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How the Supreme Court's Medicaid Decision May Affect Health Centers: An Early Estimate

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at www.gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Executive Summary

The nation's federally funded health centers are the principal source of primary health care for medically underserved populations. In CY 2011, more than 1,200 health centers, operating in more than 8,500 urban and rural locations, served 20.2 million patients, 36 percent of whom were uninsured and 93 percent of whom had family incomes below twice the federal poverty level. Federal grants provide core support to health centers, but Medicaid represents the largest single health center financing mechanism, accounting for 39 percent of revenues. Medicaid revenue growth allows health centers to preserve their core grant funding to reach uninsured patients while exerting a cumulative financial impact on overall patient care capacity.

Following passage of the Affordable Care Act (ACA), the Geiger Gibson program estimated the combined effects on health center expansion of the ACA's Health Center Growth Fund, its Medicaid expansion provisions, and its establishment of subsidized private health insurance markets through state Exchanges. We concluded that together, these reforms would enable health centers to add 19.8 million new patients by 2019, more than doubling the number of people served.

The United States Supreme Court's Medicaid holding in *NFIB v. Sebelius* has the potential to limit the impact of the ACA Medicaid expansion by barring the HHS Secretary from withholding current Medicaid funding from states that fail to cover the expansion population. Using estimates of the potential impact of the Court's holding on Medicaid coverage for the poorest Americans, we quantify the effect on health centers and their patients if states indeed fail to implement the expansion.

If fully implemented by the states, Medicaid expansion will enable health centers to reach approximately 19.8 million new patients. Conversely, without the Medicaid expansion, health centers' new patient care capacity would be reduced by nearly 27 percent, a 5.3 million drop in new patients served. Of the new patients losing services, less than half (44 percent) would have been covered under Medicaid. More than half (55 percent) would have been uninsured, Medicare beneficiaries or patients who obtain coverage through their employers or state health insurance Exchanges. Among the 10 states whose governors had most clearly indicated by mid-July 2012 that they did not intend to implement the Medicaid expansions,[1] new health center patient care capacity would decline by more than 1.5 million patients, from nearly 8.3 million patients served by 2019 to 6.8 million.

[1] Florida, Iowa, Louisiana, Mississippi, Missouri, Nevada, New Jersey, New York, South Carolina, and Texas. The Advisory Board. Where Each State Stands On ACA's Medicaid Expansion. Daily Briefing (July 5, 2012). Available online at http://www.advisory.com/Daily-Briefing/2012/07/05/Where-each-state-stands-of-the-Medicaid-expansion. (Accessed July 16, 2012).

Background

An Overview of Health Centers

Over the past half-century, community health centers have grown from a series of small demonstrations into the single largest primary health care system serving medically underserved urban and rural communities and populations. In CY 2011, more than 1,200 health center grantees operating in more than 8,500 urban and rural locations served 20.2 million patients, 36 percent of whom were uninsured and 93 percent of whom had family incomes below twice the federal poverty level.[2] Health center patients are disproportionately low-income and members of racial and ethnic minority groups.[3]

Section 330 of the Public Health Service Act (PHSA) awards grants to establish and operate health centers but this funding represents only 16 percent of health center operating revenues.[4] Instead, a series of reforms that were enacted during the 1980s make Medicaid the principal source of health center funding today. The most important of these reforms are the extension of eligibility to all low-income children and pregnant women, as well as a 1989 requirement that added "federally qualified health center" (FQHC) services as a required service for most beneficiaries. The requirement also established a cost-related payment methodology for FQHC services and other covered Medicaid services furnished by FQHCs. Medicaid's FQHC coverage and payment principles extend to both federally funded community health centers as well as "look-alike" clinics funded by state and local grants that meet all §330 requirements.[5]

