September **2016**

The Effects of the Affordable Care Act on Federally Qualified Health Centers in Michigan

Introduction

Federally Qualified Health Centers (FQHCs) form a critical part of the health care safety net, providing essential primary care services to people with limited health care access. The Affordable Care Act (ACA) increased FQHC funding from 2010 through 2015 and significantly expanded the insured population beginning in 2014. The purpose of this brief is to describe how the overall experience of Michigan FQHCs has changed with ACA implementation, based on analysis of 2008–2015 Uniform Data System data[1], 2016 Health Resources and Services Administration (HRSA) Delivery Site data, as well as data from interviews with FQHC leaders across the state.

Key Findings

- Many health centers have used increased grant funding to provide new services and expand existing ones, such as dental and mental health services.
- Coverage expansion, particularly through the Healthy Michigan Plan (Michigan's Medicaid expansion program), has substantially decreased the number of uninsured patients. Overall, the uninsured share of the Michigan FQHC population dropped by nearly 50 percent between 2013 and 2015, falling from 31 percent to 16 percent.
- Although specialty referrals are easier for insured patients, such referrals remain a major challenge in some regions and specialties, especially for Medicaid patients. Some of the more difficult services to find include those in psychiatry, rheumatology, orthopedics, and neurology.
- FQHCs have been developing new partnerships and strategies to help address the remaining needs of their patients. This includes partnerships with hospitals and community mental health organizations as well as partnerships with specialists outside their geographic area to provide telehealth services.
- FQHCs still experience many barriers to growth, including challenges with hiring necessary providers, such as psychiatrists, as well as adequate funding for particular types of services, such as oral surgery, or for personnel, such as community health workers.

[1] Data that FQHCs must submit each year related to their operation and performance.

The Center for Healthcare Research & Transformation (CHRT) at the University of Michigan is an independent 501(c)(3) impact organization with a mission to advance evidence-based care delivery, improve population health, and expand access to care.

Visit CHRT on the Web at:
www.chrt.org

HEALTH SYSTEM
UNIVERSITY OF MICHIGAN

Suggested citation: Lawton, Emily; Fangmeier, Joshua; Udow-Phillips, Marianne. *The Effects of the Affordable Care Act on Federally Qualified Health Centers in Michigan.* September 2016. Center for Healthcare Research & Transformation. Ann Arbor, MI.

Background

Number of FQHCs and Patients by Service Type

As of July 2016, there were 39 FQHCs in Michigan that altogether operated 246 permanent or seasonal health care delivery sites.[2] FQHC sites vary in the types of services they offer. These include primary medical care, dental care, mental health care, vision care, and enabling services such as transportation and eligibility assistance. From 2008 to 2015, the number of patients served by FQHCs grew by an average of 4.5 percent per year (Figure 1). There was particularly large growth in the number of mental health and substance abuse patients between 2014 and 2015, discussed in more detail below.

FIGURE:1

Total Number of Grantees and Patients in Michigan, Overall and by Service (In Thousands)

	2008	2009	2010	2011	2012	2013	2014	2015	2008-2013 Average Annual Growth[1]	2013-2014 Percent Change	2014-2015 Percent Change
Grantees	**29**	**29**	**29**	**29**	**32**	**33**	**36**	**38**	**2.6%**	**9.1%**	**5.6%**
Total Patients (In Thousands)	**469**	**515**	**538**	**546**	**570**	**558**	**596**	**639**	**3.5%**	**6.7%**	**7.2%**
Medical Patients	376	414	434	433	441	427	459	490	2.5%	7.5%	6.8%
Dental Patients	131	148	159	176	185	175	179	195	6.1%	2.0%	9.1%
Mental Health Patients	15	16	19	26	28	25	26	41	10.6%	0.9%	58.4%
Substance Abuse Patients	3	1	1	2	2	1	1	4	-12.4%	-13.9%	214.3%
Vision Patients			3	3	7	11	15	16	56.3%	34.3%	4.0%
Enabling Services Patients	37	31	38	37	46	42	51	52	2.7%	20.4%	1.9%

Source: CHRT analyses of Uniform Data System reports, 2008-2015.

