and they typically have major financial problems, such as a large deficit; vacancies on their management team; or significant losses or turnover of core medical providers. The smallest centers (5,000 or fewer patients) are more likely than larger centers to have problems; according to HRSA's estimate, over three-fourths of the smallest centers have operational problems or are struggling, in comparison with less than half of centers serving over 5,000 patients. Each year, a small proportion of centers—about 2 percent—actually lose federal funding, typically due to poor financial performance. Of the 23 centers that lost their federal grant funding from 1996 through 1998 and reported information to UDS, 74 percent had 10,000 or fewer patients and 61 percent were located in rural areas. Program experts note that centers' degree of success is not necessarily constant. C/MHCs that excel for a few years sometimes develop problems, and some having problems have turned their situation around and become more successful.

The cost-revenue balance at many health centers is tenuous. In 1998, C/MHCs reported that average costs, about $5 million, exceeded average revenues by a small margin. Half of all centers had costs that were less than or equaled total revenues. But for 5 percent of centers, costs exceeded revenues by 30 percent. Because C/MHCs operate within limited margins, it is also important for them to have cash reserves to cover unexpected expenses, particularly when they take on more financial risk through managed care and other health care ventures.[6] C/MHCs we visited reported having a difficult time maintaining such reserves. Of the eight health centers in our case studies, only one had cash reserves exceeding 60 days. Six of the centers had between 11 and 42 days worth of cash for operation, and one had no cash reserves.[7]

C/MHC Patients Are Predominantly From Vulnerable Populations, and Many Lack Health Insurance

A high proportion of C/MHC patients are from vulnerable populations, which have worse health status than the general population (see fig. 1). C/MHCs report that, overall, their user population is poor or low income: 65 percent have incomes at or under 100 percent of the federal poverty level, and another 21 percent have incomes from 101 to 200 percent of poverty. Urban C/MHCs report a higher proportion of poor patients than rural C/MHCs. C/MHCs also serve a disproportionate number of minorities. While Hispanics represent 11 percent of the population, they represent 32 percent of C/MHC patients. Similarly, blacks represent 12 percent of the population, yet they are 25 percent of C/MHC patients. Centers primarily serve children and women of childbearing age. According to health center reports, 41 percent of their patients are under age 20, with 29 percent under age 13. Women of childbearing age comprise 29 percent of C/MHC patients. Centers also report that almost one-fifth of their patients need an

[6]Sections 309(a)(3) and 309(b)(3) of the Preventive Health Amendments of 1992 facilitated the establishment of cash reserves to cover unanticipated expenses by prohibiting HHS from restricting the use of nonfederal funds to establish such reserves (P.L. 102-531, 106 Stat. 3469, 3501). Under 42 U.S.C. 254b(e)(5)(C), C/MHCs are still permitted wide latitude to use nongrant funds, including the ability to establish and maintain such reserves. Although there are differences in factors that influence the amount of cash reserves, such as the level of financial risk C/MHCs assume, HRSA suggests that a reserve amount sufficient to cover 60 to 90 days of normal operating expenses is reasonable.

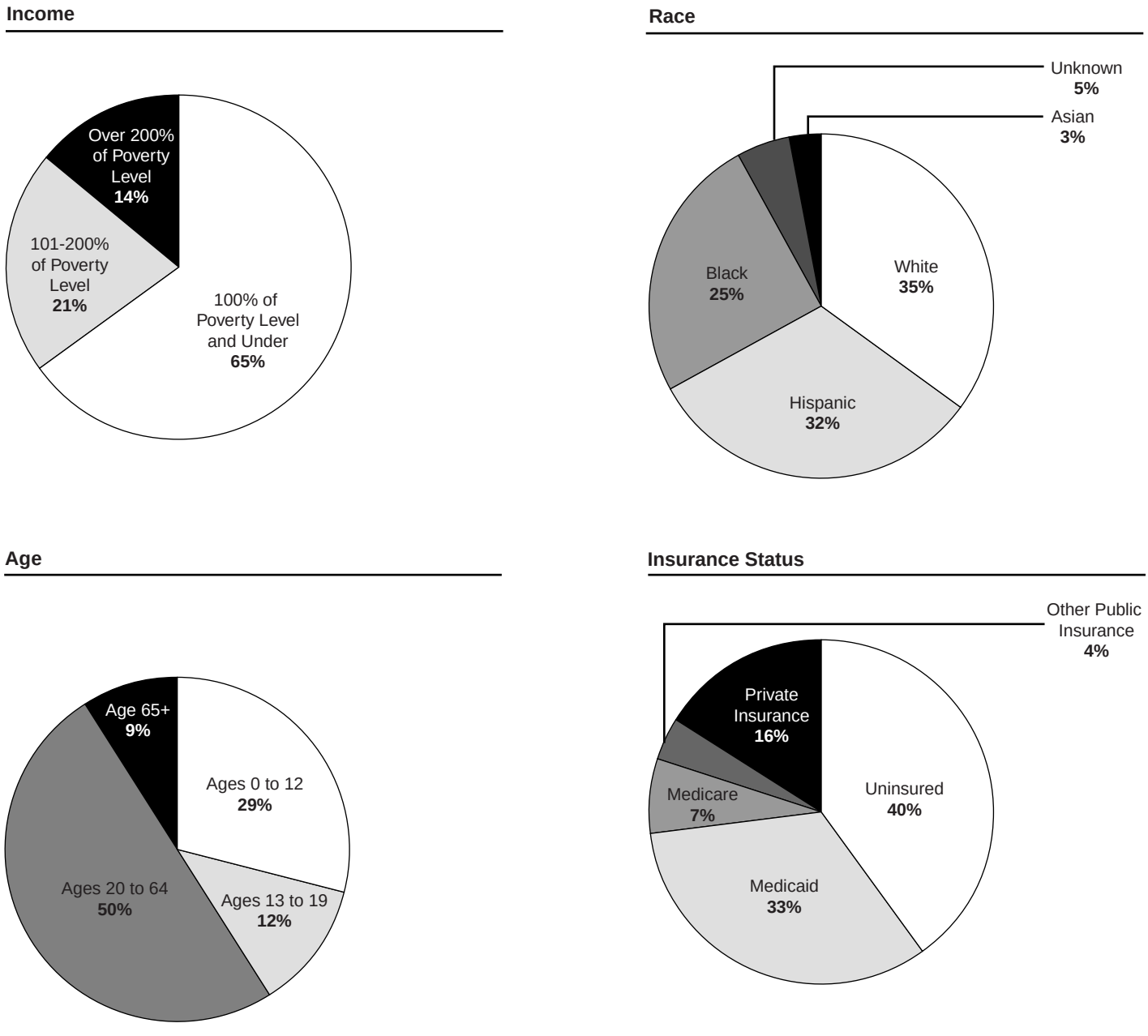
[7]This information is based on GAO's analysis of independent financial audits of the C/MHCs that were conducted between March 1998 and March 1999. We determined cash reserves for each center by calculating the average daily expenses for each and dividing this figure into the cash and cash equivalent balance on their financial statement. When we visited centers in mid-1999, however, executive directors of four C/MHCs in Florida and Maryland told us they did not have any cash reserves.

interpreter to use the services of the center, and about 6 percent of all health center users are migrant or seasonal farmworkers.

In 1998, C/MHCs reported that 40 percent of their patient population (3.3 million people) were uninsured.[8] For C/MHC users who have health insurance, Medicaid was the largest source of coverage. In 1998, 2.7 million C/MHC users—33 percent of total users—were Medicaid beneficiaries. Privately insured individuals also used C/MHCs and represented about 16 percent of users. Another 7 percent of C/MHC users were covered by Medicare.

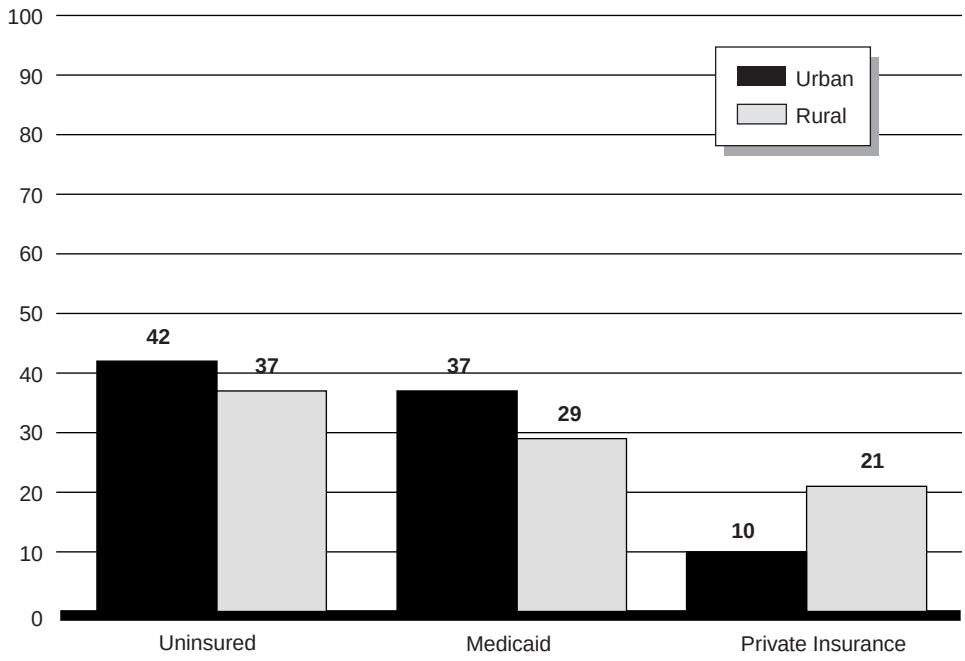
[8]Uninsured users pay a fee for services, based on a sliding fee schedule that takes into account their income level.