Together, these Medicaid reforms had the simultaneous effect of expanding eligibility and coverage while improving payment. These reforms allowed health centers to dramatically expand their reach, even as federal appropriations remained essentially flat. Figure 1 depicts the growth associated with the Medicaid expansion. It shows not only a major growth in the number of Medicaid patients served, but also a tripling of uninsured patients receiving care at health centers. In keeping with these findings, a separate study shows that health centers serving states with more limited Medicaid eligibility for adults grow at a much slower pace than those in more generous states.[6] This is because the benefits of the Medicaid investment in health centers are cumulative, allowing health centers to expand capacity to serve all residents of their communities, regardless of insurance status. The steady health center investment, through modest appropriations increases and Medicaid expansions, has had a multiplier effect on their size and scope; new grantees have grown, as have the number of access sites per grantee.[7]

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[2] Health Resources and Services Administration, Department of Health and Human Services, "Primary Care: The Health Center Program, Health Center Data. http://bphc.hrsa.gov/healthcenterdatastatistics/ (Accessed July 16, 2011)

[3] Shin P, Rosenbaum S, and Tolbert, J., *Medicaid and Community Health Centers: the Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities*, Kaiser Commission on Medicaid and the Uninsured, March 2012.

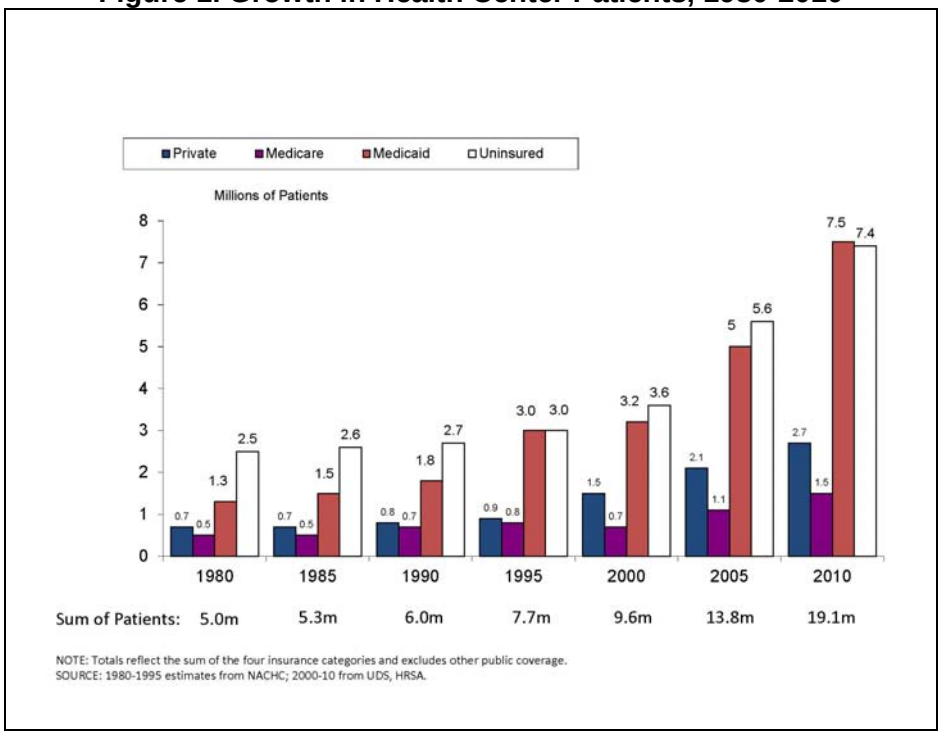
[4] *Id.*

[5] *Section 6404 of the Omnibus Reconciliation Act of 1989, P.L 100-239. Codified at 42 U.S.C. 1396d(l)(2); 42 U.S.C. 1396a(bb).*

[6] Shin P, Rosenbaum S, and Tolbert, J., *Medicaid and Community Health Centers: the Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities*, Kaiser Commission on Medicaid and the Uninsured, March 2012.

[7] Shin P, Rosenbaum S, and Paradise J. *Community Health Centers: The Challenge of Growing to Meet the Need for primary Care in Medically Underserved Communities*. Kaiser Family Foundation. March 2012.

