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Examining the Experiences of Puerto Rico's Community Health Centers Under the Government Health Insurance Plan

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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.

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Executive Summary

Overview

This research brief examines the experiences of Puerto Rico's community health centers under the Commonwealth's 1994 Government Health Insurance Plan (GHIP) – the Commonwealth's Medicaid program – also known as the *Reforma*. Of particular interest are the effects of Medicaid under-financing coupled with health centers' continuing obligations to furnish subsidized care for uninsured patients. To finance GHIP, the Commonwealth substantially curtailed its involvement with the direct provision of health care in both community and inpatient settings, transforming the former system of direct care provision into health insurance premium subsidies.

In 2007, the 47 operating sites of Puerto Rico's 19 federally funded community health centers served nearly 10 percent of all Commonwealth residents. In many communities, health centers are the only source of affordable primary health care. As GHIP network providers, health centers furnished care to more than 200,000 beneficiaries in 2007, or 15 percent of all GHIP enrollees. Like their mainland counterparts, Puerto Rico's health centers are essential primary care providers for medically vulnerable populations.

Findings

Primary care, especially primary care offered by health centers, has been severely and chronically under-financed by Medicaid managed care payments under GHIP. Systemic and severe under-financing of primary health care has led to the “perfect storm” of a shrinking and unstable primary care system with inverse incentives that push care away from low-cost primary care settings and toward episodic treatment in high-cost settings, such as emergency rooms and hospitals. Commonwealth officials have estimated that GHIP is under-financed by at least \$300 million annually; the total operating budget in 2007 was \$1.4 billion, compared with an estimated financial need of \$1.7 billion.

As a vital part of the Commonwealth's primary care system, health centers have been severely impacted by GHIP, especially in financial terms. The contractual service obligations imposed on health centers by GHIP's managed care plans extend well beyond primary care, dwarfing the obligations of most mainland U.S. health centers under managed care, and Puerto Rico health centers' per capita Medicaid payments are well below the rates for mainland health centers. The carve-out payments health centers in Puerto Rico receive for dental, mental health, HIV, and cancer services do not sufficiently compensate for the extraordinary down-streaming of financial risk resulting from the wide range of services required in exchange for a low managed care capitation payment.

Health centers are exposed to excessive financial risk under GHIP and are experiencing enormous losses. Unlike mainland health centers, health centers participating as GHIP providers accept *full financial risk* not only for standard primary

care but for all covered contract services. As a result, health centers are exposed to full financial risk for ambulatory care as well as many types of specialty, pharmacy, inpatient, and emergency care. Federal data on health center revenue show that Medicaid managed care payments cover *less than 12 percent* of health center patient expenditures.

Medicaid under-financing is associated with declining capacity at health centers, even as the need for comprehensive primary care is steadily growing. GHIP has severely depleted all primary care capacity across the Commonwealth, but health centers are particularly vulnerable to under-financing and risk -- between 2004 and 2007, the number of patients served by health centers declined by 51,450.

Health centers are implementing various strategies to continue operating despite Medicaid under-financing and risk down-streaming. One key strategy health centers have employed to counter the harmful effects of under-financing and risk down-streaming is shifting overall operating costs to their Federal 330 grants, which were designed to finance care and services not covered by traditional revenue streams. Therefore, funds originally designed to expanded services have been used to provide basic services. Other key strategies health centers use include diversifying patient populations and services offered to reach more privately insured individuals, participating in Medicare Advantage, implementing operational changes to promote efficiencies, and more aggressively attempting to recoup funds owed by GHIP health plans.

Recommendations

Numerous studies indicate that an effective and vibrant primary care delivery system is the backbone of a well-functioning health care system. GHIP achieved the goal of reducing the proportion of uninsured Puerto Rico residents, at the expense of primary care capacity and access. The experience of health centers with GHIP underscores one of the basic truths about health reform: it is possible to enact reforms that succeed in giving individuals something called “health insurance,” while simultaneously setting in motion financing strategies that undermine the fundamental goals of reform. Contrary to popular belief, expanding insurance coverage does not automatically increase access to care.

Specific suggestions to remedy the current unsustainable situation include:

- 1. Make a capital investment in health centers, coupled with implementation of the federal FQHC payment system.** Puerto Rico might invest in direct health center funding, as 37 states currently do. Congress might also make a capital investment designed to help health centers develop a formal affiliated arrangement while strengthening their own operations. This initial investment could be combined with a 100 percent federalized FQHC payment system, as granted to Indian Health Service facilities. Except for a few instances, Puerto Rico’s health centers have not received the FQHC payments to which they are entitled because of the significant under-funding of Puerto Rico’s Medicaid program.

These investments would pay off, with dividends. The efficiency and quality of health center care is so high that health centers generated an estimated \$410 million to \$469 million in savings for the 353,000 patients served in 2007 in terms of reduced hospital and emergency department services. A direct investment of \$75 million (\$423/patient) in Puerto Rico would permit health centers to expand their primary care capacity by 50 percent, enabling them to serve an additional 176,000 patients and resulting in additional system-wide cost savings of \$205 to \$234 million. This \$75 million investment would also generate at least 1,300 new jobs and over \$86 million in new economic activity.

2. Revising GHIP contracts to eliminate the excessive financial risks now borne by health centers. It is critical to prohibit financial risk down-streaming to health centers under GHIP, beyond the risks normally associated with primary health care furnished by health centers. The degree of down-streamed financial risk borne by Puerto Rico health centers far exceeds the maximum permissible risk-shifting limits allowed under federal law for entities, such as health centers, that are not licensed insurers and thus are not structured to bear full financial risk. Fundamental reformulation of GHIP financial policies to assure that risk is held at the plan level is urgently needed, and should be considered a basic condition of continuation of the *Reforma*.

3. Strengthen health centers' ability to operate in an integrated fashion. Puerto Rico's 19 health centers work closely together through their state primary care association, but they do not operate as an integrated delivery system. Creation of an integrated delivery system would be possible with capital financing investment, coupled with limitations on down-streamed risk and implementation of the Medicaid FQHC payment system that is outlined in federal law. These reforms would permit health centers to increase operational efficiencies and strengthen their delivery arrangements, while building strong ties to specialists and inpatient care providers. Although health centers are not allowed to form their own GHIP Medicaid insurance plan (a strategy pursued by health centers in several states), more integrated action through the formation of a health center Independent Practice Association (IPA) would strengthen health centers' ability to work collectively to advance and strengthen primary health care.

I. Introduction

This brief examines the experiences of Puerto Rico's community health centers under the Commonwealth's Government Health Insurance Plan (GHIP) – the Commonwealth's Medicaid program – which began in 1994 and is also known as *Reforma*. After outlining the research methodology, this paper describes the principal elements of GHIP, along with background on the role of community health centers in the Puerto Rico health delivery system. Following a summary of our principal findings, we conclude with a discussion of recommendations for enhancing the effect of GHIP on improving access to health centers. This analysis was performed by the Geiger Gibson/RCHN Community Health Foundation Research Collaborative at The George Washington University School of Public Health and Health Services.

II. Research Methods

This analysis utilizes mixed methods to explore the effects of GHIP, given the limited amount of available literature and the lack of comprehensive data on coverage, costs, and services. To gain a broader contextual understanding of the adaptation strategies developed by the Commonwealth's health centers, we first collected and analyzed data and background information on the financial and operational characteristics of the Commonwealth's healthcare system and its health centers, as well as the health status of Puerto Ricans, from several key sources: the Uniform Data System (UDS) from the Health Resources and Services Administration (HRSA); reports generated by the Puerto Rico health department agency, *Administración de Seguros de Salud* (ASES); reports and data generated by the Puerto Rico Primary Care Association (PR PCA); reports and data from specific health centers; quality of care data from health plans; publicly available background material from the academic literature and the popular press; and materials generated by the health center litigation against the Puerto Rico Department of Health and its Medicaid program. We also interviewed a representative from the Planning and Quality Affairs Office of ASES who was very familiar with the pertinent data as well as the health center program, in order to obtain available government data and the perspective of a GHIP administrator.

