Prescription for a healthy community

Celebrating 50 years of Medicaid, Medicare and Community Health Centers

As Washington state continues down a path of health care innovation, we celebrate the 50th anniversary of three pioneering programs for health care in the United States – Medicaid, Medicare and community health centers. All three programs were developed in pursuit of a "Great Society" and in response to both the Civil Rights movement and the War on Poverty. On July 30, 1965, President Lyndon B. Johnson signed the Social Security Amendments of 1965 (H.R. 6675) which established Medicare for the elderly and Medicaid for the poor. That same year, funding from the Economic Opportunity Act of 1964 was approved for the first two neighborhood health center demonstration projects in Boston, and Mound Bayou, Mississippi.

These three programs have been intricately linked since their inception, forming the pillars of our nation's health care safety net. Their shared mission is to ensure the health of local communities with community health centers providing access for Medicaid and Medicare enrollees.

Community Health Centers: Ensuring Access to Care

The first two neighborhood health centers grew to more than 100 centers even before the Health Center Program was authorized by federal law in 1975. Washington state's first community health center (CHC), Carolyn Downs Family Medical Center, opened in 1968 as part of a broad spectrum of services provided by the Seattle Black Panther Party. Since then, community health centers have grown dramatically to provide care to low-income and other special populations in rural and urban communities across the state.

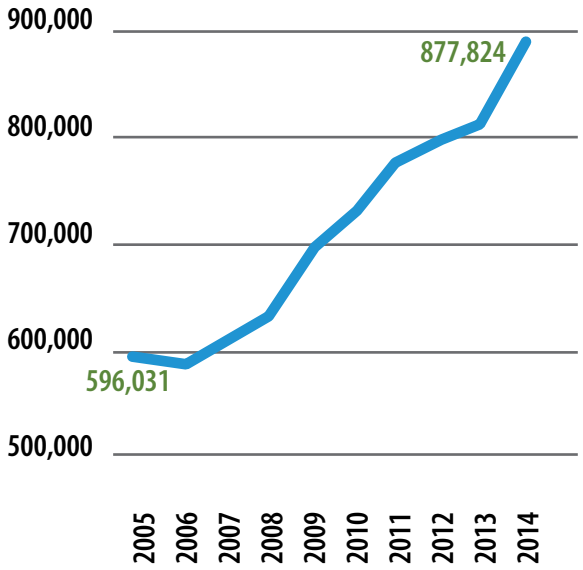
There are now over 210 clinic sites run by 26 CHC organizations in Washington. Dramatic growth came with capital and infrastructure investments from the American Recovery and Reinvestment Act (2009) and the Affordable Care Act (2010). CHCs needed to grow to meet the demand for care due to the recent expansion of Medicaid following an economic downturn. The number of patients at Washington CHCs has increased 47% since 2005 **(Figure 1)**, and 38% since the recession began in late 2007.

CHCs are often referred to as the primary care safety net because they are required to:

- **Provide health care to all,** regardless of ability to pay. They must provide care on a standard sliding fee schedule based on income.
- **Offer comprehensive health care services.** They must offer, in addition to medical and dental services, a broad range of wraparound (or supportive) services, such as interpretation and transportation, to improve access to care.
- **Be located in or serve a high-needs community.** These are defined as having a high percentage of people living in poverty, areas with few primary care physicians, higher than average infant mortality rates, and a high percentage of the elderly.
- **Be governed by a community board.** Board members use CHCs. The board must include a majority (over 50%) of health center patients, who are authorized to oversee CHC operations.

Thanks to incredible CHC work since the first open enrollment for Washington Healthplanfinder in October 2013, new and existing patients finally have coverage **(Figure 2)**.[2] The number of uninsured patients declined 33% between 2013 and 2014 as a result of these coverage expansions.

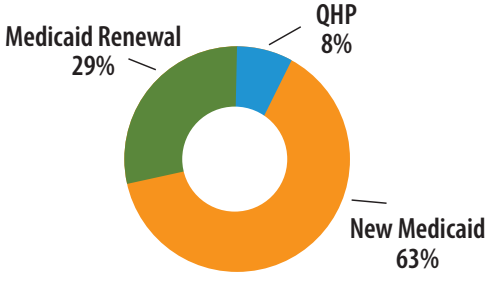
Figure 1. Community Health Center Patients Nearly Double in Last Decade



Washington CHCs deliver value to patients by using a number of **innovative care delivery concepts**, including:

- **A patient-centered medical home model**
- **Behavioral health integration**
- **Electronic health records**
- **Tele-pharmacy**
- **Residency training**
- **Acupuncture and naturopathic medicine**

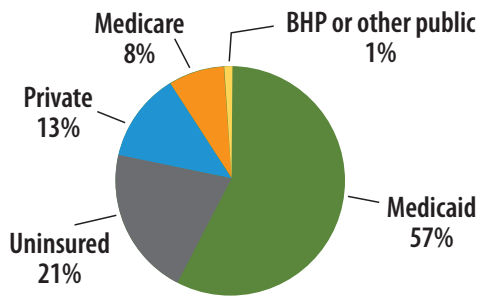
Figure 2. CHCs Enroll Nearly 170,000 Into Coverage in First 10 Months of Healthpanfinder



Washington CHCs continue to see 187,608 uninsured patients (21% of patients), many of whom struggle with the cost of insurance premiums or are ineligible for coverage due to immigration status (Figure 3). Experts expect CHC patients to experience churn between coverage as they undergo shifts in income levels, jobs, and insurance status.

CHCs will continue to play an important role in their local communities both as economic engines and in ensuring access to care. A 2013 economic impact analysis demonstrated that the CHC system contributed $1.3 billion overall to the Washington economy and directly generated over 10,500 jobs.[3] The impact of CHCs will snowball as they continue to grow to meet the community's needs.

Figure 3. CHC Patients by Payer Status (2014)



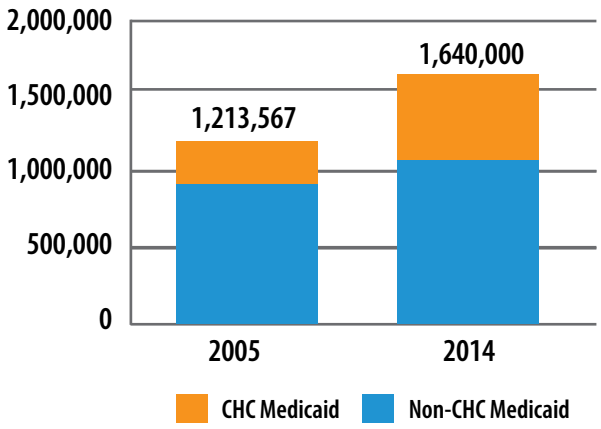
Medicaid: Providing Coverage to Lower Income Individuals and Families

When Medicaid first began states received federal matching funds to provide comprehensive benefits to dependent children and the disabled. Only six states opted to participate in the first year, but by January 1967, 20 additional states implemented Medicaid, including Washington. By 1982, all of the states implemented Medicaid.

The program varies among states with different benefit packages, eligibility thresholds, and managed care penetration. Changes and enhancements bolstered the program since its inception, but the most significant expansion came in 2014 thanks to the 2012 U.S Supreme Court decision that states had the option to cover most adults with incomes at or below 138% of poverty. Now over 71 million Americans receive health coverage from Medicaid or the Children's Health Insurance Program (CHIP).[4]

In 2013, Washington state adopted Medicaid expansion with coverage beginning January 1, 2014. The state also extended dental benefits to all of its adult enrollees. The number of Medicaid enrollees has increased 50%, adding almost 550,000 more Washingtonians for a total of 1,799,000 covered by Medicaid and CHIP. This phenomenal increase requires access from the provider community. CHCs help ensure that the newly covered Medicaid enrollees can visit a primary care provider and receive other wraparound services provided in community clinics. The Medicaid population doubled and CHCs stepped up to the demand; the CHC Medicaid population has increased from 19% to 30% in the past decade (see Figure 4).[5]

Figure 4. CHCs Provide Greater Access to Medicaid Patients as Medicaid Expands



The integral link between CHCs and their local communities has helped to ensure that their Medicaid patients receive care in the most appropriate setting. Studies of Medicaid patients receiving most of their care in CHCs have found that Medicaid beneficiaries receiving care from a health center were less likely to be hospitalized, less likely to be inappropriately hospitalized[6] and less likely to visit the emergency room inappropriately.[7]

In the coming years, a Medicaid transformation effort is expected to improve the care experience and outcomes for Medicaid enrollees. Work over the next five years will include focus on integrating behavioral health financially and in the delivery system, new benefit design, and workflow redesign. The CHCs will be front and center because of their innovative work to integrate behavioral health services into primary care and create patient-centered medical homes.