Figure 1. Growth in Health Center Patients, 1980-2010



Health center growth also is associated with community job creation and investment. In 2011, health centers employed more than 138,000 clinical and management staff, many of whom are residents of the communities in which they work. Between 2008 and 2011, health centers added more than 25,300 jobs.[8] Separate studies that measure the value of health centers show that each dollar of investment currently produces a rate of return of at least 2:1,[9] and document eight dollars in economic investment generated by every federal dollar spent on health centers, prior to the economic downturn.[10]

The Affordable Care Act and Health Center Expansions

Health center growth is a significant policy aim of the Affordable Care Act. This growth is slated to happen in three principal ways. First, the Act makes a five-year, $11 billion up-front

[8] HRSA, *The Affordable Care Act and Health Centers*. http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf (Accessed July 16, 2011)

[9] Rosenbaum S and Shin P, *Community Health Centers and the Economy: Assessing Centers Role in Immediate Job Creation Efforts*. Issue No. 25. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Sep 14, 2011; Center for American Progress. *The Importance of Community Health Centers: Engines of Economic Activity and Job Creation.* August 2010; Shin P, et al., *The Economic Stimulus: Gauging the Early Effects of ARRA Funding on Health Centers and Medically Underserved Populations and Communities*. Issue No. 17. United Health Foundation and the Gibson/RCHN Community Health Foundation Research Collaborative, Feb 16, 2010.

[10] Shin P, Finnegan B, and Rosenbaum S, *How Does Investment in Community Health Centers Affect the Economy?* Issue No. 1, Geiger Gibson/RCHN Community Health Foundation Research Collaborative. 2008.

investment in health center expansion. Although the scope and magnitude of the expansion initiative was scaled back by the Balanced Budget Act of 2011, investment in new health centers and new health center "access points" is still expected; to date, more than $928 million has been directed to urban and rural communities to support growth, with an estimated 97 new grantees, 286 new access points, and 1.6 million new patients served.[11]

Second, Medicaid is to be expanded to all nonelderly persons with family incomes up to 133 percent of the federal poverty level (138 percent of poverty when an additional income disregard allowed under the Act is included in the calculation). This expansion is accomplished by adding a new mandatory coverage group to Medicaid, with a January 1, 2014 effective date. Third, the ACA provides tax subsidies to make health insurance affordable for low- and moderate-income individuals and families ineligible for Medicaid or employer coverage. Subsidies are available at household incomes between 100 percent and 400 percent of the federal poverty level, and may be secured through enrollment in Qualified Health Plans (QHPs) purchased through state health insurance Exchanges.

Shortly after enactment, the Geiger Gibson program estimated the combined impact on health centers of the Health Center Growth Fund (as it is known) and the Medicaid and tax-subsidized insurance expansions. Our initial analysis concluded that the number of patients served by community health centers would increase from 18.8 million in 2009 to at least 33.8 million by 2015.[12] We further found that the expansion could grow by 19.8 million new patients by 2019, more than doubling the number of patients with access to services in medically underserved areas.[13]

This growth is important not only for newly insured patients, but also for people who will remain uninsured even following full ACA implementation, either because they are ineligible for subsidies or because health insurance remains unaffordable. Indeed, in Massachusetts, where more than 98 percent of all residents have health insurance as a result of the state's landmark 2006 legislation, the proportion of health center patients who are uninsured remains at 20 percent.[14] This discrepancy persists because funding for uncompensated care has decreased and the remaining uninsured population has shifted into health center settings in order to secure affordable care.[15]

Health center growth benefits the newly insured. Furthermore, health center growth is critical to ensuring the most efficient use of the ACA's new insurance coverage. This is because the populations most likely to be uninsured also are likely to reside in urban and rural

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[11] HRSA, *The Affordable Care Act and Health Centers.* http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf (Accessed July 16, 2011)

[12] Ku, L, et al., *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers through Health Reform*. Issue No. 19. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Jun 30, 2010

[13] These estimates reflect several factors: the ACA's direct investment in health center expansion; the level of additional federal health center appropriations; the Medicaid eligibility expansion; and the availability of subsidized private health insurance through state Exchanges as well as the extension of FQHC payment principles to Exchange QHPs.