This background information was presented to two focus groups, comprised of health center chief executives, chief financial officers, and medical directors. Participants in the first group provided opinions confirming or rejecting the validity and accuracy of the compiled data, and provided explanations for their perspectives. The second focus group examined how health centers have adapted to the reforms, utilizing specific examples of challenges caused by GHIP and their proposed solutions, such as changes in services and staffing, cost-containment strategies, and funding efforts. We specifically asked how the reforms impacted care delivery, especially access to different types of care, as well as changes in patient health outcomes.

In order to document and further examine the possible responses to GHIP policies in practice, we interviewed staff at two health centers: Consejo de Salud de la Comunidad de la Playa de Ponce, Inc. (Ponce) in the southern coastal area, and Corporación de

Servicios de Salud y Medicina Avanzada (COSSMA), located in the central mountainous region. Both health centers have a history of strong leadership and innovation, as well as the ability to expand their services within a financially challenging environment; they also serve different types of populations (e.g. migrant farm workers, homeless, and both urban and rural inhabitants). Whenever possible, we collected specific examples of patient experiences.

III. Background

1. The Government Health Insurance Plan (GHIP)

Enacted in 1993 and implemented in 1994, GHIP was an attempt to extend health insurance coverage to all residents of Puerto Rico, principally by expanding Medicaid, in anticipation of national health reform in the U.S. Direct subsidies to publicly operated health clinics were eliminated and most publicly administered health care services were privatized, with the exception of some emergency rooms.¹ In essence, the Commonwealth's health care investment in its low-income population was monetized, and the funds saved from the elimination of direct operational subsidies were combined with revenues from the Commonwealth's Medicaid program to underwrite private health insurance coverage for Puerto Rico residents.

Currently, 38-40 percent of the Commonwealth's residents are insured through a Medicaid plan funded through the mechanisms created by GHIP.² Approximately 90 percent of the Commonwealth's 1.5 million Medicaid beneficiaries in 2007 were enrolled in managed care health plans.³

A coverage franchise is awarded to a single health plan in each region; there are four managed care plans participating in Medicaid. As in the U.S. mainland, plans' contractual service obligations are very broad, encompassing preventive, acute, ambulatory, and inpatient care. Participating plans are obligated to cover emergency care on a 24/7 basis; much of this care is provided by emergency rooms operated by hospitals and other entities, several of which are operated by health centers.⁴ Of note, privately operated emergency services may be funded partially by the government to assure 24/7 access. Health plans contract with at least one hospital per region, with tertiary care largely concentrated in the capital city, San Juan.⁵ The system is a managed care model administered on a regional basis by an agency called ASES (*Administración de Seguros de Salud*), and permitted under special authority approved by the Centers for Medicare and Medicaid Services (CMS).

Ambulatory health care is furnished by community health centers and other independent practice associations (IPAs) organized throughout the Commonwealth. The managed care payment made by ASES to the plans covers inpatient and outpatient care, with the

¹ ASES website, (Accessed February 13, 2009: <http://www.ases.gobierno.pr/>); PR PCA, GW Profile, 2007.

² University of Puerto Rico, 2007. "Planning for Health Care Improvement for the People of Puerto Rico."

³ Puerto Rico Department of Health, 2007. "Puerto Rico State Planning Grant." September 19.

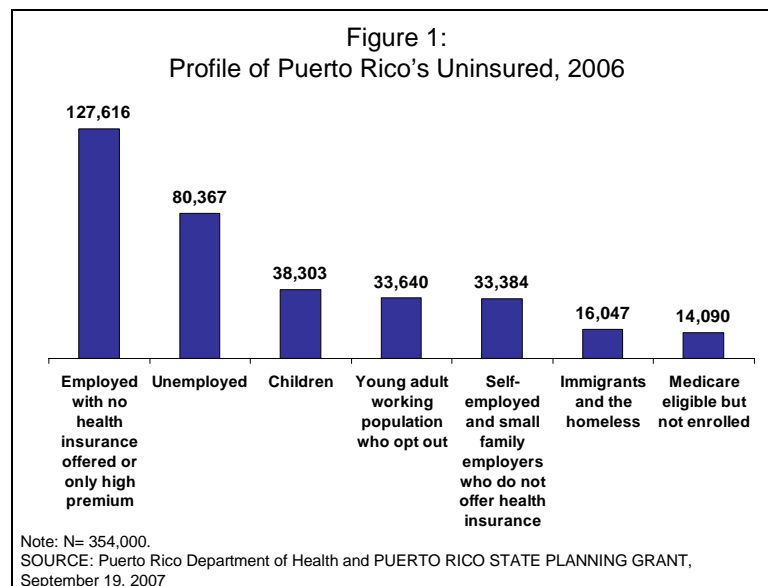
⁴ Meeting with PR PCA, January 26, 2009.

⁵ Puerto Rico Department of Health, 2007.

exception of mental health services, which are carved out of the contracts and financed through payments from Managed Behavioral Healthcare Organizations. Dental care, HIV care, and cancer care are also carved out of the contracts and financed with direct payments.⁶ In recent years the number of IPAs participating in GHIP has fallen as a result of the system's extremely low capitation payments.⁷

GHIP has succeeded in reducing the number of uninsured residents, but about ten percent of residents still lack insurance. In 2006, the Commonwealth Health Department estimated an uninsured population of 354,000,⁸ but the figure is likely higher today due to the severe economic downturn and the recent reductions in GHIP's financial eligibility standards. Thousands of low-income working families that cannot afford private coverage remain ineligible for Medicaid under GHIP. Puerto Rico's Medicaid eligibility threshold is approximately twice the Federal Poverty Level (FPL). This means that in Puerto Rico, the threshold of 100 and 200 percent of the State Poverty Level is effectively the equivalent of approximately 50 and 100 percent, respectively, of the commonly used FPL. The threshold is exceedingly low -- an individual earning more than \$902.50 on a monthly basis does not qualify for GHIP.

Figure 1, which describes the uninsured population, illustrates that the same factors that create high levels of uninsurance among the mainland population are at work in Puerto Rico: low-wage jobs that offer no or only unaffordable health insurance, a large population of young adults who opt out of coverage, and unemployment. Uninsured residents of Puerto Rico reportedly receive much of their care through emergency rooms.



⁶ Pan American Health Organization, 2007. "Health System Profile: Puerto Rico—Monitoring and Analyzing Health Systems Change/Reform." Washington, DC.

⁷ Meeting with PR PCA, January 26, 2009.

⁸ Puerto Rico Department of Health, 2007.

In recent years, coverage eligibility has been further restricted, chiefly through the lowering of applicable asset eligibility guidelines. Frequent recertification procedures, the ‘aging out’ of children, and changes in family living arrangements also contribute to a moderate level of churning, with the eligible-but-unenrolled population estimated at roughly three to four percent of the GHIP-eligible population at any given time.⁹

Enrollees are responsible for point-of-service copayments on a sliding scale basis according to income. For an individual who earns between 130 percent and 200 percent of Puerto Rico’s State Poverty Level, a typical co-payment is \$2 for a primary or specialty care visit, \$1 per prescription, and \$5 per hospital admission.¹⁰

Financing the Government Health Insurance Plan (GHIP)

GHIP’s financing is mainly drawn from general Commonwealth funds, federal Medicaid and SCHIP dollars, with modest payments from municipalities and other sources. The scholarly literature on GHIP is scarce, but available evidence suggests that the plan was severely under-financed from the outset, chiefly as a result of the limited federal contributions to the Puerto Rico Medicaid program.¹¹ Even when Puerto Rico’s lower cost of living is taken into account, health plan payments under GHIP are well below actuarially sound payment rates. Total operating revenues for GHIP are so constrained that payments to providers were frozen from FY 1999 to FY 2003.

