Federally Qualified Health Center Expansion Through the Affordable Care Act

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In crafting the Patient Protection and Affordable Care Act of 2010 (ACA), the Obama administration recognized the need to expand primary care capacity in communities with many low-income and uninsured individuals. One of the key strategies for meeting this need involved the establishment of new Federally Qualified Health Centers (FQHCs) and new sites for existing FQHCs that would target underserved locations across the country. A Community Health Center Fund of $11 billion was established, appropriating $9.5 billion for organizational expansion and $1.5 billion in capital funding. To continue the economic stimulus, the capital funding (to be used for construction and renovation of community health centers) was made available for Federal Fiscal Years (FFYs) 2011 through 2015, and the expansion funding was scheduled for release annually, starting with $1 billion in FFY 2011 and increasing to $3.6 billion in FFY 2015 [1].

The American Recovery and Reinvestment Act of 2009 (ARRA) established new health centers and sites, and passage of the ACA by Congress allowed the administration to continue funding these centers [2]. One new community health center and one expanded center in North Carolina received ACA funding in 2011 [3]. ARRA also funded nearly all health centers nationally, allowing them to serve additional patients affected by the national economic collapse [4]. This operational funding was continued through the ACA, which added $1.8 million to the base budgets of each of the 26 FQHCs in existence in North Carolina prior to 2010. North Carolina applicants struck out in the first 2 rounds of ACA capital funding, but 4 health centers in the state received a total of $9.2 million in capital funding in the third funding cycle [5]. Funding was used to build 2 new facilities in communities that had previously had none and to replace cramped, aged clinics in 2 other communities.

Prior to the passage of the ACA, the North Carolina Community Health Center Association received a grant from the Kate B. Reynolds Charitable Trust to undertake an 18-month inclusive process that brought together safety-net providers and existing health centers to develop community-level plans and to assist organizations in applying for new start-up funds. North Carolina organizations submitted 30 applications for the initial 2011 round of funding.

The Congressional budget compromise of 2011 cut $600 million per year from the $2.19 billion base health center appropriation [6]. To keep the core level of services in place, the administration chose to "backfill" the budget hole by tapping the Community Health Center Fund. This change resulted in the health center expansion being reduced from $250 million [7] to just $28.8 million [4]. Consequently, only 67 grants were awarded nationwide [4]. In spite of this reduction, North Carolina received 2 New Access Point grants (for 1 new health center and 1 expanded health center) totaling $1.38 million [8], as well as 2 health center planning awards of $80,000 each [9]. In 2012, $128.6 million from the Community Health Center Fund was used to add 219 new health centers nationally from the pool of approved-but-unfunded applications [10]. As a result, North Carolina received 9 new grants (for 4 new community health centers and 5 expanded ones) totaling $5.1 million [10, 11]. Collectively, these 9 projects are expected to serve more than 52,000 new patients in 14 previously unserved counties in the first 2 years.

The second cycle of ACA-funded New Access Point applications closed on April 3, 2013. Eight North Carolina applicants were among those competing for $19 million; only 25 awards were to be granted nationally [12]. Because more than 400 applications were submitted, the administration will likely hold over approved-but-unfunded applications for funding in FFY 2014. There will then be one final round of applications in 2015, with 22 North Carolina counties still contemplating or planning FQHC development. Cuts to the community health center program resulting from the 2013 federal sequester are estimated to range from 4% to 9% and could further deplete support for existing programs and for expansion [13].

The ACA funding design for health centers was built on the premise that a large number of patients who were uninsured in 2010 would begin receiving health care coverage in 2014, either through the Medicaid expansion or through the purchase of a commercial plan in one of the new health insurance marketplaces (formerly called health benefit exchanges). Therefore it was expected that the health centers in existence prior to 2011, as well as those funded afterward, could be sustained with less federal support. The US Supreme Court decision of 2012 upset this assumption by allowing states to opt out of the Medicaid expansion [14]. In March 2013, the North Carolina

As I have noted, however, the potential expansion of insurance coverage is only one aspect of access to care. The ACA includes many additional provisions that promote access in a comprehensive attempt to improve the nation's health. For example, some sections of the ACA aim to help consumers negotiate the system. The ACA encourages the development of ACOs [13], which were originally structured around groups of Medicare beneficiaries and were intended to reward care coordination. ACOs also promote preventive measures that reduce overall costs of care by improving outcomes and preventing costly complications or the emergence of preventable disease. Multiple groups of hospitals, physicians, and suppliers of pharmaceutical and other health care services and products have begun to form ACOs and to develop the systems that will generate these savings and improve health. A large part of this effort involves the use of electronic

General Assembly elected not to participate in the Medicaid expansion and not to partner with the federal government in setting up the state's health insurance marketplaces. Because North Carolina's FQHCs treat a large proportion of uninsured patients—52.1% of patients at the 28 reporting community health centers in North Carolina in 2011 were uninsured [15] compared with 36.4% of patients at the 1,128 community health centers reporting nationally [16]—the state's decision not to expand Medicaid threatens the financial viability of North Carolina's community health centers. In 2016 ACA funding will end, at which time the 2011 budget cuts will have reduced the total national program budget to $1.58 billion.

Foreseeing an increased reliance on commercial payers, community health centers have been preparing to be value-added participants in the transformation of the health care marketplace. Through funding in 2011 from the Blue Cross and Blue Shield of North Carolina Foundation and the North Carolina Office of Rural Health and Community Care, community health centers and other safety-net providers have partnered with Community Care of North Carolina (CCNC) to connect through the North Carolina Health Information Exchange to CCNC's informatics center. CCNC's analytics will allow health centers to provide better, more cost-effective care through a population health approach. Additionally, the majority of FQHCs in North Carolina have banded together to form the Carolina Medical Home Network, a collaborative approach to performance improvement and practice transformation. However, it remains doubtful whether these system changes will be sufficient to overcome the growing number of uninsured individuals and the concurrent loss of federal funding. NCMJ

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medical records and dedicated care coordinators or patient navigators who can help move patients through the complex health care delivery system. The ACA also includes insurance navigators to help people obtain insurance through the health insurance marketplaces that are being set up in every state [14]. Fundamental to accessing care is simply understanding what is covered by your insurance plan, so the ACA requires every health insurance policy to include a "summary of benefits and coverage" that provides a clear and simple description of coverage [15]. The ACA also provides grants to the states to support consumer assistance programs that can help people when they have problems with their health insurance coverage [16]. There is such a program in the North Carolina Department of Insurance, called Health Insurance Smart NC (www.ncdoi.com/Smart/), which has regional offices in Asheville and New Bern.