1. There were no vision patients reported prior to 2010. The average annual growth for this service was calculated for the 2010 to 2013 time frame.

FQHC Reimbursement

FQHCs receive federal grant funding under Section 330 of PL 104-299[3] and enhanced reimbursement from Medicare and Medicaid. They provide services to underserved populations and areas, and offer a sliding fee scale based on patient income, family size, and health insurance status, including lack of insurance or plans with high deductibles.

Types of FQHCs

There are four main types of health centers. They each provide comprehensive primary care services but differ in the populations they predominantly serve. Section 330(e) FQHCs serve a variety of underserved populations or areas; Section 330(g) migrant health centers provide care to migrant and seasonal agricultural workers and their families; Section 330(h) health care for the homeless programs provide care to homeless individuals including substance abuse and mental health services; and, Section 330(i) public housing primary care programs provide care to public housing residents, often on or near public housing premises. A number of Michigan's FQHCs had at least one permanent or seasonal delivery site that was classified as a migrant, health care for the homeless, or public housing health center in 2016 (Figure 2).

[2] In addition to FQHCs, there were ten FQHC look-alike sites and numerous free clinics (http://www.fcomi.org/find-a-clinic.html) continuing to operate in Michigan in 2016.

[3] Section 330 of PL 104-299, October 11, 1996, https://www.congress.gov/104/plaws/publ299/PLAW-104publ299.pdf.

FIGURE:2

Number of Michigan FQHCs With At Least One Permanent or Seasonal Delivery Site, By Type, 2016

Type	Number of FQHCs	Percentage of Total FQHCs
Total	**39**	**100%**
Community Health Only	22	56.4%
Health Care for the Homeless	13	33.3%
Migrant Health Center	5	12.8%
Public Housing	2	5.1%

Source: CHRT analyses of HRSA Delivery Site Data, 2016.

Note: Sum does not equal total because some FQHCs have more than one type of site.

Characteristics of FQHCs in Michigan

In any given year, there is substantial variation across FQHCs in terms of the number and characteristics of the patients they serve in their catchment areas. In 2015, FQHCs in Michigan ranged in size from approximately 1,000 total patients to just over 66,000. Adults aged 18–64 comprised 41 to 93 percent of the patient population depending on the FQHC (Appendix Table 1).

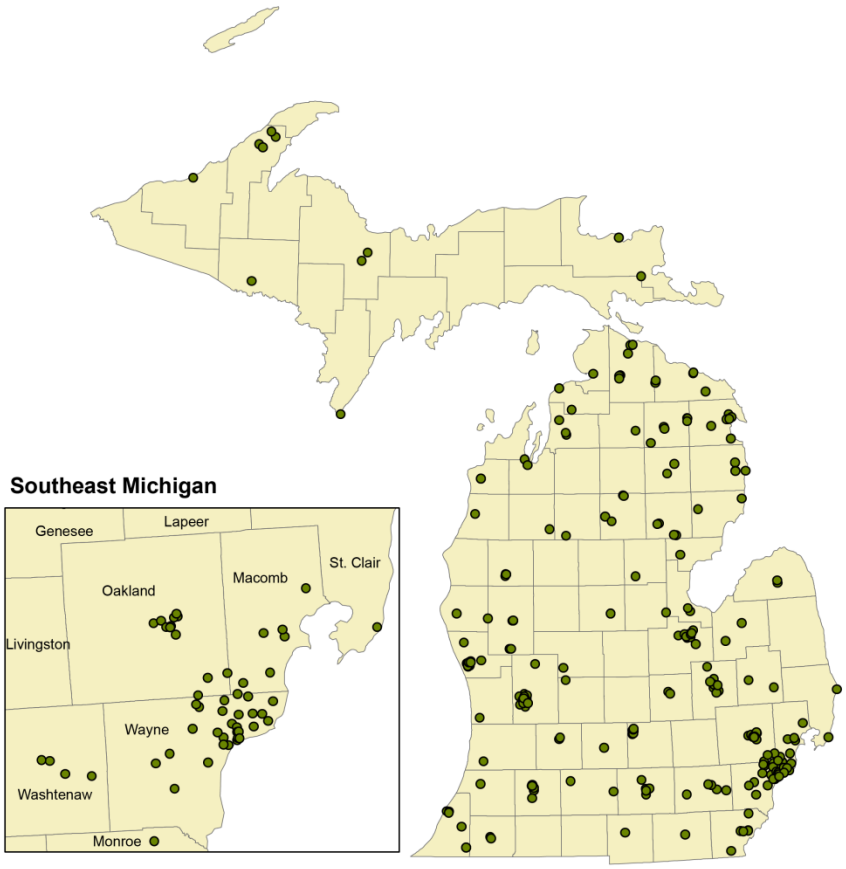
Although FQHCs generally serve a high proportion of low-income patients, the percentage of FQHC patients whose income was at or below the federal poverty level in 2015 ranged from 18 to 94 percent.[4] And as discussed above, some FQHCs focus on special populations. In 2015, the percentage of an FQHC's patients who were homeless, migrant workers, or public housing residents varied widely across FQHCs from no patients to nearly all patients.