Figure 1: C/MHC Patient Population Characteristics, 1998



In 1998, urban C/MHCs reported a higher percentage of uninsured and Medicaid patients than rural centers, while rural C/MHCs reported a higher percentage of privately insured patients than urban centers. (See fig. 2.)

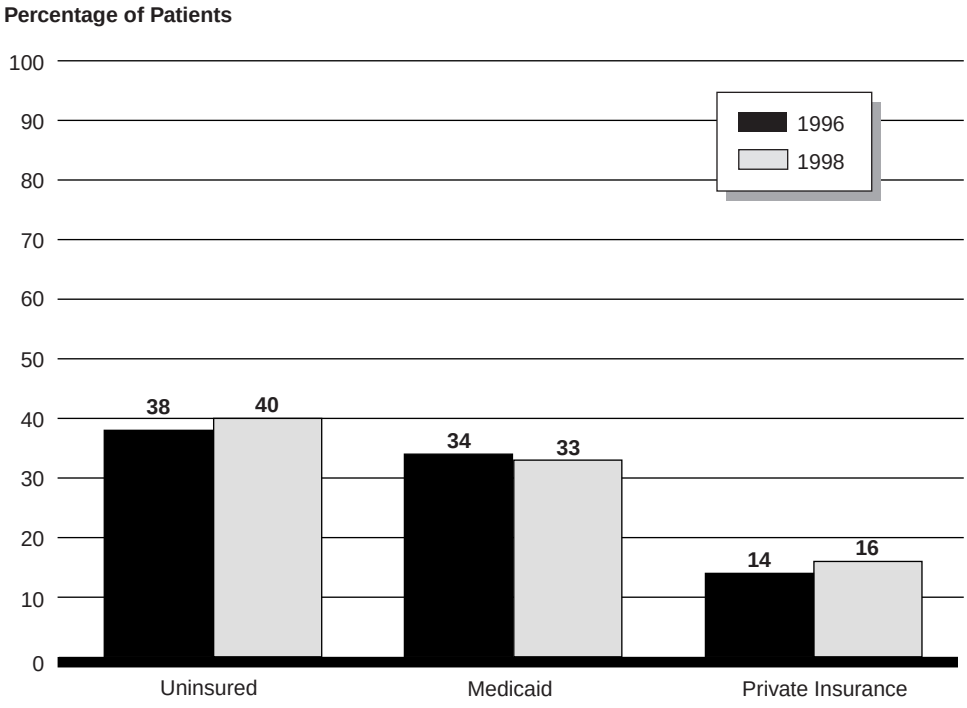
Figure 2: Urban and Rural C/MHC Patient Populations' Insurance Status, 1998



Centers report a changing payer mix over the past several years, reflecting the national growth in the uninsured (see fig. 3). In 1998, 18.3 percent of the nonelderly U.S. population—43.9 million people—lacked health insurance, a 6-percent increase from 1996. C/MHCs report that the number of uninsured people receiving care increased 10 percent between 1996 and 1998, and the proportion of users who were uninsured increased from 38 percent to 40 percent. As the proportion of uninsured users at C/MHCs increased over the 3-year period, the proportion of Medicaid patients declined slightly (from 34 percent to 33 percent). The reported proportion of privately insured individuals receiving care from C/MHCs increased from 14 percent in 1996 to 16 percent in 1998. Over the 3-year period, rural C/MHCs saw a higher increase than urban centers in the average number of uninsured patients (17 percent versus 4 percent). Urban C/MHCs reported

a 5-percent increase in the average number of Medicaid users, while rural centers showed a 1-percent decline.

Figure 3: C/MHC Patient Populations' Insurance Status, 1996 to 1998



C/MHCs Provide Access to Primary Medical Care, but Some Have Curtailed Ancillary Services

C/MHCs average four encounters per patient per year, providing mostly primary medical care. They also provide preventive dental services, and some provide restorative and emergency dental care, but these services represent a small proportion of overall encounters. About 5 percent of C/MHC encounters in 1998 were for mental health services or substance abuse prevention or treatment.

Recent HRSA evaluation studies have reported that C/MHCs have improved access to appropriate and timely health care services for underserved and vulnerable populations. For example, uninsured C/MHC users were more likely than other uninsured people to have a usual source of care and to have more frequent contacts with physicians.[9] Women who used C/MHCs were more up-to-date with Pap tests, mammograms, and clinical breast examinations than low-income and minority women in the general population.[10] Hypertensive adults who regularly use C/MHCs were more likely than their peers in the general population to discuss diet, exercise, tobacco, alcohol, and drug use with their doctor.[11] Furthermore, Medicaid beneficiaries who used C/MHCs had on average a 22-percent lower rate of hospitalization for ambulatory care sensitive conditions[12] than Medicaid beneficiaries who relied on other sources of primary care.[13]

C/MHCs are also required by federal statute to provide services that enable C/MHC users to gain access to primary health care, such as transportation and translation services.[14] State primary care representatives told us, however, that enabling services are often the first to be reduced when C/MHC revenues decline. Centers may reduce the number of staff providing a service or the scope and volume of services. The average number of enabling service encounters reported by C/MHCs declined from 8,869 in 1996 to 7,081 in 1998, although the number of enabling service encounters per user declined only slightly (3.7 to 3.4). Some state primary care representatives also reported that C/MHCs in their states had reduced enabling or dental services due to declining Medicaid revenues. For

[9]Bureau of Primary Health Care, *Primary Care for Patients Without Health Insurance by Community Health Centers* (Bethesda, Md.: Feb. 1999).

[10]J. Regan, B. Lefkowitz, and M. Gaston, "Cancer Screening Among Community Health Center Women: Eliminating the Gaps," *Journal of Ambulatory Care Management*, Vol. 22, No. 4 (1999), pp. 45-52.

[11]Bureau of Primary Health Care, *Primary Care of Patients With Hypertension by Community Health Centers* (Bethesda, Md.: Feb. 1999).

[12]Medical conditions such as diabetes, asthma, or hypertension for which timely, appropriate primary care can prevent or reduce the likelihood of hospitalization.

[13]Bureau of Primary Health Care, *ACSC Experience by Usual Source of Care: Comparing Medicaid Beneficiaries, CHC Users and Comparison Group* (Bethesda, Md.: June 1998).

[14]42 U.S.C. 254b(hh)(iv).

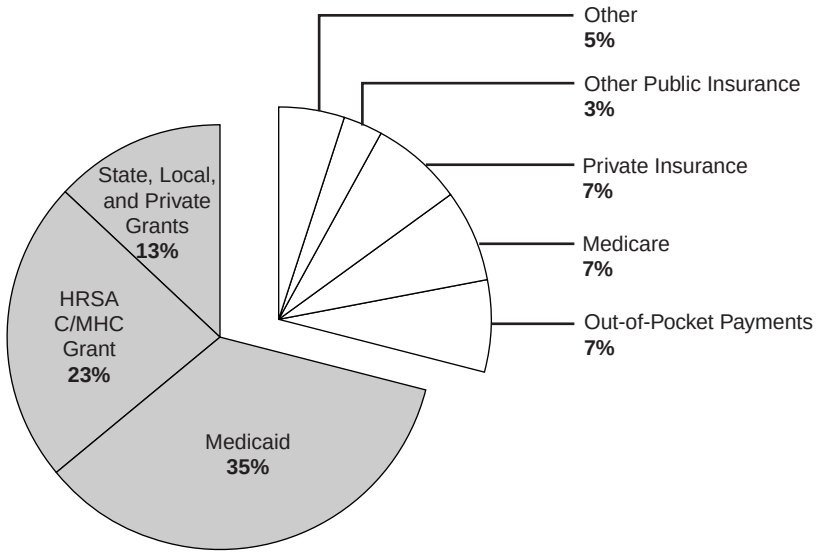
example, health centers in Ohio and Tennessee eliminated or reduced transportation, education, and counseling services.

Medicaid Has Become the Largest Source of C/MHC Revenue

In 1998, C/MHCs reported revenues of almost $3 billion. Medicaid was the largest funding source, representing about 35 percent of the total. HRSA's C/MHC grants were the second largest source, representing 23 percent of the total, and state and local government and private grants and contracts combined represented 13 percent.[15] C/MHC revenue also included patient payments, private insurance, Medicare, other public insurance, and other federal grants. (See fig. 4.)