Under the special federal dollar amount payment cap that applies to Puerto Rico and other U.S. territories, the federal contribution to the Commonwealth’s Medicaid program was 18 percent in CY 2005.¹² If the federal match rate were calculated under the same terms as it is for states on the mainland, Puerto Rico would have received the highest level of federal financial participation (about 78 percent) due to its poverty rate. Under this scenario, the Commonwealth’s Medicaid program would have received \$1.7 billion, versus the actual payments of \$219 million from the federal government in 2005.¹³

The American Recovery and Reinvestment Act (ARRA) extended additional temporary federal Medicaid funding to Puerto Rico, but the boost in federal payments is only temporary; after the stimulus, the federal contribution will remain extremely low without permanent reforms.¹⁴

2. Community Health Centers Provide Access to Care in Puerto Rico and Across the Nation

The federally qualified health centers program provides grants to clinics offering affordable primary and comprehensive health care to medically underserved communities

⁹ Focus group Meeting with CEO, CFO, CMO of PR health centers, January 26, 2009.

¹⁰ ASES. “Aplicable Deductibles, Administracion de Seguro de Salud de Puerto Rico General Bylaws,” 42-43.

¹¹ Acevedo-Vila, Hon. A., 2005. “Statement for the Record, Senate Finance Committee.” June 15

¹² Acevedo-Vila, Hon. A., 2005. June 15

¹³ Acevedo-Vila, Hon. A., 2005.

¹⁴ P.L. 111-5, § 5001(f) American Recovery and Reinvestment Act.

and communities experiencing a shortage of primary health care professionals.¹⁵ In 2007, 1,067 health centers, located in all 50 states and several of the territories, provided health care to over 16.1 million patients.¹⁶

Nationally, more than 90 percent of all health center patients have low family incomes, more than 65 percent are members of racial and ethnic minority groups, and 43 percent are either elderly or children under 18.¹⁷ Health centers provide care to one in five low-income children in the nation, serve one in seven Medicaid beneficiaries, and care for one in every eight low-income women who gives birth.¹⁸

Four key characteristics distinguish health centers from other providers, enabling them to be responsive to the communities that they serve.¹⁹ Health centers must accept all patients without regard to their ability to pay for services, and centers must offer sliding fee scales to patients according to income. Second, health centers must offer comprehensive primary care; services available at health centers include a wide range of clinical preventive care for children and adults, as well as prenatal care, treatment of acute illnesses and conditions, and chronic care for conditions such as diabetes, cardiovascular disease, childhood asthma, and mental illness. Third, health centers must be governed by a majority-community board comprised mainly of center patients. Finally, health centers must serve populations or communities that have been formally designated as medically underserved or suffering from a shortage of primary health care professionals.

Health centers are widely recognized for the quality and accessibility of the care provided,²⁰ as well as the impact of their care on population health and the reduction of racial, ethnic, and socioeconomic disparities in health status and access to health care.²¹ As medical homes for some of the most vulnerable populations with complex medical, behavioral, and social needs, health centers provide and arrange for a comprehensive array of services.²² Given their capacity and experience coordinating care, health centers

¹⁵ Rosenbaum S, Finnegan B, & Shin P, 2009. "Community Health Centers in an Era of Health System Reform and Economic Downturn: Prospects and Challenges." *Kaiser Family Foundation*, March.http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/CommunityHealthCenter_update_032309.pdf.

¹⁶ GW analysis of 2007 UDS data, HRSA.

¹⁷ Ibid.

¹⁸ GW analysis of 2007 U.S. Census Bureau data.; Ibid.

¹⁹ Rosenbaum, Finnegan, and Shin, 2009.

²⁰ Dor A, Pylypchuck Y, Shin P& Rosenbaum S, 2008. "Uninsured and Medicaid Patients' Access to Preventive Care: Comparison of Health Centers and Other Primary Care Providers." Geiger Gibson/RCHN Community Health Foundation Research Brief #4, August.

²¹ Hadley J, Cunningham P& Hargraves JL, 2006. "Would safety-net expansions offset reduced access resulting from lost insurance coverage? Race/Ethnicity differences." *Health Affairs* 25(6): 1679-1687; Shi L, et al., 2004. "America's health centers: Reducing racial and ethnic disparities in perinatal care and birth outcomes." *Health Services Research* 39(6/Part I): 1881-1901; Shin P, et al., 2003. "Reducing Racial and Ethnic Health Disparities: Estimating the Impact of Community Health Centers on Low Income Communities." *National Association of Community Health Centers*, Washington, D.C.

²² Geiger H.J, 2005. "The First Community Health Centers: A Model of Enduring Value." *J Ambul Care Mgmt* 28(4): 312-319.

are effective providers in managed care settings; in some cases, centers have initiated their own managed care plans.²³

In 2007, the 47 operating sites of Puerto Rico's 19 federally funded community health centers served nearly 10 percent of all Commonwealth residents, more than 352,000 patients. In many communities, health centers are the only source of affordable primary health care. As GHIP plan network providers, health centers furnished care to more than 200,000 GHIP beneficiaries in 2007, or 15 percent of all enrollees.²⁴ In this regard, health centers in Puerto Rico, like their mainland counterparts, are essential providers of primary care for the population that qualifies for GHIP.

With regard to the characteristics of the patient population, the challenges that health centers in Puerto Rico face are arguably far deeper than those that confront health centers serving mainland U.S. residents:

- Puerto Rico residents are 27 percent *less likely* than mainland residents to have at least a high school diploma, and 37 percent *less likely* to be in the labor force.²⁵
- More than 45 percent (three times the national average) of Puerto Rico's 3.95 million residents have family incomes below the official federal poverty level, which is \$18,310 for a family of three in 2009.²⁶ The median family income in Puerto Rico was \$18,191 in 2007, compared with \$50,007 for mainland residents.²⁷
- In the U.S. on average, 70 percent of health center patients have incomes below the poverty line; in Puerto Rico, this figure rises to 86 percent.²⁸
- Compared to mainland residents, individuals in Puerto Rico are 70 percent *more likely* to have a disability.²⁹
- Residents of Puerto Rico have the highest age-adjusted prevalence of diabetes in the U.S., 12.2 percent compared to 5.6 percent nationally.³⁰

²³ Association for Community Affiliated Plans, 2006. "Safety Net Health Plans: Critical Partners in the Health Care Safety Net."

<http://www.communityplans.net/ResourceCenter/ACAPWorkingPapers/tabid/259/Default.aspx>.

²⁴ GW analysis of 2007 UDS data, HRSA.

²⁵ GW analysis of 2007 U.S. Census Bureau data.

