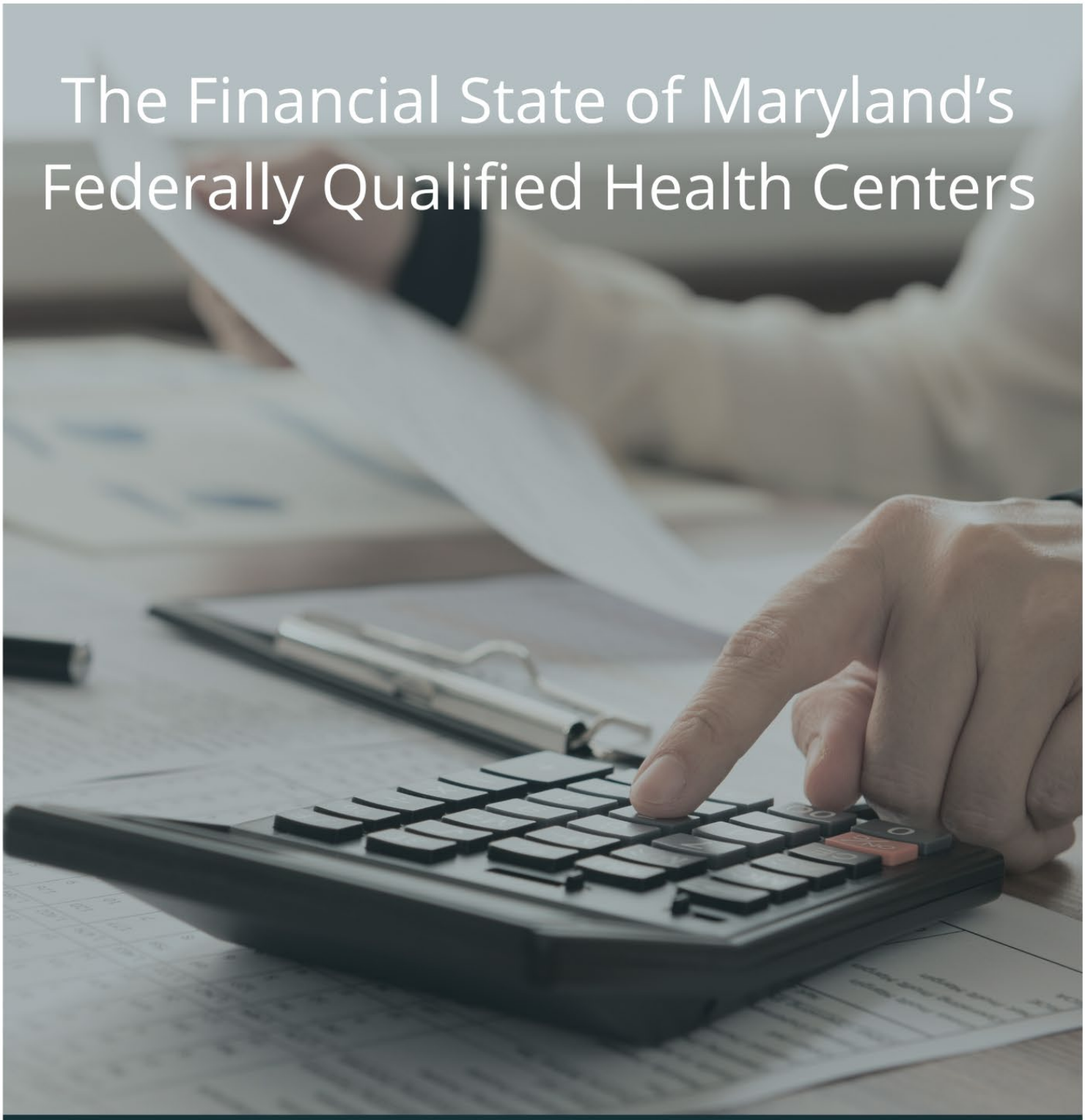
Mid-Atlantic Association of Community Health Centers

November 2024

The Financial State of Maryland's Federally Qualified Health Centers



The creation of this paper was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,180,544 with 0% financed with non-governmental sources. The contents are those of MACHC and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Introduction

Federally qualified health centers (FQHCs) provide accessible, high-quality care to underserved populations across the United States, in rural, urban, and suburban areas needing access to primary health care. Inadequate reimbursement rates from health insurance payers and the federal government pose significant challenges to FQHC sustainability.