[14] HRSA, Uniform Data Sets, 2010 Massachusetts. .

[15] Ku L., et al., Safety Net Providers after Health Reform: Lessons from Massachusetts. *Archives of Internal Medicine,* August 2011; 17(15):1379-1384.

communities that experience both elevated health risks and a shortage of primary health care providers.[16]

The United States Supreme Court's Ruling in NFIB v. Sebelius

On June 28, 2012, the United States Supreme Court handed down its landmark decision in *NFIB v. Sebelius.*[17] The Court upheld the constitutionality of the requirement that all Americans who can afford to do so secure health insurance coverage. In upholding the coverage mandate, as it is known, the Court also upheld the law's sweeping insurance reforms. These reforms prohibit insurers from denying coverage because of pre-existing conditions, bar discrimination based on health status, improve the scope and quality of coverage, establish new coverage standards for products sold in the individual and small group markets, and provide for the establishment of state health insurance Exchanges where individuals and small groups can find affordable, high quality coverage. The Court's decision also left the premium tax credits unchanged.

Despite saving the Act, the Court's ruling potentially affects the scope and pace of the ACA's Medicaid expansion. With respect to the ACA's Medicaid expansion to all nonelderly low-income people, the Court held that the expansion amounted to unconstitutional coercion of states, even though it is accompanied by highly enhanced federal funding. The coercion problem, in the Court's view, arises from the fact that the expansion is so transformative that it amounts to a new program. This means that Congress cannot enforce state compliance with the expansion by withholding *existing* program funding, as is typically the case with modifications to Medicaid's mandatory provisions. In Justice Roberts' words, Medicaid's size and importance to states means that totally withholding federal funding for not doing something completely new would be a "gun to the head."

Despite declaring that the expansion amounted to unconstitutional coercion, the Court preserved its availability and thus saved the Congressional investment from invalidation, the proper remedy in the dissent's view. A majority of the court concluded that in this case, the proper remedy for coercion was simply to bar the federal government from withholding existing Medicaid funding from states that failed to implement the expansion. While this remedy ensured the expansion's survival, it has had the practical effect of giving states flexibility regarding whether to comply with the provisions of a new, mandatory Medicaid coverage group.

In a July 10, 2012 letter to the nation's Governors, Secretary Sebelius concluded that the ruling applies only to the adult expansion and does "not affect other provisions of the law."[18] In this regard, this interpretation means that HHS considers unchanged the ACA's "maintenance of effort" (MOE) provision, which bars states from reducing their March 23, 2010 Medicaid eligibility levels until the Secretary has certified that their health insurance Exchanges are operational.[19]

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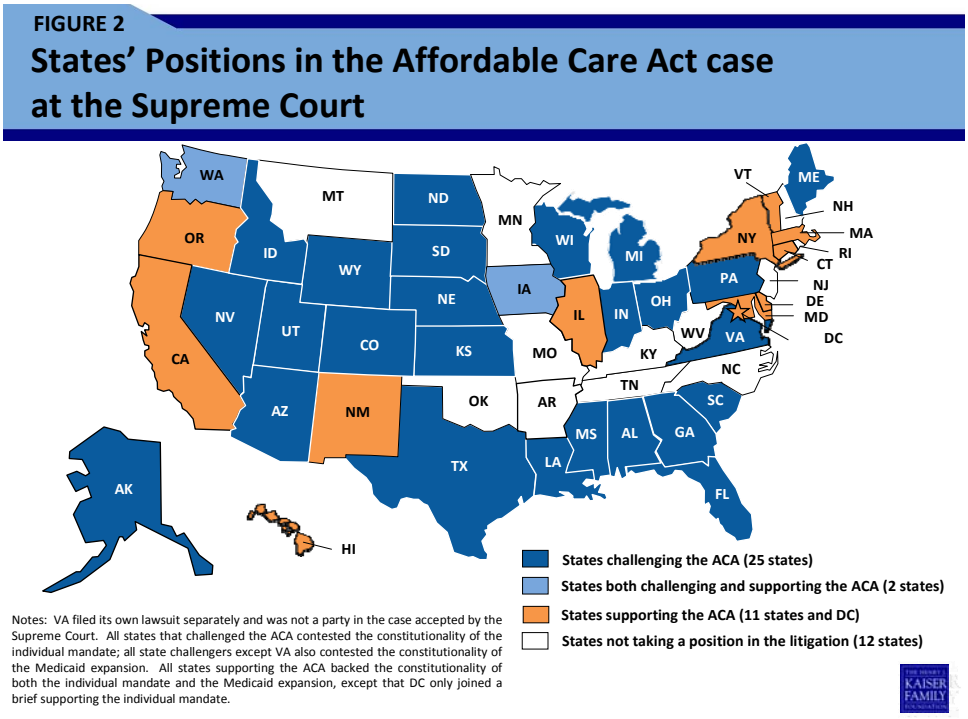
[16] Kaiser Family Foundation, *A Profile of Health Insurance Exchange Enrollees*, March 2011; Rosenbaum S, et al., *National Health Reform: How Will Medically Underserved Communities Fare?* Issue No. 10. Geiger Gibson/RCHN Community Health Foundation Research Collaborative. Jul 10, 2009.