[15]The types of state and local revenue C/MHCs receive include targeted capital improvement funding and uncompensated care revenue.

Figure 4: C/MHC Revenue by Source, Fiscal Year 1998

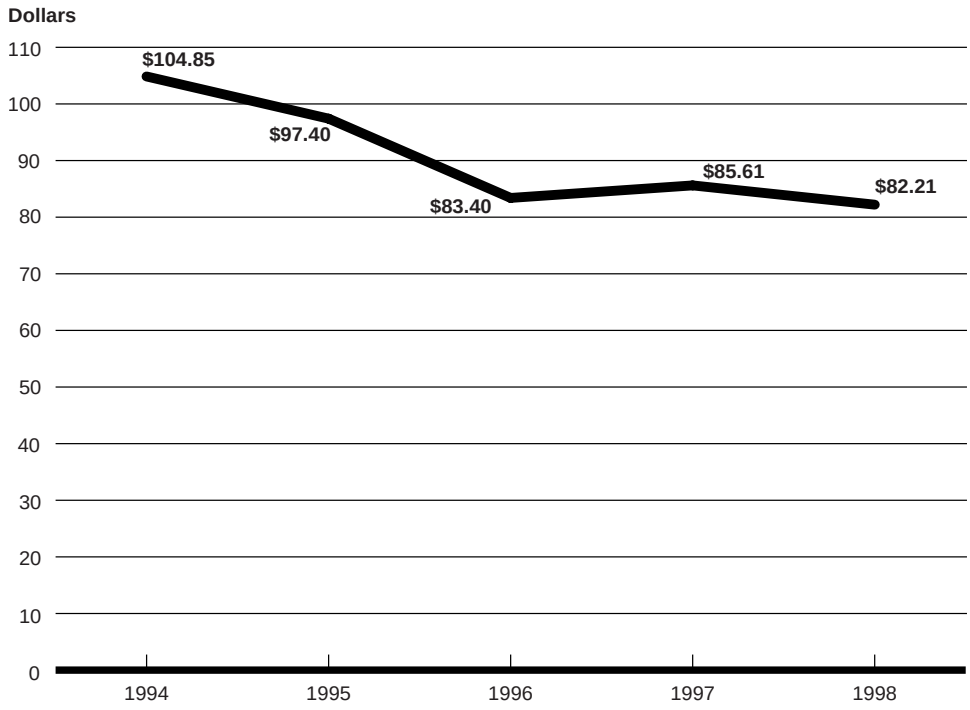


The proportion of revenue that comes from Medicaid has increased gradually, while the proportion of C/MHC revenue that comes from federal grant funding has steadily declined. In 1980, HRSA grant money accounted for over half of the revenue received by health centers, but by 1988, the percentage of revenue attributable to the federal grant had dropped to about 44 percent. In the 1980s, Medicaid eligibility was expanded significantly for pregnant women and children, and beginning in 1989, Medicaid was required to reimburse federally qualified health centers, including C/MHCs, at 100 percent of their reasonable costs.[16] After these Medicaid program changes were implemented, the percentage of revenue from federal grant funding declined further, and by 1998, it was 23 percent. Conversely, Medicaid funding in the 1980s accounted for less than 20 percent of C/MHC revenue, but by 1998, this source of funding had increased to about 35 percent of C/MHC revenue.

[16]Section 6404 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239, 103 Stat. 2258, 2264) established the Federally Qualified Health Centers program in Medicaid and Medicare. The law recognized these providers as a unique type of Medicaid and Medicare provider. Section 4704 of OBRA of 1990 (P.L. 101-508, 104 Stat. 1388, 1388-171) defined health center services as mandatory services and required Medicaid and Medicare to reimburse them at 100 percent of their reasonable costs.

In recent years, the amount of federal appropriations allocated for C/MHC grants did not keep pace with the growth in the C/MHC patient population. The adjusted appropriation per C/MHC patient decreased from $104.85 in 1994 to $82.21 in 1998.[17] (See fig. 5.) Moreover, UDS data indicate that between 1996 and 1998, federal grant dollars per uninsured C/MHC patient declined from $228 to $212.[18]

Figure 5: C/MHC Appropriations per Patient, 1994 Through 1998



In response to the increase in the uninsured and other challenges facing C/MHCs, the Congress passed legislation to substantially increase the C/MHC program budget in fiscal years 1999 and 2000. Federal funding for C/MHCs increased by $100 million in fiscal year 1999, up from about $825 million in fiscal year 1998. Over 80 percent of the existing C/MHCs

[17]Appropriation amounts are for fiscal years, and patient counts are for calendar years.

[18]Data on uninsured C/MHC users are not available prior to 1996.

received a share of this new funding. The largest portion, $45 million, increased the base funding levels of existing grantees by an average of $80,000, with funds targeted to well-performing centers providing the largest amounts of care to the uninsured. Another $20 million was invested in expanding the service capacity of existing health centers, with priority given to outreach, substance abuse, mental health, and oral health services. HRSA allocated $19 million for new community and migrant health centers and new sites in medically underserved areas, including sparsely populated rural areas. An additional $6 million was allocated to HRSA's ongoing efforts to help C/MHCs develop integrated delivery systems, including managed care and practice management networks. The remaining funds were used to establish new Health Care for the Homeless and Healthy Schools and Healthy Communities programs and for Community Development and other initiatives. For fiscal year 2000, appropriations for C/MHCs and other health center grantees increased by an additional $99 million.[19]

Recent Medicaid Changes Can Affect C/MHCs

A number of recent legislative and programmatic changes may affect the number of Medicaid beneficiaries that C/MHCs treat and centers' Medicaid revenues. While our analysis of UDS shows that, overall, the average number of C/MHC Medicaid patients has increased over the past several years, the number of Medicaid patients has declined at C/MHCs in 20 states and territories. The growth of state Medicaid managed care programs can affect C/MHC Medicaid enrollment and, in some cases, has resulted in reduced Medicaid revenues. Implementation of certain HCFA waivers to operate Medicaid managed care programs ended cost-based reimbursement for C/MHCs in some states; in other states, reimbursements can be gradually reduced, as allowed under section 4712(a) of the Balanced Budget Act of 1997, as later modified by section 603 of the Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999.[20] BBA included a degree of payment protection for C/MHCs participating in Medicaid managed care, but some states have been slow to provide required supplemental payments.

[19]This amount was later subject to a $5 million rescission.

[20]P.L. 105-33, 111 Stat. 251, 508; P.L. 106-113, 113 Stat. 1501, A-321, 1501A-395.

Declining Medicaid Population and Medicaid Managed Care Can Affect Number of Medicaid Beneficiaries Served by C/MHCs

Our analysis of C/MHC-reported data indicates that, overall, the average number of Medicaid patients seen at C/MHCs increased from 1996 to 1998. However, C/MHCs in 20 states and territories showed about 1-percent to 32-percent declines in Medicaid patients. Several factors could affect the number of Medicaid patients a specific C/MHC serves.

We recently reported that between 1995 and 1997, Medicaid enrollment nationwide declined by about 7 percent, with large variations among the states.[21] Medicaid enrollment changes were influenced by various factors, including a strong economy and welfare reform. In 1996, the Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act, severing the formal link between eligibility for cash assistance and Medicaid.[22] While eligibility criteria for cash assistance were tightened, the criteria for Medicaid eligibility remained essentially the same. However, Medicaid enrollment rates tend to be lower among eligible children and adults who do not receive cash assistance, and there is concern that people no longer eligible for cash assistance are not aware of their continued eligibility for Medicaid.

The new SCHIP program, established by section 4901 of BBA,[23] could at least partially offset declines in Medicaid enrollment and decrease the number of uninsured children, but this program was just beginning to be implemented in 1998. SCHIP provides for insurance coverage of low-income and uninsured children, many of whom are served by C/MHCs.[24] At the end of calendar year 1998, about 1 million children were enrolled in SCHIP, and C/MHCs reported that about 70,000 of their patients were covered by SCHIP, either through Medicaid expansion or a separate state program. As of September 1999, all 56 states and territories had approved SCHIP plans, and states reported that their SCHIP enrollment was 1.98 million.

[21]*Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary* (GAO/HEHS-99-163, Sept. 10, 1999).

[22]P.L. 104-193, 110 Stat. 2105.

[23]42 U.S.C. 1397aa et seq.

[24]Under SCHIP, which is funded by federal and state dollars, states may establish a new child health insurance program, expand Medicaid coverage, or do both. For additional information, see *Children's Health Insurance Program: State Implementation Approaches Are Evolving* (GAO/HEHS-99-65, May 14, 1999).