²⁶ U.S. Census Bureau, 2007; 2009 HHS Poverty Guidelines. <http://aspe.hhs.gov/poverty/09Poverty.shtml>

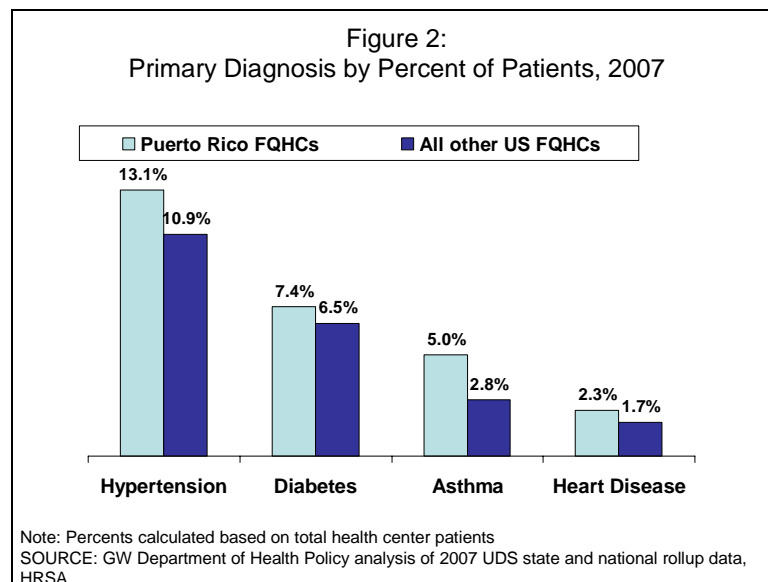
²⁷ GW analysis of 2007 U.S. Census Bureau data.

²⁸ GW analysis of 2007 UDS data, HRSA.

²⁹ GW analysis of 2007 U.S. Census Bureau data.

³⁰ CDC, 2008. "Diabetes Data and Trends: Puerto Rico - Percentage of Adults with Diagnosed Diabetes, 1994 - 2007." (www.cdc.gov).

- Compared to patients served at mainland health centers, those served at health centers in Puerto Rico are even more likely to suffer from chronic disease, as shown in **Figure 2**.



In addition to the under-financing of the GHIP and the higher health risks faced by health center patients in Puerto Rico, there are limitations on staffing patterns that constrain centers in Puerto Rico. Mainland health centers rely heavily on mid-level providers such as nurse practitioners (NPs) and physician assistants (PAs), but in Puerto Rico, NPs, PAs, and certified nurse midwives are prohibited from billing for services, leaving a significant deficiency in the number of overall primary care providers.³¹

Despite these barriers, health centers in Puerto Rico have been able to demonstrate success in managing patient care. Centers have also been leaders in quality improvement efforts aimed at reducing health disparities in the U.S. population:

- Health centers outperform other types of primary care providers — including privately organized IPAs — on chronic disease care measures, according to analysis of Healthcare Effectiveness Data and Information Set (HEDIS) measures collected from providers in selected GHIP Managed Care Organizations (**see text box**).³²
- By 2008, 17 of Puerto Rico’s 19 health centers were participating in one or more of the Health Disparities Collaboratives funded by the Health Resources and

³¹ Site visit to Playa del Ponce Health Center, January 27, 2009.

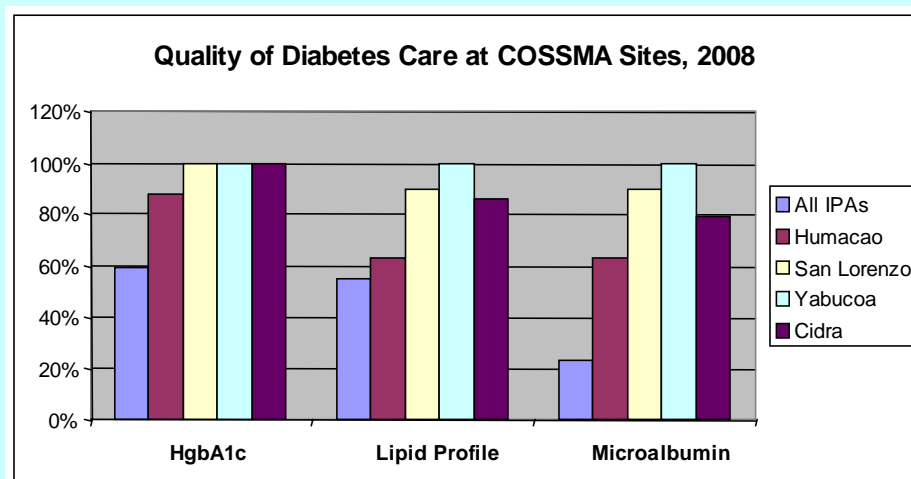
³² Humana Health Plans of Puerto Rico, 2008. “Diabetes Management Quality Indicators: COSSMA.”

Services Administration, focused on improving the quality of care for diabetes, cardiovascular disease, and long-term pharmacy management.³³

- All health centers that participated in a Health Disparities Collaborative use special electronic registry systems (known as the Patient Electronic Care System, or PECS) to track and improve care management for their high-risk patients.³⁴
- Nine of the Commonwealth's 19 health centers currently have accreditation from the Joint Commission (formerly JCAHO) for high quality ambulatory patient care.

Corporación de Servicios de Salud y Medicina Avanzada (COSSMA)

Established in 1964 as a migrant health center, COSSMA currently provides care to more than 25,000 patients at four service delivery sites. Like other health centers in Puerto Rico, COSSMA patients carry a high burden of chronic diseases such as diabetes, heart disease, and asthma. To address the need for chronic disease care, COSSMA has participated in the Health Disparities Collaboratives in diabetes, cardiovascular disease, and asthma. Furthermore, COSSMA has been innovative in integrating chronic disease care with community-based programs for health promotion, disease prevention, and social services (e.g. housing) to improve overall wellness for their patients. Recent quality of care reports (HEDIS) show that COSSMA exceeds regional averages for managing various chronic diseases. The graph shows that COSSMA's four sites — Humacao, San Lorenzo, Yabucoa, and Cidra — exceed regional averages for diabetes care (annual check for HgbA1c (percentage of hemoglobin molecules in the blood that contain glucose), lipid profile, and microalbumin)).



Source: Humana, Diabetes Management Quality Indicators, 2008.

As on the mainland, health centers serve a vital role in Puerto Rico's health delivery infrastructure. As front-line providers for the most medically vulnerable patients in the Commonwealth, health centers were significantly impacted by GHIP.

³³ HRSA, 2007. "HDC 2007 Reporting Status, HRSA Knowledge Gateway Results Sharing Site." <http://hdnr.org/html/ReportsDownload.aspx>; PR PCA internal data, March, 18, 2009.

³⁴ Site visit to Play del Ponce Health Center, January 27, 2009.

IV. Findings

GHIP has affected health centers in four basic ways:

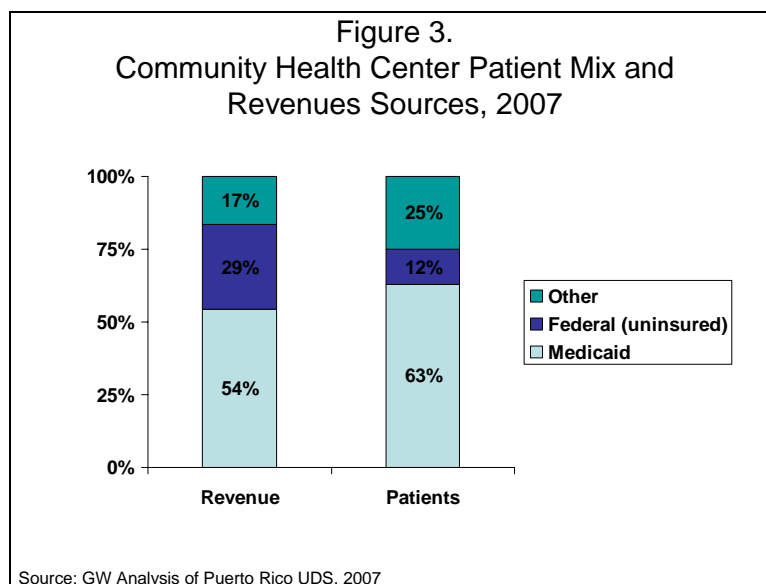
- Health centers are severely and chronically under-financed by Medicaid managed care payments under GHIP.
- Health centers are prone to excessive financial risk under GHIP.
- Medicaid under-financing is associated with declining capacity at health centers, even as the need for comprehensive primary care grows.
- Health centers are implementing various strategies to continue operating despite Medicaid under-financing and risk down-streaming.