FQHCs are most heavily concentrated in Southeast Michigan, as is most of the population in the state (Figure 3).

[4] Income was calculated only for those with known income, which was 63 percent of all patients in 2015.

FIGURE:3

Permanent or Seasonal FQHC Delivery Site Locations in Michigan, 2016



Source: CHRT analyses of HRSA Delivery Site Data, 2016

Changes Experienced by FQHCs under the ACA

FQHCs have experienced some dramatic changes in recent years as a result of the ACA's coverage expansion and increased FQHC funding. The most notable effects include changes in the number of patients, payer mix, the ways patients engage with the health care system, the services offered, and FQHCs' financial stability.

Changes in Number of Patients and Patient Characteristics

Between 2008 and 2013, the total number of FQHC patients grew an average of 3.5 percent per year. When the ACA coverage expansion took effect in 2014, the number of FQHC patients increased by 6.7 percent in the first year and by 7.2 percent the following year (Appendix Table 2). The demographic composition of FQHCs' patient populations remained relatively stable post-expansion, but FQHCs did experience some larger growth in the number of male patients as well as older patients (Appendix Table 3).

Changes in Payer Mix and Where and When Patients Seek Care

"The best thing is when you have patients with insurance and you can get lab work, x-rays, diagnostic work, get them to specialists—so much better than before when you couldn't. It's a frightening world when you're practicing medicine in areas where you're not an expert but you don't have a choice." —FQHC CEO

From 2013 to 2015, the payer mix for Michigan FQHCs changed substantially. The proportion of uninsured patients dropped from 31 percent to 16 percent overall, while the proportion covered by Medicaid rose by nearly the same amount, from 45 to 59 percent (including patients with both Medicaid and Medicare coverage). As more patients gained coverage, overall visits increased. Patients began seeking visits to specialists that they had delayed due to cost and lack of insurance coverage.

Interviewees suggested that despite changes in insurance status for many patients, they retained most of their existing patients and added new patients. However, they found that some patients did seek care elsewhere, either to access a particular specialty service or to get services at a center offering more specialty services in one location. One interviewee noted that FQHC staff must now focus more on customer service and on improving patients' experiences in their center because more patients are now insured and have greater access to services from other providers.