States' implementation of Medicaid managed care may also affect the number of Medicaid patients served by some C/MHCs. All but 2 of the 56 state and territorial Medicaid programs serve at least some beneficiaries through managed care plans,[25] and between 1991 and 1998, the proportion of Medicaid beneficiaries enrolled in managed care increased from 9.5 percent to 54 percent. Under waiver authority of section 1115 or 1915(b) of the Social Security Act, states may require people eligible for Medicaid to enroll in a managed care plan.[26] In addition, section 4701 of BBA gave states the ability to implement mandatory managed care programs without obtaining a special waiver from HCFA if they meet certain requirements.[27] In these programs, states typically pay a managed care organization (MCO) a fixed monthly capitation fee to provide all covered services needed by enrolled beneficiaries. Therefore, to serve Medicaid beneficiaries in managed care, C/MHCs must either contract with an MCO to provide services to its enrollees or form their own MCO.[28]

All Medicaid beneficiaries, even those in managed care programs, must have access to federally qualified health center services,[29] although they may not have access to a particular C/MHC. Some states' programs contain specific provisions to safeguard C/MHCs' ability to serve Medicaid patients. For example, Colorado's statewide Medicaid managed care program designates C/MHCs as "essential community providers" and requires each MCO to solicit proposals from all such providers located within its service area.

[25]Wyoming and Alaska do not have Medicaid managed care programs.

[26]42 U.S.C. 1315 and 1396n(b).

[27]Under section 1932(a) of the Social Security Act, states may establish Medicaid managed care programs simply by amending their state Medicaid plans.

[28]Many states' Medicaid managed care programs also use a primary care case management model, in which primary care providers receive per capita management fees for coordinating patients' care and fee-for-service payments for each of the health services a patient receives. In this arrangement, C/MHCs can serve as case managers or provide services approved by the case manager.

[29]This provision is not typically waived under a section 1115 waiver and cannot be waived under section 1915(b) or 1932(a) Medicaid managed care programs.

A C/MHC's Medicaid patient base can also be affected by how Medicaid beneficiaries choose or are assigned to a provider in their managed care plan. Some states with mandatory managed care programs assign plan enrollees to a provider if they do not choose one within a specified period of time. Federal law requires that states that mandate managed care enrollment for Medicaid beneficiaries maintain, if possible, patients' existing relationships with providers when making assignments,[30] although there is not a similar requirement under section 1115 or 1915(b) managed care programs. Consequently, the relationship between Medicaid beneficiaries and their C/MHC provider has been affected in some states. For example, when Maryland and Colorado implemented their Medicaid managed care programs, some Medicaid beneficiaries were assigned to plans that did not include the C/MHC that they had used.

States' Implementation of Medicaid Payment Requirements May Affect C/MHC Revenues

C/MHC revenues may also be affected by states' implementation of statutory Medicaid requirements for reimbursing federally qualified health centers. For example, as of September 1999, 15 states had been exempted, under their section 1115 waivers, from a requirement to provide 100-percent cost-based reimbursement for federally qualified health centers, such as C/MHCs. The terms and conditions of a majority of such waivers included a provision that centers be reimbursed on a cost-related or risk-adjusted basis. Section 4712(a) of BBA allowed all states to gradually reduce their reimbursement levels for federally qualified health centers through fiscal year 2004; section 603 of the Balanced Budget Refinement Act modified these provisions, slowing the phase-down.[31] If an MCO's payment for a Medicaid service is insufficient to meet a health center's costs, states are required under section 4712(c) of BBA to make up a portion of the difference with a supplemental, or "wraparound," payment. The payment amount, when combined with the MCO payment, should equal the statutorily required percentage of costs—for example, 95 percent in fiscal year 2000.

Our analysis of health center data indicates that the effect of Medicaid managed care on C/MHC revenue varies by state and individual center,

[30]42 U.S.C. 1396u-2(a)(4)(D)(ii)(I).

[31]Section 603 of H.R. 3426–which was enacted as an appendix to P.L. 106-113, 113 Stat. 1501–amended the language established by section 4712(a) of BBA to permit states to pay 95 percent of costs in fiscal years 2000, 2001, and 2002; 90 percent in 2003; and 85 percent in 2004.

reflecting differences in payment practices among states and MCOs. Between 1996 and 1998, C/MHC per capita Medicaid revenues increased overall. However, in 13 states, per capita Medicaid revenue decreased. In 1998, over three-quarters of C/MHC Medicaid patients in managed care were enrolled in capitated plans, an increase of about 34 percent since 1996. From 1996 to 1998, the average monthly Medicaid capitation payment to C/MHCs fell from about $34 to $29. Changes in the C/MHCs' average monthly capitated payment over the 3-year period ranged from one with an increase of over 50 percent to one with a decrease of over 50 percent.

Directors of primary care associations in several states with Medicaid managed care programs told us that the implementation of managed care had resulted in a loss of Medicaid revenues at some C/MHCs. For example, Tennessee's section 1115 Medicaid managed care program, TennCare, has been slow to implement the special term and condition of the state's waiver requiring it to pay centers either on a cost-related basis or a capitated basis that takes into account adverse selection.[32] A study conducted by consultants for the state primary care association estimated that between 1994 and 1996, TennCare reimbursement per visit decreased by over 7 percent. The consultants estimated that, for 1997, payments from TennCare fell short of covering the costs of C/MHCs in the state by over $9 million.

A consultant for HRSA found that the terms of New York's section 1115 waiver have also had a detrimental effect on the revenues of some C/MHCs in the state. In October 1997, New York began to implement, on a county-by-county basis, its mandatory Medicaid managed care program under the waiver. It provides that C/MHCs be reimbursed at 90 percent of reasonable costs during the first year and 50 percent during the second year for beneficiaries who enrolled after the plan took effect in the county.[33] The consultant conducted site visits to two New York C/MHCs in counties that were among the first to implement Medicaid managed care. The consultant estimated that one C/MHC received $2 million less than it would have received under the requirements established by BBA, and that the other lost $400,000 to $500,000 and had to lay off 50 employees. New York has submitted an amendment to its section 1115 waiver that would increase

[32]Adverse selection occurs when a larger proportion of persons with poorer health status enroll in specific plans or insurance options.

[33]There are no reimbursement guarantees for years 3 through 5, and those reimbursement levels are currently under negotiation.

payments to C/MHCs in the state, although the increased payments would still be lower than the minimum established by BBA for states without a waiver.

Few states have made long-term decisions about how to pay C/MHCs and other federally qualified health centers that provide services to Medicaid patients in light of the changes in the federal requirement for cost-based reimbursement. Indiana, Iowa, Maine, Rhode Island, and Texas have passed legislation ensuring 100-percent payment. Twenty-five other states will continue 100-percent reimbursement for at least fiscal year 2000, but most have not made any decisions about what payment method they will use in the long term. (See app. III for a list of the 30 states that will continue cost-based reimbursement through fiscal year 2000.) Michigan has developed an alternative payment methodology for paying centers, and Maryland is developing one. Seven states have already reduced their reimbursement to the BBA floor of 95 percent of costs, while decisions in three other nonwaiver states are pending. The remaining states are waiver states that have other methodologies for payments made to C/MHCs.

Some states with large Medicaid enrollments delayed giving C/MHCs the required supplemental payments established by BBA until HCFA intervened or until C/MHCs filed suit. For example, when BBA changes took effect, California did not directly give supplemental payments to C/MHCs participating in managed care plans, as required; instead, the state relied on MCOs to provide these payments. When the MCOs did not do so, HCFA had to make clear that the state was obligated to make these payments, which the state began doing in July 1999. Similarly, Pennsylvania failed to make supplemental payments to C/MHCs providing services to Medicaid patients enrolled in MCOs. As the state Medicaid program converted to managed care by region, it had concerns about the administrative difficulties in making the payments because it previously had paid C/MHCs only on a fee-for-service basis. Several Philadelphia C/MHCs filed suit against the state to compel payment of the supplemental amounts; their state primary care association also pressed state officials to comply with BBA. Pursuant to a December 1998 agreement, the state began making retroactive payments in February 1999 and has continued with quarterly payments as due.

In 1998, the Florida primary care association also sued the state on behalf of C/MHCs seeking to receive supplemental payments owed them. In October 1999, Florida and the primary care association settled the case, agreeing that the state would make required supplemental payments and

the primary care association would voluntarily withdraw its suit in federal court. As of September 1999, 9 of the 26 C/MHCs had requested and received their retroactive supplemental payments from the state, totaling about $1.2 million. In addition, the state began making quarterly supplemental payments to C/MHCs that requested them.

Centers That Adapt to Changes in the Health Care Environment Are More Likely to Succeed

Individual C/MHCs face varying degrees of pressure from changes in the health care market, such as increased competition for Medicaid patients. Through our site visits and discussions with HRSA and C/MHC officials, we found that centers that have taken appropriate and timely actions to respond to these changes, such as forming partnerships and networks or participating in managed care, are more likely to succeed. Successful centers typically have management teams with strong business skills and dedication to carrying out the C/MHC mission as well as boards that actively perform their policy and oversight roles. Attracting patients with diverse payment sources and pursuing other revenue sources—such as foundation grants—are strategies that also contribute to maintaining financial sufficiency. Encouraged by HRSA, a growing number of C/MHCs are obtaining JCAHO accreditation, believing that it improves their competitiveness and the quality of care they provide. However, evidence of whether JCAHO accreditation improves C/MHCs' bargaining position with MCOs is just beginning to be reported.