1. Health centers are severely and chronically under-financed by Medicaid managed care payments under the Government Health Insurance Plan.

Commonwealth officials have estimated that GHIP is underfinanced by at least \$300 million annually; according to the ASES official whom we interviewed, the total operating budget in 2007 was \$1.4 billion compared with an estimated financial need of \$1.7 billion.³⁵ This estimate may be conservative in light of the government's concern over publicizing the true size of the financial shortfall.

Under GHIP's managed care system, health centers continue to operate at a financial loss. The 2007 UDS data show that Medicaid managed care capitation rates were less than 12 percent of expenditures, forcing health centers and other providers to shift resources that were allocated for providing care to the uninsured to provide care for GHIP-insured patients. **Figure 3** shows that while Medicaid patients account for 63 percent of patients, Medicaid revenues make up only 54 percent of total revenues.

³⁵ Interview with ASES official, January 28, 2009.



Despite the broad scope of their service obligation under GHIP, Puerto Rico health centers averaged \$239 in annual per capita Medicaid payments in 2007, compared with \$593 in annual per capita Medicaid payments in 2007 for mainland health centers.³⁶ According to the health centers and ASES officials interviewed, GHIP health plans receive \$39 per member per month for all contractual care and administrative costs, a figure far below the per member per month (PMPM) payments for Medicaid managed care on the mainland. Of this amount, health centers receive \$29 PMPM. However, this amount, which might be reasonable if limited to primary care, is provided to health centers to finance *all contractual care* for Medicaid patients, including primary and specialty ambulatory care, pharmacy, inpatient care, and emergency care.

Even the \$29 PMPM payment figure greatly overstates actual plan payments. According to members of our health center focus group, it is common for health centers to receive no payments at all from the plans in which they participate. Some health centers are informed that they actually owe the plans money because the total cost of patient care exceeds the capitation payment. Other health centers report that the health plans utilize various tactics to avoid paying health centers, such as disputing the figures presented by the health centers and forcing health centers to pursue legal remedies in order to secure reimbursement. Some health centers report that payments often bear no relationship to centers' estimates of what they are owed, and may be a fraction of what they expect to receive. One health center director reported that in response to a \$100,000 invoice, it received a payment of \$4,000 from the managed care plan.³⁷

Furthermore, the \$29 PMPM total figure includes capitated payments as well as Medicaid payments for carve-out services such as dental and mental health services. According to health center officials, direct payments for carve-out services are essential to the financial

³⁶ GW analysis of 2007 UDS data, HRSA.

³⁷ Focus Group with CEOs, CMOs and CFOs of PR FQHCs, January 26, 2009.

viability of health centers, and are used to subsidize GHIP and uninsured patient care.³⁸ In addition, this figure also includes all Medicaid revenues, including revenues received in caring for other populations not enrolled in Medicaid managed care under GHIP (e.g., elderly and disabled persons).

Contrary to the situation for health centers on the mainland, Puerto Rico's health centers do not receive a Medicaid funding supplement (often referred to as a 'wraparound' payment) equal to the difference between what health plans pay for covered services and their prospective cost-related FQHC payment rates.³⁹ If the usual federally qualified health center payment system were operating in Puerto Rico, health centers would receive supplemental payments directly from ASES for the difference between the centers' Prospective Payment System (PPS) rate for projected care and services and the amounts actually received from GHIP plans. The PPS office has been established, but the system has not yet been implemented.

There is ongoing litigation on the wraparound payment issue. Two health centers received wraparound payments from the Commonwealth in 2008 after successfully litigating their case; however, a subsequent ruling from a federal court refused to require the Commonwealth to make further payments on Constitutional grounds.⁴⁰ Although the federally mandated supplemental payment system has been held applicable to the Puerto Rico program by recent response by the U. S. Attorney General,⁴¹ presumably, during the ongoing appeals process, no wraparound payments will be received.

The sale or transfer of real estate property or health facilities previously owned by the government also had a direct and immediate financial impact on health centers, ultimately resulting in new mortgage or rental obligations. Prior to GHIP, many of the Commonwealth's community health centers occupied publicly owned buildings on a rent-free basis. Following the establishment of GHIP, these buildings were sold to health centers or other private entities, in order to generate revenue to partially fund the program.⁴² Health centers took over a number of previously public clinics, but in some municipalities, a public health access point may simply have disappeared.⁴³ Legislation enacted in 2002 and 2003 slowed privatization in an effort to maintain health care access points, but the trend continues.

³⁸ Site visit to Playa del Ponce Health Center, January 27, 2009.

³⁹ Focus group Meeting with CEOs, CFOs, CMOs of PR health centers, January 26, 2009.

⁴⁰ Correspondence with PR PCA and health center CEOs, February 23, 2009. See, National Senior Citizen's Law Center. D.D.C. "Providers can't force HHS to enforce Medicaid." (Accessed on March 15, 2009: http://www.nslc.org/areas/federal-rights/area_folder.2006-05-26.6012943467/d-d-c-providers-can-t-force-hhs-to-enforce-medicaid/article_view).

⁴¹ Consejo de Salud Playa Ponce et al. vs. Secretary of Health of the Commonwealth of Puerto Rico. Civil No. 06-1260. March 16, 2009. "Intervention by the United States to Defend the Constitutionality of Federal Medicaid Provisions."

⁴² As a result of these legislative reforms, the Department of Health continues to hold approximately 22 private diagnostic and treatment centers, a number of which are operated by private entities. Pan American Health Organization. 2007. "Health System Profile: Puerto Rico"; Meeting with PR PCA, January 26, 2009.

⁴³ Focus group Meeting with CEOs, CFOs, CMOs of PR health centers, January 26, 2009.

The financial constraints imposed by GHIP also prohibit many health centers from undertaking needed renovations, expansions and technology improvements. Many facilities currently owned or operated by health centers are grossly inadequate for patient care.⁴⁴ In a few instances, natural disasters, such as landslides, have severely damaged the facilities and they have remained unrepaired for several years.⁴⁵ Other facilities lack adequate space to accommodate the large volume of patients. Technology to improve quality and efficiency of care such as electronic health records (EHR) has been delayed. 17 of 19 health centers are pursuing adoption of EHR systems, but none currently possesses one.

2. Health centers are prone to excessive down-streamed financial risk under GHIP

Unlike mainland health centers, health centers participating as GHIP providers accept *full financial risk* for all covered contract services, not merely those services that are generally considered an aspect of primary health care.⁴⁶ Federal Medicaid regulations prevent any provider from accepting financial risk above 25 percent, or a maximum of \$10,000 per covered life per coverage period.⁴⁷ Nevertheless, according to one government official, this regulation is not enforced due to unclear government policies and varying MCO interpretations.⁴⁸ As a result, health centers are exposed to full financial risk for ambulatory primary and specialty care, as well as inpatient and emergency care. In order to control this financial risk, health centers offer services such as mental health or dental services that generate direct payment to subsidize primary and specialty medical care, as well as emergency care when costs exceed capitation.

The adverse effects of the financial risk ambulatory care providers assumed in Puerto Rico led to the enactment of certain reforms in 2002 and 2003 to stem the loss of health care access points. One current health center physician who previously owned his practice incurred a \$15,000 operational debt in only nine months after agreeing to participate in GHIP, forcing him to close the practice. The legislative reforms were designed to allow ASES to directly contract with ambulatory care providers and hospitals in order to offset the financial effects of very low plan payments. The legislation also prohibited the further transfer of municipal emergency facilities and clinics to private interests.⁴⁹

3. Medicaid under-financing is associated with declining capacity at health centers, even as the need for comprehensive primary care grows.