The Mid-Atlantic Association of Community Health Centers (MACHC) is the federally designated Primary Care Association (PCA) serving Maryland's 16 FQHCs. As the PCA, MACHC supports health centers in efforts to increase healthcare access, accelerate value-based care, develop the healthcare workforce, and improve the quality of care for those most in need. With these responsibilities, the association examined utilization, cost, and payment issues that may impede health centers' success.

MACHC analyzed payment adequacy and uncompensated care trends to illuminate the state of the fiscal health of Maryland's community health centers. The association used health center data from the Uniform Data System (UDS) 2019-2023; FQHCs report these data annually to the Health Resources and Services Administration within the Department of Health and Human Services. The analyses are intended to dispel myths that FQHCs are free clinics and shine a light on the growing problem of an underfunded primary care system. While the federal government provides grants to help supplement the expense of delivering primary care in medically underserved areas, these dollars do not cover the full costs. As healthcare costs have increased in recent years, growth in the uncompensated care burden for providers has escalated. The analyses outlined below are intended to inform policymakers and healthcare stakeholders about the necessity of adequate reimbursement to ensure that FQHCs can thrive and meet the needs of Maryland's communities.

FQHC Background

FQHCs Provide Full Complement of Comprehensive Services

The collective mission of Maryland's 16 community health centers is to deliver high-quality primary and preventative care to individuals in medically underserved areas, ***regardless of ability to pay***. Rooted in the Primary Care Medical Home model, health centers deliver comprehensive medical and support services, including prenatal care, dental care, pharmacy, substance use treatment, mental health, onsite laboratory and pharmacy services, and other social supports that facilitate access to care for marginalized Marylanders.

Maryland's health centers are nonprofit, community-directed providers that serve as the health home for over 362,000 people. Most patients—59 percent—are either Medicaid or Medicare beneficiaries, more than a quarter—28 percent—are children under 18, and the overwhelming majority—86 percent—live at or below 200 percent of the federal poverty level.

FQHC Value Proposition & Financial Landscape

As essential primary care providers for medically underserved areas, health centers receive federal grants that support costs associated with treating patients that struggle to afford care, even with insurance coverage, also known as underinsured. All health centers operate sliding

fee scales, meaning patients may be charged less for services based on household income. Consumer-driven boards also help ensure sliding fees are affordable for the local community. Centers may also use targeted grants to finance innovations and stay afloat, but the relief is often limited and not guaranteed in perpetuity.

Federal funding for community health centers has demonstrated a positive return on investment. According to a Congressional Budget Office report issued in February 2024, care provided at community health centers lowers federal spending for Medicaid and Medicare through decreased emergency department use and inpatient hospital stays, as well as avoidance of costly outpatient services.[1] In 2021, community health centers were estimated to have saved more than $25.3 billion for the Medicaid and Medicare programs[2].

Maryland's Total Cost of Care Model

Since 2014, Maryland hospitals are paid under a unique all-payer global budget model. The model is intended to reduce total cost of care across all healthcare settings under the premise that quality primary and preventative services keep people healthy. Most Maryland community health centers participate in the Maryland Primary Care Program—a Medicare value-based payment model and extension of the unique hospital model. Between 2019 and 2022, MDPCP primary care providers collectively reduced avoidable hospital utilization by 28 percent[3]. Health centers provide high-value, low-cost care, contributing to a decrease in total cost of care, yet payment adequacy for FQHCs is lacking.