Forming Partnerships and Participating in Managed Care Help Make Centers More Successful

Market conditions in health care, such as the level of competition for Medicaid patients and the size of the uninsured population, vary in different locations, creating different challenges for C/MHCs. Information from our case studies, HRSA staff, and experts who provide technical assistance to C/MHCs suggests, however, that C/MHCs that take appropriate and timely actions to respond to changes in the health care market are more likely to succeed. Typically, their management teams demonstrate strong business skills and a dedication to the health center's mission of providing services to vulnerable populations. In addition, their boards take an active role in overseeing the centers.

Increasingly, C/MHCs are trying to compete for patients and improve their operations by forming partnerships or networks. These networks can include other C/MHCs, similar types of providers, or hospitals and health systems. Networks can enable centers to share expertise and resources—such as information systems or fiscal operations—control costs, or improve the quality of clinical services. For example, in a rural area of

Michigan, two C/MHCs and a hospital are in the process of integrating their clinical services, management information systems, and training programs. This relatively new network recently received federal funding for a dental program, which will primarily serve the area's low-income children. The participating C/MHCs expect the network to give them more visibility and credibility among other providers.

Health Choice Network in the Miami, Florida, area consists of four C/MHCs and one homeless health center. This network helps the constituent centers to provide primary and preventive health care by integrating administrative, fiscal, information system, clinical, and program planning and development services. Participating centers have improved their efficiency by sharing four major positions—chief financial officer, chief information officer, managed care director, and development director—and a centralized automated information system, including financial, patient accounting, and clinical quality and tracking. Furthermore, the network has helped its members raise almost $2 million in additional grant funding over the last 3 years.

Another factor that HRSA officials believe contributes to C/MHC success is responding to the growth in managed care. While some C/MHCs participate in managed care by contracting with MCOs, others have formed their own managed care plans, either individually or in networks with other C/MHCs or other health care providers.[34] As of June 1999, 25 C/MHC managed care plans in 18 states served almost 959,900 members. In Colorado, 11 C/MHCs and 3 hospitals formed a not-for-profit Medicaid health maintenance organization (HMO), Colorado Access, 5 years ago. The HMO covers about 42,000 Medicaid beneficiaries, almost half of the state's total Medicaid population. According to state officials, Colorado Access is efficient and is the third most profitable HMO in the state. Seventeen C/MHCs in Michigan formed a Medicaid HMO, Community Choice Michigan, in 1996. Three years later, it had enrolled about 56,000 patients and served almost half of the state's counties. It is the third largest Medicaid HMO in the state.

HRSA officials and others knowledgeable about C/MHCs believe that the more successful centers know how to attract patients with diverse payment sources, including those with private and public insurance. These

[34]The degree to which health centers that form MCOs assume financial risk ranges from no risk to full risk for all primary, secondary, and tertiary care; HRSA policy is that health centers should assume risk only for the services they manage.

centers also pursue a wide variety of revenue sources to pay for services and facilities, such as private donations, foundation grants, or local government funding. Good billing, collection, and reporting systems help to maximize collections from these various revenue sources. The centers we visited have taken a variety of steps to attract patients and revenues. For example, in Maryland, when state-supported community-based mental health services moved out of one community, the neighborhood C/MHC responded by expanding its behavioral health care program, including mental health and substance abuse services. A rural C/MHC in Colorado identified a need for dental health services among the local indigent and migrant farmworker population and applied for and received additional federal funding to meet this need. A health center in Miami has been repeatedly successful in obtaining United Way funding to supplement its revenues and cover the cost of providing enabling services.

Many C/MHCs are also seeking JCAHO accreditation, believing this will improve their competitiveness. HRSA is encouraging all centers to take this action. As of August 1999, 124 C/MHCs had received accreditation. C/MHC directors and HRSA officials believe that preparing for and going through the accreditation process are valuable experiences because they can improve the quality of services and staff commitment to high standards. Some center managers also believe that achieving accreditation gets them recognition from both other providers and consumers and that it will improve their ability to negotiate favorable contracts and rates with MCOs and other providers. However, evidence that having JCAHO accreditation improves C/MHCs' bargaining position is just beginning to be reported.

Poor Management Has Contributed to Some C/MHCs' Problems

Information from our case studies and interviews with program experts indicate that C/MHCs that do not respond appropriately to changes in the health care market are more likely to have serious problems. Some centers have lost market share as the demographics or socioeconomic status of their communities changed or as competition from other providers increased. Others have unfavorable contracts with other providers and MCOs, leading to lost revenues.

Most of the C/MHCs that we reviewed and that were defunded or identified by HRSA as having serious operational problems had management that demonstrated a lack of understanding of their centers' business operations. The centers operated inefficiently, resulting in expenses that exceeded income. When faced with difficult financial situations, the managers of these centers did not take the necessary actions to control expenditures

and restore their center's financial viability. In some cases, the center's board had not provided active oversight, including exercising its responsibility to replace the C/MHC director.

Some centers had significant debts to vendors or the Internal Revenue Service. A C/MHC in Florida was defunded about 10 months after a consultant reported numerous problems with its financial operations, management information system, CEO leadership, and board direction and expertise. HRSA also defunded a C/MHC in Colorado after it had experienced financial problems for several years, including an inability to collect payment for its services, high overhead costs, and unfavorable contracts with insurers and vendors.

Some HRSA Strategies to Help C/MHCs Show Promise; Others Need Improvement

HRSA coordinates with HCFA to support C/MHCs' continued participation in Medicaid. HRSA also supports several initiatives that encourage centers to plan strategically, form partnerships, and participate in managed care. To monitor and improve the performance of C/MHCs, HRSA conducts onsite program reviews and problem assessments and interventions, provides technical assistance and training, and collects and analyzes program data. Some HRSA monitoring tools, however, could be improved. In particular, there have been problems with the completeness and reliability of UDS data, and accurate financial data have not been readily available for monitoring. Further, the JCAHO accreditation process does not provide HRSA with some information it needs to monitor C/MHC performance; consequently, HRSA collects additional fiscal and other data. Moreover, HRSA has not always identified performance problems and intervened with C/MHCs in a timely manner.

HRSA Works With HCFA to Identify Effects of Medicaid Program Changes on C/MHCs

Both HCFA and HRSA have responsibilities for helping to ensure that vulnerable populations have access to health care services. HCFA's oversight includes ensuring that states comply with Medicaid federally qualified health center reimbursement provisions. For section 1115 waiver states, this implies compliance with their waivers' special terms and conditions; for all other states, it implies compliance with provisions of BBA and the Balanced Budget Refinement Act. Noncompliance with these provisions can lead to the impairment of a health center's ability to serve Medicaid patients as well as the uninsured. Over the years, HCFA has sent state Medicaid agencies instructions on how to implement C/MHC payment changes; two were sent in 1998 to explain the effect of changes established by BBA. HCFA does not routinely review state operations to determine

their compliance with the laws affecting C/MHCs; instead it typically responds to issues brought to its attention.

HRSA regularly provides input to HCFA on matters important to C/MHCs, such as proposed directives to states on supplemental payments and managed care requirements. HRSA also reviews states' waiver applications and requests for plan amendments that would affect the centers and discusses these applications with HCFA and state Medicaid officials. HRSA field office staff with expertise on C/MHC issues have also participated in state site visits conducted by HCFA regional offices during the approval process for sections 1115 and 1915(b) waiver proposals. HRSA also encourages HCFA to support policies that strengthen the role of C/MHCs in Medicaid managed care. For example, HRSA officials are working with HCFA to try to encourage state Medicaid programs to ensure that each C/MHC receives at least one Medicaid MCO contract.

HRSA may also alert HCFA when action is needed to resolve a Medicaid issue affecting C/MHCs. For example, HRSA informed HCFA that the California C/MHCs participating in managed care were not receiving full supplemental payments, as required under BBA, prompting HCFA to make clear to the state its obligation to make these payments. However, a number of other states have been slow to give the supplemental payments to C/MHCs participating in managed care. HCFA is working with HRSA to review each section 1115 waiver state's compliance with the requirement that federally qualified health centers be reimbursed on a cost-related or risk-adjusted basis. To date, HCFA has contacted each state with an approved section 1115 waiver to ask for its C/MHC payment methodology and has also sought input from those states' primary care associations.

In 1998—in response to continued concern over low Medicaid enrollment among eligible children, and because past efforts to increase enrollment were not fully successful[35]—HRSA worked with HCFA to initiate an "outstationing" project, under which Medicaid eligibility workers would be placed at C/MHC sites in an effort to increase Medicaid enrollment of eligible C/MHC patients. Under this project, HRSA provides assistance to primary care associations to work with state Medicaid programs and C/MHCs. There are 37 grantees covering 39 states, and the average Outstationing Project grant award is $60,000.[36] Some grantees have already reported to HRSA that the Outstationing Project has resulted in increases in Medicaid and SCHIP enrollment.