GHIP has severely depleted primary care capacity across the Commonwealth, but health centers are particularly vulnerable to under-financing and excessive risk down-streaming, as outlined above. The low reimbursements combined with administrative barriers have

⁴⁴ Ibid.

⁴⁵ Interview with Sandra Garcia, Executive Director, Salud Integral en la Montana, Inc., March 27, 2009.

⁴⁶ Focus group Meeting with CEOs, CFOs, CMOs of PR health centers, January 26, 2009.

⁴⁷ 42 CFR 422.208.

⁴⁸ Interview with ASES official, January 28, 2009.

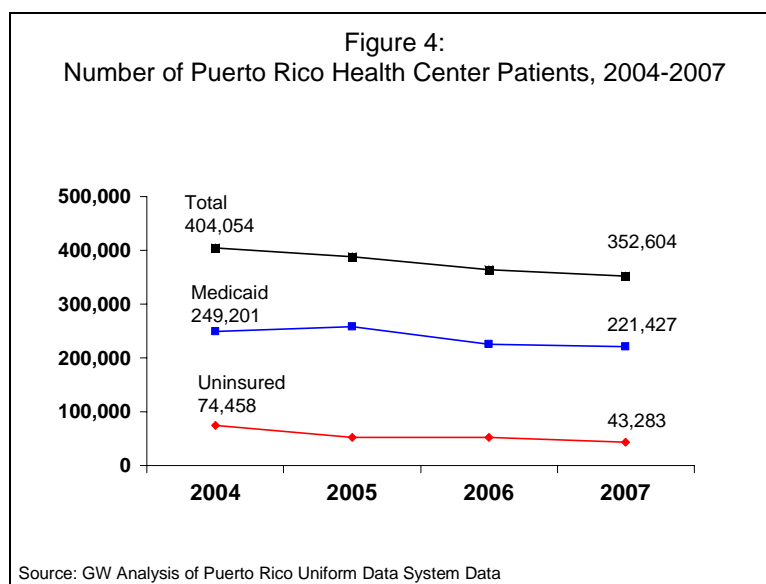
⁴⁹ Pan American Health Organization, 2007.

caused many primary care providers to stop accepting GHIP patients or to close their practices completely, increasing demand at health centers operating in the region.

In addition, the lack of medical specialists for commonly encountered conditions has created further demand for primary care. For example, 2007 UDS data indicate that only one psychiatrist was on a Puerto Rico health center staff, despite a high need for mental health care. Mental health care on the island is primarily provided by psychologists with limited scope of practice (e.g. limitations in prescribing certain medications). Even if specialists are available, there are disincentives for the health centers to refer patients to specialists, such as cardiologists and gastroenterologists, due to the centers' obligation to cover the costs of specialty care. All services ordered or delivered by the specialists including diagnostic tests (e.g. echocardiogram, CT scan, or special laboratory tests) must be paid by the health center. The combination of factors that deplete the supply of specialists and non-health center primary care providers creates enormous demand for both preventive and curative services that the health centers are unable to meet.

Despite the increased demand, health centers treated 51,450 fewer patients over the last four years, with the declines principally comprised of Medicaid and uninsured patients.⁵⁰

Figure 4 shows a decline of 51,450 patients (13 percent) served by health centers in Puerto Rico over the past four years.⁵¹ Almost the entire decline can be attributed to a drop in the number of uninsured and Medicaid patients treated.



The decline in Medicaid and uninsured patients served by health centers is not surprising, in light of previous studies of health center financing conducted by researchers at The

⁵⁰ GW analysis of 2007 UDS data, HRSA; although uncertain of its impact, more accurate patient counting systems have been implemented to reduce duplicate records.

⁵¹ Because patient counting methods changed in 2003 we restrict analysis of patient caseload to the last four years. In addition, there were eligibility reforms and increased enforcement efforts in 1999, which began a decrease over the coming years. The vast majority of the decreases attributable to the reforms and enforcement efforts would have occurred prior to 2003.

George Washington University. There is a significant positive association between growth in Medicaid revenue and growth in health centers' capacity to treat both Medicaid and uninsured patients.⁵² An infusion of Medicaid funding, for example, due to expanded eligibility and higher payment levels for covered services, allows health centers to achieve overall efficiencies that expand service capacity, which has a positive spillover effect on health care access among the uninsured.⁵³

The evidence from Puerto Rico suggests that as Medicaid revenues shrink in relation to the cost of providing care, the impact is felt system-wide, affecting patient care capacity as fewer physicians are available to provide care for GHIP patients. The 2007 UDS data suggest that of the 19 health centers reporting, eight were operating with negative net margins that year; in at least four cases these negative margins stood at \$1 million or greater. A negative net margin means that the health center is unlikely to meet the ongoing costs of its operations and cannot undertake any of the routine investments that are essential for the maintenance of its care capabilities and quality.

4. Health centers are implementing various strategies to continue operating despite Medicaid under-financing and risk down-streaming.

In our discussions with the health center focus group, we posed the obvious question: how are health centers surviving in the face of heavy financial risk down-streaming coupled with severe Medicaid under-financing? Not surprisingly, their collective answers were multi-faceted and reflected a variety of strategies employed by clinics struggling to survive. Health centers face unique administrative challenges under the GHIP, given that they must negotiate and adhere to 26 managed care contracts, including GHIP and Medicare. Salient strategies to counter the deleterious effects of under-financing and risk down-streaming include shifting overall operating costs to health centers' federal 330 grants, diversifying patient populations and services offered, pursuing operating efficiencies, and more aggressively attempting to recoup funds owed by health plans.

Shifting costs to Section 330. Some respondents noted that they are applying their Section 330 grants, the federal grant payments made by the Health Resources and Services Administration (HRSA), to finance costs and activities that should be borne by Medicaid payments. In essence, Puerto Rico's health centers are using the same survival strategy employed by health centers prior to the 1990 federal Medicaid reforms, namely, using federal grants intended for care of the uninsured to offset the costs of serving Medicaid beneficiaries. In the case of Puerto Rico, however, the fiscal urgency is even greater, since health centers are contractually responsible under GHIP not only for primary care but also for specialty, inpatient, and emergency care, as well as other GHIP benefits.

⁵² Ku L, Finnegan B, and Shin P, Forthcoming. "Strengthening the Primary Care Safety Net for the Uninsured." *Health Affairs*.

⁵³ Ibid.

Diversifying patients, services, and revenues. Health centers have been aggressively pursuing other patients and payers. Many report positive experiences contracting with Medicare Advantage plans (several of the insurers that participate in GHIP also operate Medicare Advantage plans), which offer much higher payment levels and far more equitable contract terms. Some health centers (see text box) have been successful in expanding their care to privately insured populations. Other health centers report expanding their pharmacy, dental, mental health, and laboratory operations in order to generate direct payment revenues to supplement managed care capitation payments.

Consejo de Salud de la Comunidad de la Playa de Ponce, Inc.

Established in 1970, Ponce currently provides care to more than 54,000 patients at four service delivery sites and one mobile unit.