Uncompensated Care Costs Rising Excessively

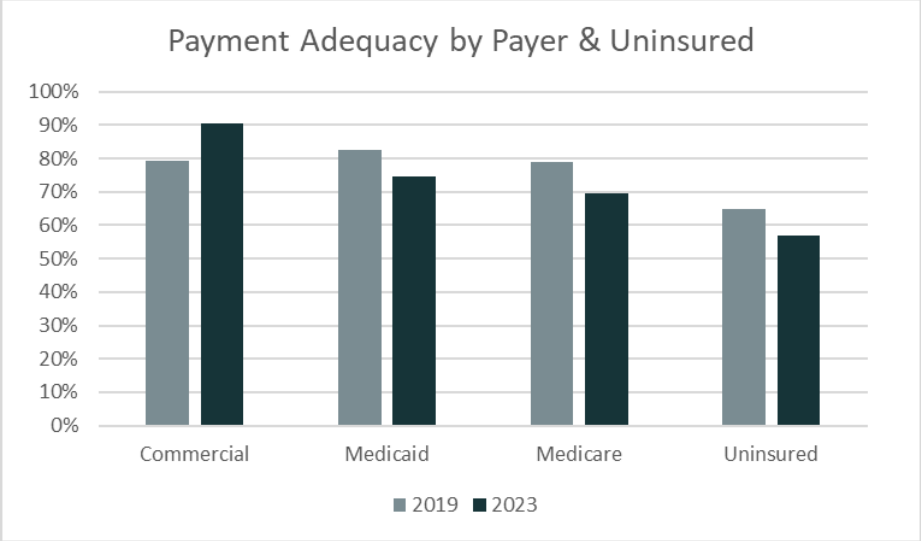
FQHCs are required to discount charges using a sliding fee based on a patient's ability to pay; discounts are tiered using income and household size. Even with discounted fees, patients can't always afford to pay. Uncompensated care includes costs associated with the discounts and the amount patients are unable to pay, including copays and deductibles. The total annual cost of uncompensated care for Maryland's community health centers rose 32 percent between 2019 and 2023 to an unprecedented ***49.7 million dollars***.

Inadequate Reimbursement Among Payers

In addition to rising costs of uncompensated care, insufficient primary care investments from commercial payers, the federal government, and states, combined with ongoing threats to discounted medication access under the 340B program, place FQHCs in the untenable position of scaling back essential services.

MACHC defines payment adequacy as the percentage of payment that covers the cost of a service. See Table 1

Table 1—Payment Adequacy for Maryland Health Centers | 2019 and 2023 Comparison



Source: MACHC Analysis of Department of Health Human Services | Health Resources Services Administration 2019 and 2023 Uniform Data System data.

Payment inadequacy—or low payments relative to the cost of services—is growing across Medicaid, Medicare, and federal grant dollars. Over four years, payment relative to costs for Medicaid, Medicare, and the uninsured decreased by 10 percent, 12 percent, and 12 percent, respectively. Costs among payers are not risk-adjusted as UDS data does not contain the details needed to make such adjustments. Revenue received from patients is not broken out by payer and, therefore, is not reflected in Table 1 above. Total payments in 2023, including payments made by patients and reimbursement from all payer types, including federal investments through the Community Health Center Fund, covered only 77 percent of centers' total costs.

Overall, reimbursements from all payers have not kept up with operating costs due to rising salaries, inflation of goods and services, the cost of maintaining buildings, the potential for IT and artificial intelligence to support efficiencies, and increased staffing needs to participate in value-based care.

Notably, the Medicare Payment Advisory Commission has found that Medicare payments do not adequately reimburse primary care services, especially those provided to low-income patients[4]. Despite Maryland FQHCs' participation in the MDPCP, Medicare reimbursement still fell during the review period, likely due to inadequate base Medicare rates. While many primary care providers can offset such losses with commercial insurance, FQHCs' payer mix, in addition to inadequate commercial insurer reimbursement, makes that unfeasible.