HRSA Encourages C/MHCs to Plan Strategically, Form Partnerships, and Participate in Managed Care

To help C/MHCs strategically respond to changes in the health care environment, HRSA launched a pilot in January 1998 to provide grants to states' primary care associations to conduct marketplace analyses. As of August 1998, HRSA had awarded 27 grants. HRSA plans to expand this initiative to every state. The marketplace analyses help C/MHCs identify key purchasers, health care systems, and suppliers, as well as assess competitive trends and opportunities in their market area. The analyses assess patterns and trends in demographics, the legislative and regulatory environment, provider supply and demand, and managed care. State reports indicate that these analyses have helped target areas that require new or expanded services to improve access. For example, a marketplace analysis in Colorado found that one area had no doctors accepting Medicaid patients or offering care on a sliding-fee basis. Subsequently, an existing health center grantee established a new site with HRSA funding in 1999.

[35]Section 4602 of the Omnibus Budget Reconciliation Act of 1990, 101 Stat. 1388, 1388-167, required states to establish outstationed Medicaid enrollment programs at all federally qualified health centers and made federal funds available to states to support these programs. Only some C/MHCs–often large, urban centers–established outstationing programs under this initiative. Section 114(h) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 110 Stat. 2105, 2179, provided states with a one-time appropriation of $500 million to support the cost of Medicaid outreach. Because states have been slow to draw down these funds, recent legislation eliminated the fiscal year 2000 deadline for using these funds, permitting states to draw down these funds for an unspecified period (section 602 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, P.L. 106-113, 113 Stat. 1501, 1501A-321, 1501A-394).

[36]Three grantees each cover two states.

To encourage C/MHC participation in managed care, HRSA launched in 1994 the Integrated Services Network initiative—now the Integrated Services Development Initiative. This initiative focuses on the development by C/MHCs of comprehensive integrated delivery systems and practice management networks. HRSA awards C/MHCs one-time grants, generally ranging from $100,000 to $250,000, to support systems and network development. Of the 44 grants HRSA has awarded, 13 have resulted in managed care networks (safety net providers organized to negotiate managed care contracts) and 31 have resulted in practice management networks (integrated and coordinated service delivery systems that link providers to achieve cost efficiencies and improve access and quality of care).

HRSA also provides training, technical assistance, and financial support to help C/MHCs participate in managed care. As C/MHCs enter into managed care contracts, they need to know their costs, understand their competition, and carefully consider how much financial risk they can assume. HRSA training in managed care operations and procedures focuses on implementing managed care arrangements, including negotiating and reviewing contracts with managed care organizations. While some C/MHC managers have found HRSA's courses on managed care helpful, others told us that HRSA's training on negotiating managed care contracts could have been more timely and provided more specific information to help them negotiate contracts.

For certain initiatives, HRSA supports mechanisms to help C/MHCs learn from one another. For example, it supports peer-to-peer technical assistance and a network mentoring program for Integrated Services Development Initiative grantees. It also acknowledges successful C/MHCs through its "Models That Work" initiative, which identifies centers whose overall programs are outstanding. However, HRSA does not have a systematic mechanism to allow all C/MHCs to regularly share information about best practices, particularly concerning ways to operate more efficiently and effectively. Consequently, many centers individually work on developing solutions to the same problems for which other centers have already devised successful strategies. For example, we learned of two C/MHCs that independently developed a productivity measurement system.

HRSA Monitors C/MHC Performance, but Timely Problem Identification and Intervention Are Difficult

HRSA assesses each C/MHC's financial health, user growth, staffing capacity, and competitiveness in the health care market. HRSA also looks at the stability and quality of the C/MHC management team. HRSA considers several characteristics to be markers of success, such as having growth in the number of users and a stable, high-quality management team. Conversely, they consider to be at risk and more closely monitor centers that have a high budget deficit, use their HRSA grant too quickly, or have significant management or medical team vacancies.

To monitor C/MHC performance, HRSA uses data reported by the centers, financial audits and status reports, and data from its Primary Care Effectiveness Reviews (PCER). PCERs are a mandatory part of the grant renewal process, which occurs every 3 to 5 years. During onsite PCER visits, a team of HRSA reviewers[37] identifies strengths and weaknesses in C/MHC administration, governance, clinical and fiscal operations, and management information systems. PCER emphasizes process and does not evaluate the efficiency or effectiveness of center operations. The usefulness and value of PCER findings can vary depending on the reviewer's technical expertise and ability to probe for underlying problems. Moreover, C/MHCs rarely receive onsite followup visits to ensure that problems have been corrected.

Within the last 5 years, a PCER team assessed each of the eight C/MHCs we visited and cited two C/MHCs in Florida and two C/MHCs in Maryland for having significant amounts of accounts receivable that were long overdue from private payers, commercial insurance, or patients. Another PCER review found numerous fiscal problems that threatened the survival of a Florida C/MHC corporation 17 months after it was created from the merger of five C/MHCs. In addition to submitting false financial data to HRSA, the C/MHC corporation had virtually depleted its 1995-96 grant within 8 months and had used over 60 percent of its 1996-97 grant in 2 months.

[37]Generally, the PCER team is composed of three reviewers that spend 3 days onsite, but additional time and/or reviewers may be needed for large centers or those receiving funds from multiple HRSA programs. The team may include field office staff and/or consultants, depending on available resources, but HRSA prefers that one or more field office staff participate in the review.

C/MHCs with identified problems are expected to take corrective actions before receiving additional grant funding. When necessary, HRSA sends consultants to help C/MHCs develop a financial recovery or action plan that can help them solve their financial or operational problems. For example, at one urban health center in Maryland, a consultant helped develop a financial recovery plan that significantly reduced staff and some services and enabled the center to stay in business until its cash-flow problems were resolved.[38]

Sometimes HRSA's interventions with centers that have problems have been too late to make a difference. For example, at a health center in Florida, which served a large number of migrant and seasonal farmworkers, technical assistance came too late to overcome the C/MHC's poor management decisions; HRSA ultimately discontinued the center's federal grant funding. HRSA's process for deciding whether to continue funding a particular C/MHC or pursue other alternatives can also be lengthy. First, HRSA must become aware of a potential problem. After the problem has been identified, HRSA provides technical assistance to correct the situation. If the problem is not corrected, HRSA hires a consultant to conduct an independent assessment of the effect the center's closing could have on the community and to explore alternative approaches for providing primary care services in the area, including merging with another grantee. HRSA took several years to defund a rural C/MHC in Colorado—despite mismanagement, problems with the board, and past-due federal taxes—because of concerns about maintaining access to health care for the area's large Hispanic population. Eventually, HRSA funded a stronger C/MHC to take over the service for that population.

In 1996, HRSA began working with JCAHO to combine PCER with JCAHO's accreditation survey for ambulatory care organizations. While JCAHO accreditation is respected in the ambulatory care community, it does not provide HRSA with specific information it needs on C/MHCs' fiscal, information system, and other operations. To obtain some of this information, HRSA currently supplements the JCAHO survey with PCER's fiscal and information system protocols and includes a checklist covering other issues. JCAHO accreditation is more expensive than PCER—$17,000 versus $12,000—and a JCAHO official told us that center directors

[38]These problems occurred when a Medicaid HMO reduced and later failed to make payments to the center.

estimated that associated costs, such as preparation, could range from $30,000 to $50,000.

HRSA Could Improve Its Collection and Use of Data From C/MHCS

HRSA needs information to understand how C/MHCs are operating and to evaluate their overall performance. To accomplish this, HRSA collects information from C/MHC grantees and conducts studies to evaluate centers' performance. In this effort, HRSA officials attempt to balance their need to have useful information for performance monitoring with the importance of limiting data collection burdens placed on grantees.

HRSA annually collects administrative, demographic, financial, and utilization data from each center through UDS. C/MHCs submit these data to their HHS field office, which in turn submits the data to a HRSA contractor for cleaning, editing, and analysis. The purpose of UDS is to ensure center compliance with legislative mandates and to report to the Congress and policymakers on program accomplishments. HRSA requires that centers report information that is appropriate for monitoring and evaluating performance and for reporting on annual trends. HRSA has used UDS to report annual trends in health center operations in its budget justification. It also uses several demographic measures from UDS to assess its accomplishment of annual performance goals related to increasing access to health care. In addition, HRSA used UDS to develop nine performance measures for C/MHCs, including user growth rate, provider productivity, and cost per encounter. The agency uses these measures to make decisions about increasing or decreasing grant awards, identify centers that might have weaknesses, and give centers feedback on how they compare with other centers.

While UDS gathers some useful information, it also has weaknesses and limitations. Because HRSA has revised UDS each year, changing some of the information collected, it is difficult to make year-to-year comparisons. Furthermore, some of the revised instructions have been unclear, making it difficult for centers to report accurately. HRSA validates information collected by UDS through a series of edit checks, through PCER, and during onsite reviews. The data editing and cleaning processes, however, have not always corrected problems they were designed to catch, and PCER and onsite reviews are not conducted frequently enough to ensure timely validation of the data. In addition, some C/MHCs have failed to report certain data elements or have reported them very late, even though complete and accurate reporting of UDS data is a condition of their receiving a HRSA grant.