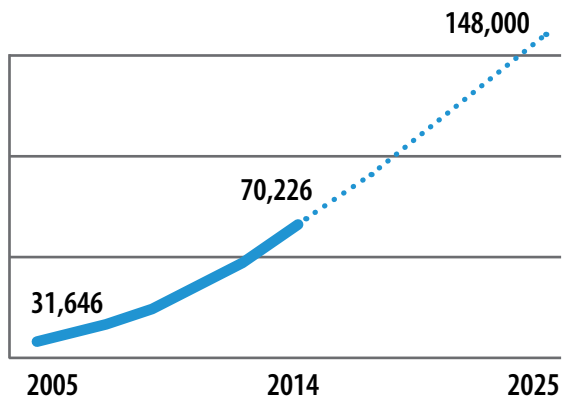
Medicare: Covering the Elderly and Preparing for the Age Wave

Older and disabled patients rely on Medicare. For 50 years, Medicare paid their medical bills, ensuring their access to needed health care services, and protected them from potentially crushing health expenses. In the early years, the Medicare benefit package was modest. It required substantial deductibles, copayments, and premium contributions, and there were no out-of-pocket cost limits. It did not include long-term care or prescription drug benefits. Medicare evolved to meet the needs of our older and disabled population. This includes extending benefits to nonelderly individuals with disabilities or with end-stage renal disease (1972) and adding a prescription drug benefit (2003). Recent efforts include addressing the program's financial sustainability as the overall population ages—looking at alternative payment models and payment reform to deliver better care at lower costs.

Millions of Americans entrust their lives to the care they receive from the program. While 48% of the elderly lacked health coverage in 1962, today only 2% lack coverage. Without Medicare many elderly Americans would simply not have had access to the medical advances that have contributed to rising longevity. Over one million Washingtonians currently receive Medicare and the number is expected to grow substantially in the coming years. Medicare spending per enrollee in Washington state is $8,497—ranking the state #11 as a low spend leader at nearly $2,000 lower than the national average cost per enrollee.[8] Washington's low cost per enrollee is partially due to the state's high population of Medicare enrollees receiving care in home and community-based settings instead of institutions.

The Medicare population in Washington state CHCs increases annually and the number is expected to increase steadily over the coming decade (**Figure 5**). It is anticipated that the patient-centered medical home model, integrated and comprehensive care will combine with the extensive wraparound services provided to CHC patients to make CHCs an increasingly attractive place for our aging population to seek care.

Figure 5. CHC Medicare Patients More than Doubled in the Last Decade, and Expected to Repeat in the Next Decade



Continuing the Legacy in Washington State

Medicaid and Medicare will continue to be critical programs, and CHCs will work hard to meet the needs of these beneficiaries and others in their communities. Medicaid and Medicare provide many CHC patients with access to specialty care and prescription drugs—care they would struggle to access without insurance coverage. The two programs provide security and support to vulnerable populations and while their differences will persist, they will both continue to be very important to CHCs and their patients.

CHC's commitment to providing high-quality and cost-effective care with continuing innovation, will ensure that public program enrollees experience improved health outcomes and quality of life. CHCs will pursue infrastructure advancements and new sites to assure success in these endeavors, recognizing that the growing aging population has different needs than their families and neighbors. CHCs will continue advocating to make sure all of their patients can afford health insurance coverage, regardless of their immigration status, and expand their role training the next generation of primary care providers.

[1] All data on CHC patients is from Uniform Data System, reported annually by CHCs and available at http://bphc.hrsa.gov/uds/datacenter.aspx. 2014 numbers are based on preliminary data submissions.

[2] See endnote #1

[3] Capital Link. The Economic Impact of Washington's Community Health Centers. 2014

[4] Kaiser Family Foundation. Total Monthly Medicaid and CHIP Enrollment. http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/. Accessed 7/3/2015.

[5] State Medicaid data from WA State Health Care Authority and Department of Social and Health Services.

[6] Falik M. et al. Ambulatory care sensitive hospitalizations and emergency visits: experiences of Medicaid patients using federally qualified health centers. Medical Care 2001;39(6):551-561.

[7] Falik M. et al. Comparative Effectiveness of Health Centers as Regular Source of Care. Journal of Ambulatory Care Management 2006;29(1):24-35

[8] Kaiser Family Foundation. Medicare Spending Per Enrollee, By State. http://kff.org/medicare/state-indicator/per-enrollee-spending-by-residence/. Accessed 7/3/2015.

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