"Nowadays, you're not just the health center where people can go when they have no insurance anymore-people have options now…they don't have to choose you. You have to be the best you can be so they'll want to choose you and come back. We had several customer service trainings for our staff to make sure that was ingrained." —FQHC CEO

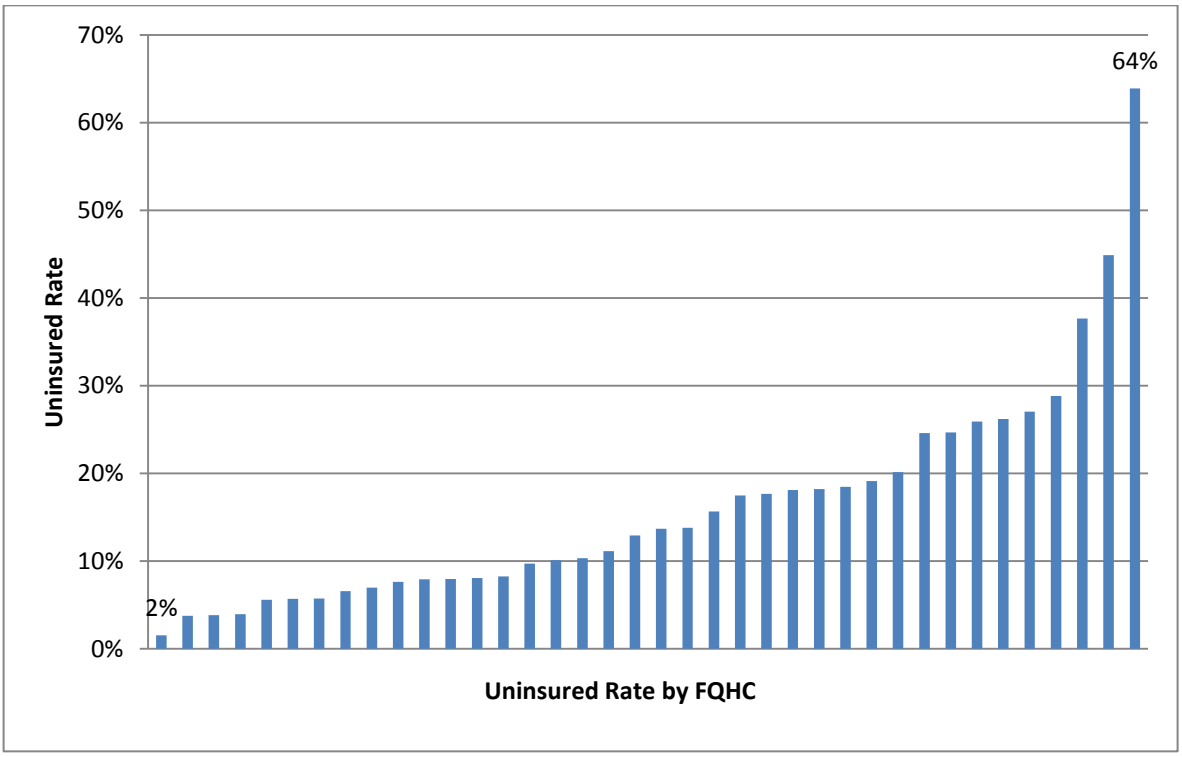
Why Some Patients Remain Uninsured

Despite large coverage gains with the ACA, some FQHC patients remain without health insurance. The 2015 uninsured rates varied widely across FQHCs in the state, from just 2 percent to 64 percent (Figure 4). Interviewees suggested that the most common reason was that many patients still consider their coverage options unaffordable. In addition, some patients do not realize that they are eligible for new coverage options or have not had needed assistance applying for coverage. Others, including some agricultural workers, may not be eligible for Medicaid or for subsidies to buy private coverage due to the eligibility requirements for immigrants.[5] For these reasons, migrant health centers have relatively high proportions of patients who remain uninsured. An additional challenge for patients at migrant centers or centers close to the border with another state is that Medicaid coverage does not easily transfer across state lines.

[5] Immigrants must be legal residents for a minimum of five years before they can be eligible for Medicaid or CHIP, unless they qualify for a status such as refugee status. Unauthorized immigrants are not eligible for Medicaid, CHIP, or subsidies to purchase private insurance.