Patient Diversification

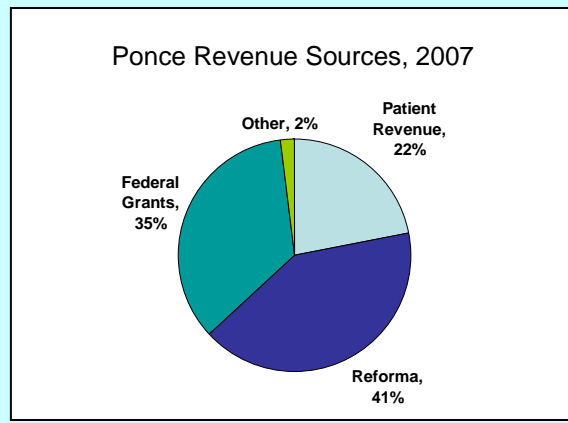
The Ponce health center actively seeks patients with private insurance and Medicare. They use print marketing, radio programs, and video productions to educate the community about key health issues and to encourage patients to utilize their health center. In addition, they use a mobile unit with full medical and dental capabilities to provide initial care off-site, using it as a “hook” to encourage future patronage to the main clinic.

Service Diversification

In an effort to control ambulatory primary and specialty care costs, Ponce strongly encourages patients to utilize laboratory, pharmacy, and other services offered on-site. Health centers collect direct reimbursement for these services rendered. Ponce also provides dental and mental health services, which are “carved out” under GHIP, and these services further subsidize the provision of primary and specialty medical care.

Revenue Diversification

The driving force behind diversifying the patient base and services is to broaden the health center’s revenue base. Ponce currently earns about 22 percent of its income from patient revenue, including private insurance and Medicare, while continuing to rely on Federal and GHIP grants. Revenue diversification allows the Ponce center to continue offering necessary services to patients while maintaining financial viability.



Improving operations to achieve efficiency. Health centers have pursued a number of operational changes that reflect their innovative approach to fulfilling their mission and their efforts to find less costly and more efficient ways to give care of greater value. Numerous examples offered by the health centers that we interviewed included:

- Using medical residents to reduce costs;
- Utilizing on-site care for professional, ancillary, diagnostic, and other services, rather than off-site services, which tend to cost more due to contractual arrangements;

- Using hospitalists and care managers to more efficiently manage care and shorten lengths of inpatient stay;
- Aggressively implementing evidence-based practice guidelines.

More aggressively pursuing recoveries from GHIP MCOs. Several respondents noted that they have ceased being passive about slow payment, non-payment, and clawback attempts by the MCOs. One health center director reported hiring consultants to review claims and plan payments line by line; others reported litigation efforts against the plans. With respect to these strategies, health center directors noted that they were forced to spend thousands of dollars to simply recover the payments that are rightfully theirs.

V. Discussion and Recommendations

Numerous studies point to the critical importance of an effective and vibrant primary care delivery system as the backbone of a reformed health care system.⁵⁴ GHIP achieved its goal of reducing the proportion of uninsured Puerto Rican residents, but the reforms of 1994 have negatively impacted the health care delivery system. Severe under-financing and inappropriate risk down-streaming have led to a reduction in health center capacity and forced centers to employ creative strategies to remain financially viable. Payments to health centers and other primary care providers are so low that physicians have gone out of business, IPAs have pulled out of GHIP, and health centers face critical funding shortfalls, even though they are a critical source of primary care available to GHIP enrollees. Quality of care is suffering; emergency room utilization is excessive by center directors' own admission, and centers are losing the capacity to care for an increasingly uninsured population.

These developments have occurred even prior to the severe current economic downturn, which has significantly affected Puerto Rico. In the past four years, health centers have lost the capacity to care for 51,450 patients, with the deleterious effect concentrated among the Commonwealth's poorest residents who face the greatest health risks. The economic fallout for health centers has led to precisely the type of financial situation that the FQHC payment system was meant to avert, namely, the use of Section 330 grants to offset severe Medicaid under-payment, to the detriment of uninsured patients.

For any group of patients, a strong system of primary care is the linchpin of a workable health care system. Primary care is particularly important for patients burdened by chronic conditions and personal financial constraints, and for those at risk for significant disparities in health and health care. The effects of GHIP on health centers suggest that underpayment, the absence of a workable system for primary care financing, and uncontrolled risk down-streaming have combined to produce a perfect storm: a shrinking

⁵⁴ Institute of Medicine, 1996. "Primary Care: America's Health in a New Era."; Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, 1996. "The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998." *HSR* 38 (3); 831–865.

and unstable primary care system with inverse incentives that push care away from low-cost primary care settings and toward episodic treatment in high cost settings such as emergency rooms and hospital admissions.

Several policy recommendations flow from the experiences of health centers adapting to the effects of GHIP:

1. Make a capital investment in health centers, coupled with implementation of the federal FQHC payment system.

A viable primary care infrastructure is the foundation for an effective health care system. This can be created by a sustained and deliberate investment by either the Commonwealth or Congress to strengthen and expand health centers.⁵⁵ Such an initiative could target not only health centers but also other primary care providers who seek to provide high quality primary care to underserved communities. The high cost of hospitalizations and of emergency room use for conditions that could have been prevented with regular access to primary care continues to place significant financial burden on the health care system. Analysis of emergency room visits for Medicaid enrollees in Florida, for example, indicates that 43 percent of the state's emergency room visits were for minor or low-moderate acuity conditions that could have been treated in a primary care setting. Health centers save the system approximately \$18 billion annually, and the savings range from \$36 million to nearly \$2 billion per state.⁵⁶ In 1990, Kansas directly invested in health centers and saw a 25 percent decrease in uninsured emergency care, saving the state \$12 million.⁵⁷

Although estimating the savings from hospitalizations and averted emergency room costs is difficult, health centers in Puerto Rico are likely to save money by reducing the costs associated with preventable complications of undetected and untreated conditions such as diabetes, heart disease, and asthma. In 2007, primary care visits at Puerto Rico's health centers cost only \$423 per patient (including mental health, dental care costs, and other enabling services). The medical component alone cost \$256 per patient.⁵⁸ This is in comparison to the \$1,585 per capita expenditure for physician and clinical services nationally.⁵⁹ If we use this figure to estimate the cost savings health centers provide to Puerto Rico patients by substituting health center services for other forms of primary health care services, we arrive at a cost-savings of \$410 million to \$469 million for the 353,000 people served in 2007. While data on emergency care use for conditions which could have been prevented and treated in primary care, and other cost information, were

⁵⁵ Rosenbaum S, Shin P, & Whittington RPT, 2006. "Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative." June.

⁵⁶ The Robert Graham Center, Capital Link, and NACHC, 2007. "Primary Care Payoff." (Accessed on March 24, 2009: http://www.nachc.com/client/documents/issues-advocacy/policy-library/research-data/research-reports/Access_Granted_FULL_REPORT.pdf).

⁵⁷ Smith-Campbell B, 2005. "Emergency Department and Community Health Center Visits and costs in an Uninsured Population." *Journal of Nursing Scholarship* 37(1): 80-86.

⁵⁸ GW analysis of 2007 UDS data, HRSA.

⁵⁹ Centers for Medicare and Medicaid Services. (Accessed on March 24, 2009: <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf> (Table 8)).

not available for the state of Puerto Rico, the estimates are in line with other state-specific studies which indicate health centers are cost-effective and efficient providers of care.⁶⁰

Shifting overall health care utilization away from hospitals and emergency rooms is desirable, however, this will further reveal the inadequacy of the existing primary care infrastructure. Improvements and expansion of current facilities (including the adoption of health information technology), as well as breaking ground for new health centers, will be necessary to match current and future demand for services. If GHIP's objective to control costs and improve access to care is to be achieved, it must strengthen primary care capacity in the Commonwealth to ensure that population health and spending can be addressed. Otherwise, the current infrastructure is likely to become further destabilized and unable to meet the growing demand under what is likely to be a long recession period, leaving Puerto Rico with fewer resources.