[17] 132 S. Ct. 2566. June 28, 2012.

[18] Letter from Secretary Kathleen Sebelius to Governors. July 10, 2012. . Available at: http://www.healthreformgps.org/wp-content/uploads/Secretary-Sebelius-Letter-to-the-Governors-071012-3.pdf (Accessed July 17, 2012)

[19] The Patient Protection and Affordable Care Act (ACA) P.L. 111-148, §2001(b).

While the Court's decision to preserve the ACA Medicaid expansion is of paramount importance, its bar against the use of normal enforcement powers to assure state compliance with its terms is also highly significant. Despite the enhanced federal funding to expand their state plans to cover all newly eligible persons (100 percent federal financing beginning in 2014, declining over time to 90 percent FFP in 2020 and thereafter),[20] 27 states (Figure 2) took part in the lawsuit challenging the ACA and its Medicaid expansion (two of the 27 state opponents both challenged and supported the law as a result of splits between their Governors and their Attorneys General).



Some state opposition may be ideological; some may be based on their concern over the ACA's "woodwork" effect (*i.e.*, uninsured individuals seeking coverage through the Exchange would be determined to be Medicaid-eligible, resulting in increased enrollment of individuals already Medicaid-eligible under existing program standards but not enrolled). For these individuals, states would receive their regular federal contribution payments toward the cost of health care, which average about 57 percent. In addition, states have raised concerns that the federal share drops to 90 percent in the out years, and may be further reduced in the future.

In response to the new flexibility afforded by the Supreme Court ruling, six Republican governors have announced that they do not intend to expand Medicaid coverage.[21] Many other states reportedly are in the process of determining whether to proceed, and if so, what degree of flexibility they will have in moving forward. Of particular note, states have inquired on matters

[20] ACA §2001(a).
[21] The Advisory Board. *Where Each State Stands On ACA's Medicaid Expansion*. Daily Briefing (July 5, 2012). Available online at http://www.advisory.com/Daily-Briefing/2012/07/05/Where-each-state-stands-of-the-Medicaid-expansion. (Accessed July 16, 2012).

such as whether the enhanced federal contribution payments would still be available were they to delay the initial date of their expansions, cover the new group but only up to a lower income eligibility threshold (100 percent of poverty), or cover all individuals who are part of the new eligibility group.

States' failure to expand Medicaid would eliminate coverage for the poorest residents because Exchange tax subsidies are not available to uninsured persons with family incomes below 100 percent of the federal poverty level.[22] A further downstream consequence would be the loss of the infusion of Medicaid resources into thousands of poorer urban and rural communities. These communities experience elevated unemployment, and their health care providers – health centers, hospitals, physicians, pharmacies, and other health care providers – struggle with the burden of uncompensated care.