Pharmaceutical Manufacturer 340B Contract Pharmacy Restrictions Wreak Havoc

Established more than 30 years ago, the 340B program allows safety-net providers to buy outpatient medicines for less. The program is not funded by taxpayers. Instead, pharmaceutical manufacturers sell drugs to providers at discounted prices to receive payment for medications under Medicare and Medicaid. The program enables safety-net providers to stretch scarce

funding to make health care more accessible. Providers use 340B savings to enhance primary and preventive programs, wraparound services, and medication access. Such savings are essential to keep health center doors open. Over the last four years, pharmaceutical companies have imposed increasingly strict limitations on FQHCs, particularly not allowing 340B drug discounts at more than one pharmacy, wreaking havoc on patient access to both medications and services.

In 2024, the Maryland General Assembly took action to protect the 340B program, making drug manufacturer restrictions on contract pharmacies illegal. The Maryland court upheld the law after several manufacturers sued for a preliminary injunction. Despite continued state efforts to protect 340B, many manufacturer restrictions remain. FQHCs face additional financial threats with the establishment of Maryland's Prescription Drug Affordability Board. As deliberations of the board evolve, unintended consequences impacting safety net provider 340B savings need to be addressed.

Without adequate funding, including the void caused by ongoing 340B restrictions and future Prescription Drug Affordability Board actions, gaps in patient care result. As lawsuits continue, the lack of stable, consistent funding jeopardizes centers' ability to finance effective IT infrastructure, invest in capital improvements (even for the most basic wear and tear on a building), accommodate cost of living increases, and address healthcare provider recruitment and retention challenges.

Today, Maryland's community health centers are in dire straits, even though FQHCs are known to be cost-effective and high-quality providers. Marginalized rural and urban communities, already facing health challenges, are further disadvantaged.

Provider Moral Injury Results When Effective Medications Are Not Accessible

Some drug companies refuse to comply with state legislation, making certain medications difficult for patients to access. Providers endure moral injury when patients are unable to access appropriate medicine. Because of contract pharmacy restrictions, providers, including doctors, nurse practitioners, and physician assistants, spend time navigating a maze of options to find alternative drugs that may not be as beneficial to patients. Providers then spend unnecessary time educating and re-educating patients because of frequent medication changes, further reducing productivity and harming patient health outcomes. Not being able to deliver consistent, high-quality care to all is a heavy weight borne by providers that further exacerbates retention challenges in an already strained healthcare workforce.

Cost Increases Driven by Workforce

From 2019 to 2023, Maryland health center costs increased by 45 percent. Because 57 percent of community health centers' expenses are salaries and benefits, adequate financing is needed to maintain a strong workforce. As communities face a silver tsunami—provider retirements—and high attrition due to work stressors, payment adequacy must be addressed with federal and state action. The movement to value-based care places further demands on centers to hire talent that typically do not provide billable services but instead focus on quality improvement efforts. Staff with population health expertise can also be challenging to retain with the evolving

healthcare landscape moving to value-based care, including hospitals and insurance companies.

Nationally, salaries across all healthcare sectors have risen significantly since 2019. As illustrated in Table 2 below, Maryland salaries across different provider sectors also considerably increased.

Table 2—BLS Maryland Salary Increases for Critical Job Roles

Medical Occupations	2019 Salary	2023 Salary	Percent Difference
Family Medicine Physicians	$193,080	$263,340	36%
Nurse Practitioners	$111,800	$127,990	14%
Medical Assistants	$37,320	$44,100	18%
Billing & Posting Clerks	$42,050	$48,900	16%
Receptionist & Information Clerks	$32,600	$38,360	18%

Dental Occupations	2019 Salary	2023 Salary	Percent Difference
Dentists	$159,130	$234,670	48%
Dental Hygienists	$86,940	$101,140	16%
Dental Assistants	$42,160	$50,040	19%