One option would be for the Commonwealth to directly invest additional funding in health centers, as 37 states currently do.⁶¹ Based on per capita medical expenditure data, a direct investment to health centers of approximately \$75 million (\$423/person) would increase access by 50 percent, or provide needed services for additional 176,000 individuals.. By increasing the number of patients served by health centers by 50 percent, Puerto Rico could realize a cost savings of \$205 to \$234 million. Such a direct investment would be in lieu of the FQHC payment system, which has never been implemented in the Commonwealth. In other jurisdictions that have made the transition to broader insurance coverage for the poor through a modified Medicaid program (e.g., Massachusetts' Medicaid reforms enacted as part of its 2006 comprehensive reform legislation), officials have provided continued direct funding through supplemental payments, direct grants, or both.⁶² These financial safeguards stabilize ambulatory care safety net providers during the transition period, so that they can continue providing care for uninsured patients as key elements of the primary care delivery system in medically underserved communities.

A supplemental Congressional investment in health center stabilization, above and beyond the capped payment to Puerto Rico, is another option, given that Puerto Rico's capacity to invest is severely constrained. This type of payment arrangement, analogous to the special federal Medicaid payment arrangements used for Indian Health Service (IHS) facilities, could be in lieu of the FQHC supplemental payment provisions applicable in states. By virtue of the special mission of the IHS, Congress provides 100 percent federal financing to state Medicaid agencies for the cost of services furnished to

⁶⁰ Smith-Campbell FIRST INITIALB, 2005; Proser M, 2005. "Deserving the Spotlight: Health Centers Provide High-Quality and Cost Effective Care." *Journal of Ambulatory Care Management* 28(4): 321-330; NACHC, "Primary Care Payoff," 2007.

⁶¹ NACHC, 2007. "Safety Net on the Edge: What Legislators Can do to Support Their Local Health Centers" August. (http://www.nachc.com/client/documents/issues-advocacy/policy-library/research-data/fact-sheets/State_Support.pdf).

⁶² Ku L, Jones E, Finnegan B, Shin P, & Rosenbaum S, 2009 "How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform." Kaiser Family Foundation, March. 2009.

Medicaid patients by IHS facilities.⁶³ . The nation has a major interest in the health of Puerto Rico's residents, especially given the constant movement between the Commonwealth and the mainland. In recognition of severe medical underservice in Puerto Rico, the importance of primary health care, and the special role of health centers in meeting the needs of the Commonwealth's low income residents, Congress could make a similar investment in health centers.

A supplemental payment program in Puerto Rico could compensate for the absence of a Medicaid FQHC payment system and could be established without the normal federal matching requirements that would otherwise apply; and the payment arrangement would help health centers regain and maintain their primary care capacity, which is urgently needed by the Commonwealth's hundreds of thousands of medically underserved residents.

Indeed, the health center investment contained in the American Recovery and Reinvestment Act (ARRA) signals a strong federal desire to assure that health insurance coverage reforms are built on a strengthened system of primary care. The \$75 million investment described earlier in this recommendation, which would strengthen health centers to serve 50 percent more people, is also estimated to generate at least 1,300 new jobs and over \$86 million in new economic activity.⁶⁴ As a result of the investments contained in the ARRA, Puerto Rico health centers stand to gain an additional 4.8 percent in operating fund grants to meet the growing demand for care.⁶⁵ Although the total amount is still undetermined, one projection estimates health centers in Puerto Rico would receive \$13 million for capital financing under the stimulus plan to make necessary capacity improvements. However, ARRA health center investments are temporary. As important as they are, ARRA resources cannot, by themselves, result in sustained primary care improvements without a more long term and deliberate investment plan.

2. Revise the GHIP contracts to eliminate the high financial risks now borne by health centers

A fundamental reformulation of GHIP financial policies to assure that risk is held at the plan level is urgent, and should be a condition for future federal payments. The degree of risk down-streaming occurring in GHIP is prohibited on the mainland because health centers are not licensed insurers and are thus not structured to bear full financial risk.

⁶³ CMS, 2009. "Medicaid Program-General Information: Technical Summary." (Accessed on March 25, 2009: http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp).

⁶⁴ Estimates based on cross-multiplication methods using HRSA projections (Accessed on March 24, 2009: www.hss.gov/recovery/hrsa/napawards.html) and NACHC, Capital Link, and The Robert Graham Center 2007 economic impact analysis (Accessed on March 24, 2009: http://www.nachc.com/client/documents/issues-advocacy/policy-library/research-data/research-reports/Access_Granted_FULL_REPORT.pdf).

⁶⁵ Health Resources and Services Administration, 2009. "The Health Center Program: Recovery Act Grants." (Accessed on March 10, 2009: <http://bphc.hrsa.gov/recovery/default.htm>). IS THIS A PERMANENT OR CHANGING DOC?

Health centers have proven themselves remarkably adept at managing both primary care costs and the costs associated with specialty and inpatient care. Indeed, studies of health centers have shown that they can achieve as much as a 32 percent reduction in costs associated with the treatment of Medicaid patients;⁶⁶ these cost savings result from more comprehensive primary care, coupled with active management of specialty and inpatient care and reduced reliance on emergency rooms.

Regulatory reforms to address enormous risk down-streaming must be coupled with addressing the basic underlying problem, namely, a severely underfinanced Medicaid program. The Commonwealth's Department of Health is already required to review MCO contracts and ensure that they are within the legal authority granted by the Medicaid managed care state plan. Therefore, Congress might consider combining new rules on financial risk management with a basic restructuring of Puerto Rico's federal Medicaid payments, coupling a major increase in funding with new, more realistic, standards and oversight regarding the management of financial risk.

3. Strengthen health centers' ability to practice collectively

Puerto Rico's 19 health centers work closely together through their state primary care association, but they do not operate as an integrated delivery system. A collective approach among health centers toward managing financial risk and achieving operating efficiencies is permissible under applicable antitrust laws and other regulations relevant to the formation and operation of integrated delivery systems. Although health centers as providers are not allowed to form their own GHIP Medicaid Plan according to health center leaders⁶⁷ (a strategy pursued by health centers in several states), more integrated action through the formation of a health center IPA might strengthen the bargaining position of health centers with insurers and with the Commonwealth.

Conclusion

The experience of health centers with GHIP underscores one of the basic truths about health reform: it is possible to enact reforms that succeed in giving individuals something called "health insurance" while simultaneously setting in motion financing strategies that ultimately undermine the fundamental goals of health reform. Health reform's ultimate goal should be providing access to appropriate care for as many people as possible. A reform plan that achieves coverage in name only, while simultaneously diminishing the investment in primary care, has the potential to undermine rather than advance the goals of reform. Effective insurance reform must do more than "cover" people: it should foster a health care system that emphasizes the very services and system supports that enable even the most at-risk populations to maintain the best possible health status.

The severe under-financing of GHIP, coupled with the unregulated financial risk down-streaming, has meant that GHIP plans are assigning full contractual patient care

⁶⁶ NACHC, Capital Link, The Robert Graham Center, 2007.

⁶⁷ Focus group Meeting with CEO, CFO, CMO of PR health centers, January 26, 2009; Meeting with health centers, March 25, 2009

obligations to health centers for an average annual Medicaid payment of no more than \$239 per patient in 2007, according to the UDS data. In essence, even though their Medicaid contractual obligations dwarf those of health centers that participate in managed care generally, Puerto Rico health centers' Medicaid per capita payments — including separate payments for dental or mental health not covered under the managed care contracts — are well below those received by mainland health centers for primary care alone. Without a Medicaid payment supplement, health centers face full financial exposure to low GHIP payments, eroding their capacity to appropriately serve the residents of Puerto Rico.

Federally qualified health centers have provided the people of Puerto Rico with high quality, efficient, and community-oriented primary care services despite the many challenges they face. Health systems change that support health centers, not only will help them carry out their missions, but will lead to a more vibrant and sustainable primary care infrastructure for the entire commonwealth.