Analysis

This preliminary analysis was undertaken to estimate the potential impact on health center expansion and growth capacity of state decisions to forego the Medicaid expansion funding. A fuller explanation of our research methods can be found in the Appendix.

Findings

One recent estimate of the impact of states' failure to implement expansion suggests that as many as 11 million poor adults could remain uninsured.[23] Translating these figures into estimates of how a reduction of Medicaid coverage would affect health centers' growth capacity, we find that the downstream impact of states' failure to expand could be a nearly 25 percent reduction in overall health center growth between now and 2019. Table 1 shows that the financial effects of the ACA's Medicaid expansion account for almost 27 percent (5.3 million of the 19.8 million newly eligible children and adults) of the additional patient care capacity that health centers are projected to develop by 2019. Put another way, if no state were to adopt the Medicaid expansion, health center growth would be cut by more than one quarter.

It is, of course, too early to know with real certainty which states will be affected. But states whose Governors had by mid-July been relatively outspoken about rejecting Medicaid expansion funding include Florida, Louisiana, Mississippi, South Carolina, and Texas.[24] In those states alone, as many as 5.5 million individuals who would otherwise have received coverage under Medicaid will remain uninsured.[25] Republican Governors in an additional five states (Iowa, Missouri, Nebraska, New Jersey and Nevada) have indicated that they are inclined

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[22] ACA §1401.

[23] Based on 22,347,000 uninsured estimated by the Urban Institute to be eligible for Medicaid and Census' 33,723,100 uninsured under 200 percent of the Federal Poverty Level. Kenney, G.M., Dubay, L., Zuckerman, S., and Huntress, M., *Making the Medicaid Expansion an ACA Option: How many Low-Income Americans Could Remain Uninsured.* Urban Institute. June 2012; Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 and 2011 Current Population Survey (CPS: Annual Social and Economic Supplements).

[24] The Advisory Board. *Where Each State Stands On ACA's Medicaid Expansion*. Daily Briefing. Available online at http://www.advisory.com/Daily-Briefing/2012/07/05/Where-each-state-stands-of-the-Medicaid-expansion. (Accessed July 19, 2012).

[25] See Kenney, G.M., Dubay, L., Zuckerman, S., and Huntress, M., *Making the Medicaid Expansion an ACA Option: How many Low-Income Americans Could Remain Uninsured.* Urban Institute. June 2012.

not to expand coverage, although a final decision has not been reached.[26] Those states represent an additional 1.4 million uninsured individuals who would likely have been covered under Medicaid. If these 10 states ultimately were to decline Medicaid expansion, coverage for nearly 6.9 million low-income persons would appear to be at risk. Health center growth in these states would decline from a projected 8.3 million additional patients served by 2019 to 6.8 million.

Furthermore, as Table 1 shows, this projected lost growth would affect all types of health center patients, both those who are insured and uninsured. Notably also, only 44 percent of the 5.3 million patients whose ability to secure care through a health center would be Medicaid-enrolled patients; the remainder would be individuals with Medicare or private insurance coverage as well as patients who completely lack coverage even after full ACA implementation. In the 10 states that have indicated an early decision to decline the Medicaid expansion funding, over 1.5 million individuals could lose access to health center care, including 624,100 who would fail to gain Medicaid coverage.

Table 1. Estimated Impact of States' Medicaid Expansion Decisions on Health Centers' Growth Capacity by 2019