UDS also has limitations for monitoring and evaluating performance. First, UDS data are reported to HRSA 3 months after the end of the calendar year, and the information is typically not available for analysis until 3 months later. In addition, UDS collects only limited information on health status and health utilization, and the financial data in UDS cannot provide an accurate indication of an individual center's financial status because costs are reported on an accrual basis, while revenues are reported on a cash basis.[39] According to HRSA officials, financial information is reported this way because this is how centers report information to their various payers, such as Medicaid and Medicare, and they wanted to reduce the reporting burden on centers. Yet this practice makes it difficult to estimate the extent to which centers' revenues cover costs. The financial audit is perhaps the best source of independent, accurate information on a C/MHC's fiscal health, but there are delays in HRSA's receipt of the financial audits.[40]

HRSA officials have taken steps to improve UDS and the collection of performance information. For example, HRSA is phasing in a system to enable grantees to transmit UDS data electronically, which should allow for faster reporting and data cleaning. HRSA also plans to give health center grantees a comprehensive set of revised instructions for reporting 1999 data. HRSA has recently begun to automate and track information from the financial audits, although, to date, its efforts have not been systematic or comprehensive.

As part of its overall data strategy, HRSA also funds a number of independent evaluation studies to determine the performance of C/MHCs, understand the C/MHC patient population and their needs, and assess C/MHCs' effect on health status and access to care. These studies include sample surveys of health center users to compare with nationally representative samples; analyses of secondary data sources (for example, Medicaid claims data); and studies of clinical performance for specific diseases, such as diabetes, or interventions, such as immunizations. In 1995, HRSA funded a survey of health center users comparable to the

[39]Using the cash method of accounting for revenues requires that revenue be recorded when it is received. However, the accrual method of accounting for expenses requires that the costs of goods or services be recorded when received, regardless of whether payment has been made for them.

[40]The financial audit is governed by OMB Circular A-133, which states that the audit shall be completed and reported within 30 days of receiving the auditor's report or 9 months after the end of the audit period.

National Health Interview Survey and a survey of health center visits based on the National Hospital Ambulatory Medical Care Survey. The surveys provided useful information on C/MHC performance, such as how well they treat patients with diabetes or hypertension and screen women for cancer.

HRSA also helps centers to collect their own information that can support their efforts to improve efficiency, control costs, and become more competitive. For example, under a collaborative arrangement with HRSA, the Medical Group Management Association (MGMA),[41] National Association of Community Health Centers, and state primary care associations, 55 C/MHCs in 11 grantee states have been learning to use MGMA's Physician Services Practice Analysis software, which is designed to analyze practice performance and procedure costs. With this information, C/MHCs can conduct self-assessments and compare their performance with that of other outpatient practices. HRSA plans to implement this initiative in every state.

Conclusions

Most C/MHCs continue to operate in the changing health care environment and serve vulnerable populations. Despite recent changes in the Medicaid program that have the potential to affect C/MHCs, there has not been an overall decline in Medicaid patients or Medicaid revenues at C/MHCs. Many C/MHCs have risen to the challenge of participating in Medicaid managed care, but the actions of some state Medicaid programs have made it more difficult for some centers to succeed in the managed care environment. HCFA's role in ensuring that state Medicaid programs comply with the statutory requirements that affect C/MHCs and that changes in the Medicaid program do not unduly diminish C/MHCs' ability to serve the Medicaid population will become increasingly critical as Medicaid managed care grows. Continued coordination between HRSA and HCFA can provide HCFA with some of the information it needs to carry out this responsibility.

HRSA recognizes the importance of monitoring C/MHC performance as centers adapt to changes in Medicaid and the health care market in general. However, the agency could improve its monitoring processes and oversight tools, especially its data collection efforts. Although UDS provides HRSA

[41]MGMA is a national organization that has represented the medical group practices of health care facilities and physicians since 1926. Its research arm, the Center for Research in Ambulatory Health Care Administration, is serving as a subcontractor for this initiative.

with useful information for understanding aggregate trends and individual C/MHC performance, more complete and accurate data would increase its value. HRSA's move toward electronic reporting by C/MHCs should help improve the reliability and timeliness of the data, but HRSA needs to take additional steps, such as ensuring that every grantee submits required data on time—a condition of receiving federal grant funding. It is particularly important for HRSA to either improve the financial information reported in UDS or develop a better way to use the information from centers' financial audits. The health status and health service utilization data that HRSA collects through surveys and other studies have the potential to provide valuable information for performance monitoring.

HRSA has made commendable efforts to help C/MHCs improve performance and adapt to the changing health care market, but it has opportunities to do more. For example, C/MHCs could benefit from a systematic best practices program that would allow them to learn from one another's successes and implement proven solutions. Finally, it is not yet evident that health centers' pursuit of JCAHO accreditation, which HRSA encourages, will provide the anticipated benefits of improving quality and competitiveness. Furthermore, because JCAHO accreditation is more costly than HRSA's own review process, it may not be a cost-effective method for HRSA's oversight of all centers.

Recommendations to the Administrator of HRSA

To ensure that C/MHCs continue to provide access to care for vulnerable populations, we recommend that the Administrator of HRSA

- further improve the quality of UDS data, enforce the requirement that every grantee report complete and accurate UDS data, and use more accurate and timely financial data for monitoring performance;
- determine, before encouraging all C/MHCs to seek JCAHO accreditation, whether it is a cost-effective tool for the oversight of the C/MHC program and whether it is beneficial for improving the quality and competitiveness of C/MHCs; and
- establish a best practices program to facilitate C/MHCs' sharing of information about the successful innovations and best practices they have used to adapt to changes in the health care market.

Recommendation to the Administrator of HCFA

To ensure that states comply with federal requirements regarding C/MHCs, we recommend that the Administrator of HCFA monitor whether state Medicaid programs, in their implementation of Medicaid managed care, are complying with the BBA payment provisions or the special terms and conditions of their section 1115 waivers and intervene promptly when states do not meet their financial obligations to centers.

Agency Comments

We provided a draft of this report to HHS for comment. In general, HHS concurred with our recommendations to the Administrators of HRSA and HCFA. (See app. IV). The comments noted that each of the three areas where we made a recommendation to HRSA is an area where it is undertaking action to consider opportunities for improvement. HHS generally concurred with our recommendation to improve data collection. However, it did not agree with part of the draft recommendation related to collecting more data on health status and health service utilization. HHS said that HRSA has other initiatives in place to collect this information. After assessing HHS' comment, we modified our recommendation and our discussion of HRSA's data collection efforts.

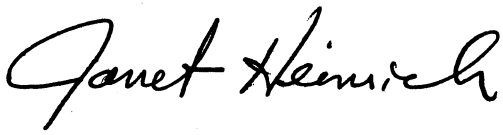
HHS also generally agreed with our recommendation regarding JCAHO accreditation for C/MHCs, stating that it plans to evaluate its experience of working with JCAHO and determine whether the accreditation process is a beneficial and cost-effective means for improving the quality of C/MHCs. In addition, HHS concurred with our recommendation to establish a best practices program, noting that it is one of HRSA's major priorities to implement a strategy to facilitate the systematic replication of best practices of community-based primary care providers. Finally, HHS concurred with our recommendation that HCFA monitor state Medicaid programs' compliance with federal requirements regarding reimbursement of C/MHCs and intervene when they do not meet their financial obligations to centers. The comments state that HCFA will do this and will work closely with HRSA on these and related issues.

In its comments, HHS expressed concern about some of the information in the draft report and provided technical comments for consideration. We modified the report where appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to the Honorable Donna

E. Shalala, Secretary of Health and Human Services; the Honorable Claude Earl Fox, Administrator of HRSA; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; appropriate congressional committees; and other interested parties. We will also make copies available to others upon request.

If you or your staff have any questions, please contact me at (202) 512-7119, or Helene Toiv, Assistant Director, at (202) 512-7162. Other major contributors are listed in appendix V.



Janet Heinrich
Associate Director, Health Financing
and Public Health Issues

Objectives, Scope, and Methodology

This report (1) describes the current status of C/MHCs, the populations served, the types of services provided, and their sources of revenue; (2) describes changes in Medicaid that have had an effect on C/MHCs; (3) discusses how C/MHCs have responded to these and other changes in the health care environment; and (4) assesses HHS' actions to monitor C/MHC performance and help them improve operations.

To provide an overview of health center experience and performance, we analyzed national administrative, demographic, financial, and utilization information on C/MHCs using HRSA's UDS for 1996 to 1998. Our analysis of the data revealed numerous problems with the accuracy and completeness of the data, particularly in 1996, and we edited and corrected errors to the extent possible. We did not check the data's reliability against the source documents. These problems with the data limited our ability to provide detailed analyses of individual centers. Consequently, our analysis consists mostly of results that are aggregated across many centers.