Source: U.S. Bureau of Labor Statistics. Maryland – May 2019 OES State Occupational Employment and Wage Estimates. Maryland – May 2023 OEWS State Occupational Employment and Wage Estimates. https://www.bls.gov/oes/2019/may/oes_de.htm; https://www.bls.gov/oes/2023/may/oes_de.htm

From 2019 to 2023, the Bureau of Labor Statistics shows that the average Maryland physician salary increased by 36 percent, and receptionist salaries increased by 18 percent. Also, health centers face stiff competition from about 60 Maryland and the District of Columbia hospitals, including large world-renowned organizations with educational benefits, numerous provider practices, the National Institutes of Health and Veterans hospitals, and federal government healthcare-related positions. With limited nonprofit budgets, the increased cost across all major job roles has placed additional pressure on already overburdened health centers, making it more challenging to competitively recruit providers.

Cost Challenges Due to Service Expansion Needs

Health centers are masterful at stretching scarce resources to help patients. That said, there are limits. From 2019 to 2023, the number of Maryland community health center patients grew by six percent, with slightly more than four visits per patient. The high number of visits per patient reflects the higher acuity and complex needs common among FQHC communities.

From 2019 to 2023, the cost of medical services provided by Maryland health centers increased by 29 percent, likely driven by the cost of salaries and supplies. During the same time, other clinical service costs increased by 34 percent, with the largest increases from mental health and pharmacy.

Despite working with limited resources, health centers understand the diverse and complex needs of communities served and deliver comprehensive care for all patients. Without appropriate reimbursement, health centers will be unable to continue to meet the needs of Marylanders living in medically underserved areas.

Poor Health Outcomes Increase State Cost Burden

Not only do community health centers have a proven track record of quality, savings, accountability, and positive economic impact, but they are also an invaluable breeding ground for innovation to drive further savings and better health outcomes while responding to community needs. FQHCs are shining examples of vital investments with localized control, creating system-wide returns through improved health, economic development, and better health outcomes in otherwise underserved communities.

Even with numerous blockbuster medications to control chronic conditions, advancements in home monitoring technology, and artificial intelligence that can contribute to healthcare delivery efficiencies, Maryland health centers struggle to sustain care innovations without consistent primary care investments. This is not because centers lack the knowledge of what communities need but because innovations are often financed by one-off, time-limited grants. If federal and state investment in primary care infrastructure continues to diminish, the best part of the health care system—community health centers—will ultimately be destroyed.

Recommendations

The intent of the analyses presented is to inform policymakers about the financial health of Maryland's community health centers. The data presented indicates that multiple solutions are likely needed. MACHC welcomes the opportunity to discuss solutions with federal, state, and other stakeholders to work towards payment adequacy improvements that support the vibrancy of Maryland community health centers.

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[1] *Congressional Budget Office Cost Estimate. S. 2840, Bipartisan Primary Care and Health Workforce Act, February 6, 2024.* https://www.cbo.gov/system/files/2024-02/s2840.pdf.

[2] Robert Nocon, Kaiser Permanente Bernard J. Tyson School of Medicine. *Testimony on Community Health Centers: Saving Lives, Saving Money before the United States Senate Committee on Health, Education, Labor and Pensions Committee*. March 02, 2023. Accessed at https://www.help.senate.gov/imo/media/doc/Testimony-Nocon-CHCs%202023-0228_Final.pdf.

[3] Maryland Primary Care Program. 2024. *Maryland Primary Care Program (MDPCP) – MDPCP Advisory Council Meeting.* Maryland Health Care Commission. Accessed at https://mhcc.maryland.gov/mhcc/pages/apc/apc/documents/apc_mdpcp_ac_pmo_pres.pdf

[4] Medicare Payment Advisory Commission. 2024. *Medicare Payment Advisory Commission Releases Report to Congress on Medicare Payment Policy*. Washington, DC: MedPAC. Accessed at https://www.medpac.gov/wp-content/uploads/2024/03/March_2024_MedPAC_Report_Press_Release_SEC.pdf.