State	Total Patients (No Medicaid Expansion)	Total Patients (Medicaid Expansion)	Medicaid Expansion Impact on New Patients	Number of New Patients Eligible for Medicaid	Pct of New Patients Eligible for Medicaid	Total State Population Eligible for Medicaid
AK	152,400	184,400	32,000	9,700	30%	53,000
AL	476,500	652,500	176,000	69,000	39%	435,000
AR	247,200	316,500	69,300	24,600	35%	275,000
AZ	743,200	807,100	63,900	30,600	48%	463,000
CA	5,381,600	6,168,200	786,600	367,600	47%	2,875,000
CO	826,900	962,000	135,100	59,000	44%	351,000
CT	596,200	626,400	30,200	18,600	62%	122,000
DC	212,300	230,200	17,900	8,900	50%	21,000
DE	60,500	69,600	9,100	4,400	48%	42,000
FL	1,786,700	2,185,000	398,300	162,500	41%	1,795,000
GA	500,800	655,300	154,500	55,800	36%	974,000
HI	249,900	273,700	23,800	12,200	51%	51,000
IA	298,400	359,000	60,600	24,000	40%	148,000
ID	173,600	254,800	81,200	23,700	29%	150,000
IL	2,108,900	2,293,600	184,700	105,500	57%	782,000
IN	471,800	543,700	71,900	36,700	51%	517,000
KS	205,000	281,000	76,000	26,000	34%	200,000
KY	462,300	577,900	115,600	44,400	38%	399,000
LA	360,300	434,700	74,400	34,000	46%	422,000
MA	1,164,800	1,235,000	70,200	32,000	46%	117,000

[26] The Advisory Board – Daily Briefing. Available online at http://www.advisory.com/Daily-Briefing/2012/07/05/Where-each-state-stands-of-the-Medicaid-expansion.

Table 1. Estimated Impact of States' Medicaid Expansion Decisions on Health Centers' Growth Capacity by 2019						
State	Total Patients (No Medicaid Expansion)	Total Patients (Medicaid Expansion)	Medicaid Expansion Impact on New Patients	Number of New Patients Eligible for Medicaid	Pct of New Patients Eligible for Medicaid	Total State Population Eligible for Medicaid
MD	524,600	559,000	34,400	16,100	47%	251,000
ME	341,600	367,900	26,300	8,700	33%	64,000
MI	972,900	1,129,500	156,600	76,300	49%	730,000
MN	303,500	354,400	50,900	21,200	42%	202,000
MO	706,400	824,900	118,500	57,200	48%	452,000
MS	509,000	660,700	151,700	59,800	39%	333,000
MT	137,800	203,100	65,300	17,500	27%	88,000
NC	611,400	860,400	249,000	74,900	30%	804,000
ND	53,200	64,700	11,500	3,500	30%	35,000
NE	97,300	132,400	35,100	12,700	36%	110,000
NH	115,200	138,300	23,100	6,500	28%	64,000
NJ	822,800	907,900	85,100	43,400	51%	395,000
NM	479,800	579,100	99,300	34,200	34%	187,000
NV	128,900	157,700	28,800	10,400	36%	266,000
NY	2,771,600	2,976,600	205,000	100,600	49%	903,000
OH	828,300	957,000	128,700	61,200	48%	789,000
OK	227,400	276,500	49,100	20,700	42%	348,000
OR	494,700	583,000	88,300	40,200	46%	325,000
PA	1,171,700	1,297,100	125,400	59,900	48%	682,000
RI	232,000	257,000	25,000	11,900	48%	57,000
SC	534,300	655,500	121,200	48,200	40%	447,000
SD	98,300	128,300	30,000	10,000	33%	59,000
TN	646,800	789,000	142,200	59,300	42%	501,000
TX	1,552,700	1,992,300	439,600	150,800	34%	2,502,000
UT	160,700	241,300	80,600	20,800	26%	190,000
VA	461,200	574,300	113,100	31,800	28%	462,000
VT	226,700	236,800	10,100	3,100	31%	18,000
WA	1,415,000	1,581,900	166,900	81,700	49%	419,000
WI	524,700	558,500	33,800	21,100	62%	274,000
WV	629,800	763,800	134,000	39,800	30%	166,000
WY	30,400	43,600	13,200	3,100	23%	34,000
U.S.	34,638,200	39,960,600	5,322,400	2,350,110	44%	22,349,000

Participating; Leaning towards participation;
Leaning towards not participating; Not participating

Source: http://www.advisory.com/Daily-Briefing/2012/07/05/Where-each-state-stands-of-the-Medicaid-expansion.
Note: Estimates based on state proportion of uninsured (potentially) eligible for Medicaid by the Urban Institute (*Making the Medicaid Expansion an ACA Option*, 2012) and from 2010 UDS data. FQHCs in the U.S. territories are excluded. Estimates are rounded.

