

## Summer Enrichment- NC Community Health Center Association

Health care is expensive and the systems in place to pay for it can be difficult to navigate. For the uninsured and impoverished people in our society, health care can thus seem unobtainable. My goal this summer was to better understand how health care is provided to people in our country that do not have the means to afford it, and the policy decisions that affect the provision of that care.

Discussions with faculty at the Brody School of Medicine led to an interest in community health centers' role in serving the underserved, which led to my summer internship with the NC Community Health Center Association (NCCHCA). Essentially, community health centers are non-profit clinics that, through multiple mechanisms, are created to serve underserved populations. It was the mechanisms they used to achieve their mission and their use of government aid that interested me.

Community health centers must first achieve a designation as Federally Qualified Health Centers by meeting a slate of requirements set forth by the government. They then estimate the number of underinsured people they intend on serving and are given a block grant by the government to cover those costs. However, the money granted is sparse in comparison to the money required to treat some of the neediest people in the health care system. Yet, the health centers are required to provide comprehensive clinical care along with dental and mental health services; they also make social workers available and partner with public service organizations to provide assistance beyond clinical care. In order to make up for the budget windfalls they face, they make use of "payer mix", preferred Medicaid reimbursement rates, sliding-scale fees, the 340B Drug Pricing Program, and federal loan forgiveness for providers that staff the clinics.

"Payer Mix" refers the mix of uninsured patients, patients with Medicaid, and patients with private insurance. The patients with Medicaid and with private insurance bring in revenue to offset the lack of reimbursement for care for the uninsured; Medicaid reimburses these clinics at higher rates to further supplement that income. Sliding-scale fees are also instituted to charge people what they can pay based on their income. The 340B pricing program is a program in which the government negotiates huge bulk orders of medications at very low prices. Health centers are then able to sell those medications at near-cost prices to patients below a certain income threshold. Patients above that income threshold must pay standard prices, which provides a substantial source of revenue for health centers. Participating in loan forgiveness programs also allows these health centers to spend less of their budget on provider salaries by instead forgiving loans of those providers.

During my internship with the NCCHCA, I was able to sit down with employees of the NCCHCA and with employees of individual health centers to discuss these different facets of health center operations in detail. I was also able to visit two health centers and multiple sites that those organizations encompassed. We also spent time discussing Medicaid Managed Care, which I was unfamiliar with, and which greatly bears on how reimbursement for care is structured.

My personal project while there was to explore cost data that health centers had accumulated and to compare those costs to the costs of emergency department visits. I chose

this project because I worked in EMS for a number of years before medical school and know first-hand that emergency departments operate as a main source of health care for people who have nowhere else to turn. It is widely accepted that this emergency department utilization is one reason for the high cost of health care in the United States.

While working on my project, I utilized data on health centers made publicly available via the Health Resource Service Administration. That data placed the *cost to health centers per encounter* at \$223.08 on average. The amount charged per patient was typically slightly higher, and the amount that the health centers were typically able to actually collect was slightly lower than that number. Data on the *cost to emergency department per encounter* was not as easy to attain. Chargemasters on hospital websites, which are now legally required, specifically state that the prices listed should not be used to estimate health care costs to patients. For practical use by potential patients, they are minimally helpful at best. Information on how emergency departments arrive at assigning costs for encounters was also largely missing from scholarly databases. However, scholarly articles on average charges to patients were obtainable. A widely accepted number for the *average charge to the patient per ED encounter* was around \$1,300- over 4 times the average charge for a visit to a community health center. This comparison is important because, according to the NYU algorithm, anywhere from 20% to 50% of ED encounters are “impactable” by primary care providers. In other words, a large proportion of ED patients could have been treated in a lower cost primary care setting. This becomes even more important when you consider that on average there are 44 ED visits for every 100 people per year, nationally. The homeless population, a large patient base of community health centers, utilize ED’s at a much higher rate- 263 visits per every 100 homeless people per year. The information I came across during this project, and importantly, the information that I was unable to find, were informative. The lack of transparency around costs in our health care system is troublesome. However, the accountability and ensuing clarity of health center costs is encouraging.

How do we provide health care to those who can’t afford it? How do we decrease government expenditures on health care? How do we ensure that charges for healthcare do not unreasonably exceed the actual costs of providing that healthcare? These questions are frequently discussed as one large unsolvable puzzle, but community health centers are already addressing them on a federal, state, and community level. Due to their sliding-scale fees, responsible administration of funds, and benevolent mission, community health centers have also been able to maintain bipartisan support from the government. Overall, my summer experience with the NCCHCA showed me that many of the tough problems in health care have solutions, and that those solutions are being implemented with great care by community health centers. While there is still much work to be done, it was inspiring and informative to take a closer look at the work of community health centers.