To supplement our quantitative analysis and to obtain more in-depth knowledge and information about C/MHCs, we conducted case studies of eight C/MHCs in urban and rural areas in Colorado, Florida, and Maryland. These states were selected because they have (1) more than 50 percent of their population enrolled in Medicaid managed care, (2) different types of managed care plans, (3) C/MHCs in urban and rural areas, (4) C/MHCs serving a total of over 100,000 patients annually, and (5) a high proportion of low-income uninsured. These states also provided variation in the extent of state support for safety net providers and geographic diversity.

For each state we selected, we obtained background information on the state's population (demographic and health status), organization and financing of its primary health care system, and Medicaid policies from state public health and Medicaid officials and C/MHC membership organizations. Within each state, we selected several urban and rural C/MHCs for comparison, including ones that were performing well and some that were struggling financially, as identified in information provided by HRSA. We reviewed reports for each C/MHC and conducted site visits with C/MHC management teams. We also reviewed reports and conducted interviews concerning one C/MHC in Colorado and one C/MHC in Florida that had lost their federal grant funding.

To assess HHS' oversight activities and obtain additional information about C/MHCs, we interviewed officials at HRSA, HCFA, and HHS field offices and reviewed documents they provided. We also interviewed primary care

experts and representatives of several national organizations. To further examine the impact of federal and state Medicaid policies on C/MHCs, we held discussions with representatives of C/MHC membership organizations from other states.

Our work was conducted from September 1998 to January 2000 in accordance with generally accepted government auditing standards.

Number of C/MHCs Receiving Federal Grant Funding in 1998 and Reporting to UDS, by State or Territory

State/territory	Urban centers	Rural centers	Total
Alabama	4	10	**14**
Alaska	1	1	**2**
Arizona	2	9	**11**
Arkansas	1	8	**9**
California	21	17	**38**
Colorado	5	8	**13**
Connecticut	8	0	**8**
Delaware	2	0	**2**
District of Columbia	1	0	**1**
Florida	12	14	**26**
Georgia	5	12	**17**
Guam	0	1	**1**
Hawaii	2	1	**3**
Idaho	0	7	**7**
Illinois	11	5	**16**
Indiana	6	0	**6**
Iowa	5	0	**5**
Kansas	2	3	**5**
Kentucky	4	5	**9**
Louisiana	4	7	**11**
Maine	0	7	**7**
Maryland	5	4	**9**
Massachusetts	20	2	**22**
Michigan	8	11	**19**
Micronesia[a]	0	2	**2**
Minnesota	5	2	**7**
Mississippi	3	17	**20**
Missouri	7	5	**12**
Montana	2	4	**6**
Nebraska	1	1	**2**
Nevada	2	1	**3**
New Hampshire	1	3	**4**
New Jersey	7	3	**10**
New Mexico	2	9	**11**
New York	27	5	**32**

State/territory	Urban centers	Rural centers	Total
North Carolina	4	15	**19**
North Dakota	1	0	**1**
Ohio	6	8	**14**
Oklahoma	3	1	**4**
Oregon	2	7	**9**
Palau[a]	0	1	**1**
Pennsylvania	13	12	**25**
Puerto Rico	1	17	**18**
Rhode Island	3	1	**4**
South Carolina	3	13	**16**
South Dakota	2	4	**6**
Tennessee	4	13	**17**
Texas	15	16	**31**
Utah	3	4	**7**
Vermont	1	1	**2**
Virginia	2	15	**17**
Virgin Islands	0	2	**2**
Washington	10	10	**20**
West Virginia	0	19	**19**
Wisconsin	4	5	**9**
Total	**263**	**348**	**611**

[a]Not a U.S. territory; received funding for C/MHCs under a compact with the United States.

States Continuing Medicaid Cost-Based Reimbursement to Federally Qualified Health Centers Through Fiscal Year 2000

State	Administrative action	Legislative action
Arkansas	X	
California	X	
Colorado	X	
Florida	X	
Georgia	X	
Idaho	X	
Illinois	X	
Indiana		X
Iowa		X
Kansas	X	
Maine		X
Massachusetts	X	
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
North Carolina	X	
North Dakota	X	
Rhode Island		X
Ohio	X	
South Dakota	X	
Texas		X
Vermont	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming	X	
Total	**25**	**5**

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JAN 21 2000

Ms. Janet Heinrich
Associate Director
Health Financing and Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Heinrich:

Enclosed are the Department's comments on your draft report, "Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided extensive technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano

for June Gibbs Brown
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report "Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success"

General Comments

The Department appreciates the opportunity to comment on the General Accounting Office's (GAO) draft report. In general, we concur with the three recommendations to the Department's Health Resources and Services Administration (HRSA) and the recommendation to the Department's Health Care Financing Administration (HCFA). Each of the three areas where GAO has made a recommendation to HRSA is an area where there is already activity in progress in the Department's Bureau of Primary Health Care (BPHC) to consider opportunities for improvement.

GAO Recommendation

To ensure that Community and Migrant Health Centers (C/MHC) continue to provide access to care for vulnerable populations, we recommend that the Administrator of HRSA

o continue with efforts to improve the quality of UDS data, enforce the requirement that every grantee report complete and accurate data, and collect more useful financial, health status, and health service utilization data;

Department Comment

In general, the Department concurs with this recommendation. The Department's BPHC has always emphasized the importance of timely and accurate reporting by grantees on the Uniform Data System (UDS), and on the Bureau's Common Reporting Requirements, the precursor to the UDS as a data collection tool. The considerable effort that BPHC has put into improving the quality of data submitted has produced a body of information that is, overall, very sound. During Fiscal Year (FY) 2000, the UDS will be evaluated to consider whether any changes in the data set are warranted (for example, potential changes to the financial data required from grantees). Because BPHC believes that more appropriate initiatives are in place to assess whether grantees are achieving success in improving the health status of their patients (for example, the health collaborative activity that began 2 years ago with diabetes, and is being expanded in FY 2000 to include immunizations and depression), the BPHC will not be amending the UDS to include health status indicators.

GAO Recommendation

o determine, before encouraging all C/MHCs to seek JCAHO accreditation, whether it is a

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cost-effective tool for the oversight of the C/MHC program and whether it is beneficial for improving the quality and competitiveness of C/MHCs; and

Department Comment

In general, the Department concurs with this recommendation. The BPHC will be using FY 2000 data to evaluate what has been achieved over the past few years through their contract with the Joint Commission on Accreditation of Healthcare Organizations, considering necessary modifications. If it is determined that the accreditation process is a beneficial and cost-effective means for improving the quality of C/MHCs, the BPHC plans to proceed with a new procurement when the current contract expires.

GAO Recommendation

o establish a best practices program to facilitate C/MHCs' sharing of information about the successful innovations and best practices they have used to adapt to market changes.

Department Comment

The Department concurs with this recommendation, which is also a timely one. The BPHC has had a successful experience with its "Models That Work" Campaign in establishing a forum for the sharing of successes. A major priority for BPHC is the implementation of a strategy that will enable the systematic replication of best practices and lessons learned by community-based primary care providers.

GAO Recommendation

To ensure that states comply with federal requirements regarding C/MHCs, we recommend that the HCFA administrator monitor whether state Medicaid programs, in their implementation of Medicaid managed care, are complying with the payment provisions of the BBA or the special terms and conditions of their 1115 waivers, and intervene promptly when states do not meet their financial obligations to centers.

Department Comment

The Department concurs with this recommendation. In the course of monitoring compliance of State Medicaid programs with the payment provisions of the Balanced Budget Act of 1997 or the special terms and conditions of the Medicaid waivers, HCFA will determine whether States are meeting their financial obligations to C/MHCs. The HCFA will work closely with HRSA on issues regarding the medical care of vulnerable populations, including payment issues.

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While we are in general agreement with GAO's recommendations, we have concerns about some of the information presented in the "Background" section of the draft report. Specifically, there are two areas that the Department believes, as described in the draft report, do not accurately represent the current situation. First, we believe the draft report does not adequately document BPHC's strategy for data collection, which addresses the rationale for the design of the UDS. Incorporating correct background information on BPHC's data strategy is important to understanding decisions that have been made in the past, and that may be made over the next year regarding the UDS. We have therefore included clarification regarding BPHC's data strategy in technical comments, which were sent to GAO on January 14, for inclusion in the Background section of the report. Second, we do not believe that some of the complex health care financing issues that affect health centers were accurately described in the narrative and should be clarified. Specifically, we believe that some of the Medicaid managed care provisions were not described correctly in the draft report. These concerns were also addressed in our technical comments.

GAO Contacts and Staff Acknowledgments

GAO Contacts

Helene Toiv, (202) 512-7162
Anne Dievler, (202) 512-7006

Staff Acknowledgments

In addition to those named above, Lisanne Bradley; William E. Brown; Renalyn Cuadro; Brenda James; Mary Reich; and Evan Stoll, Jr., made important contributions to this report.

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