Discussion

States' decisions to reject Medicaid eligibility expansion funding can be expected to have a profound impact on access to health insurance coverage for more than 16 million of the nation's poorest residents. In addition, rejection of expansion funding can be expected to adversely affect the economic conditions facing health care providers in medically underserved communities. This study attempts to provide an early measurement of this potential impact, focusing on the consequences of non-expansion under Medicaid and its effect on health centers' ability to grow to meet the needs of low-income urban and rural communities. The impact here is measured in terms of patient care capacity lost. But the impact also can be measured in the economic losses to poorer communities in the form of employment and local investments.

Much time remains, of course, and the Secretary of Health and Human Services has indicated her willingness to work with states to ease the pathway to implementation. In the meantime, however, it is important to understand the systemic effects of non-participation. These effects go well beyond the immediate reduction in the number of individuals insured by Medicaid, and can be measured by examining a declining health system capacity on a broader scale. This broader loss of patient care capacity should be a matter of particular concern in the case of primary health care services in medically underserved communities because of the documented, population-wide, favorable health impact of a primary care investment.

Appendix: Methodology

The estimates are based in part on *Bending the Curve* briefs and the Urban Institute's *Making the Medicaid Expansion an ACA Option*.[27] With the expansion of Medicaid, we estimated that the number of Federally Qualified Health Center (FQHC) patients would increase from 19 million up to 50 million in 2019, and that the proportion of FQHC patients covered by Medicaid would rise from 36 to 44 percent.[28] However, due to an ongoing shortfall in federal FQHC appropriations and reductions in other sources of local and state grant funding,[29] we assume for the purpose of this analysis that FQHCs still would be able to leverage the $11 billion in mandatory health center funding to double their capacity to serve approximately 40 million patients by 2019.

To the extent possible, we used a simple and straightforward approach to estimate the potential loss of new patients if states chose not to expand their Medicaid programs. Two principal sources of data were used: the Uniform Data System (UDS) health center data collected by Bureau of Primary Health Care provided baseline data and the Urban Institute gave estimates of potential new Medicaid beneficiaries in each state.

The Urban Institute estimated that 47.2 percent of uninsured nationally would potentially be eligible for Medicaid. We applied their state-by-state estimates to FQHC data on the number of uninsured patients to calculate the number of patients who would have also been eligible, and adjusted for the unique patient, payor and income mix at FQHCs to ensure some consistency with their patient profile and performance.

The state-by-state Medicaid estimates were then used to calculate the impact on overall capacity. Because the literature indicates that FQHCs rely heavily on Medicaid to generate growth,[30] we assume that the lack of any major change to Medicaid would not significantly affect the general growth pattern of FQHC capacity. That is, even when FQHCs are expected to see an increase in patient volume under this scenario, we assume that the proportion of Medicaid patients, and thus, revenues, would not increase significantly if states chose not to expand their Medicaid program.

Estimates are rounded due to the high degree of uncertainty in state decision-making and other external factors, and a general lack of more precise data on health center patients. Because our estimates can only approximate the impact on FQHC capacity should states not implement the option to expand Medicaid, they should be used with caution.

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[27] Kenney, G.M., Dubay, L., Zuckerman, S., and Huntress, M., *Making the Medicaid Expansion an ACA Option: How Many Low-Income Americans Could Remain Uninsured.* Urban Institute. June 29, 2012.

[28] Ku, L, et al., *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers through Health Reform*. Issue No. 19. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Jun 30, 2010.

[29] Shin P, Rosenbaum S, and Paradise J. *Community Health Centers: The Challenge of Growing to Meet the Need for primary Care in Medically Underserved Communities*. Kaiser Family Foundation. March 2012.

[30] Shin P, Rosenbaum S, and Tolbert, J., *Medicaid and Community Health Centers: the Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities*, Kaiser Commission on Medicaid and the Uninsured, March 2012.