FIGURE:4

Variation in Patient Uninsured Rates Among Michigan FQHCs, 2015



Source: CHRT analyses of Uniform Data System report, 2015

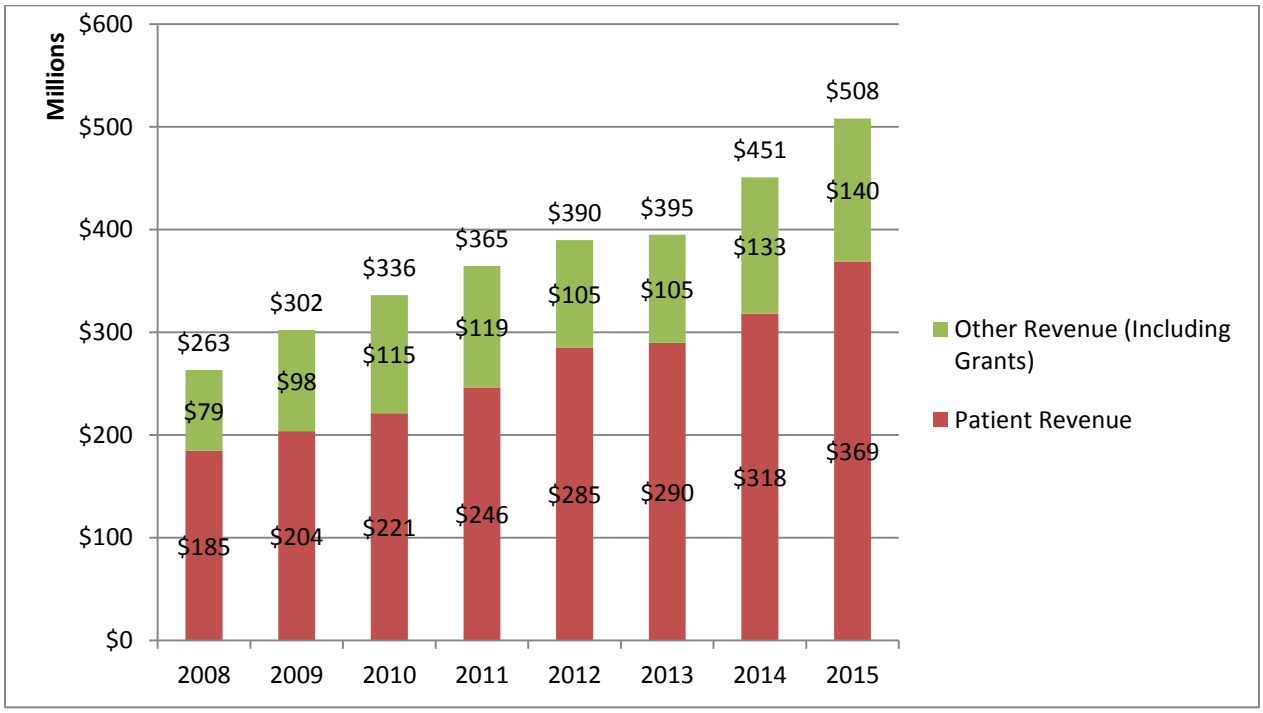
Changes in Health Center Financial Status

"The ACA has played a major role in helping our center to survive because we can't survive with [nearly half] of the people not paying for services. You just can't even make the money to make payroll."—FQHC CEO

Lower patient uninsured rates and additional health center funding from the ACA have improved FQHCs' financial outlook overall and have enabled them to make changes to their centers that increase access to services. As a result, both total costs and total revenue grew more quickly post-coverage expansion. Between 2008 and 2013, total costs grew by an average of 7.8 percent per year. In 2014 costs grew by 13.2 percent and by 13.7 percent in 2015 (Appendix Table 4). Including both grants and patient revenue, from 2008 to 2013 total revenue increased an average of 8.5 percent per year. In 2014 revenue increased by 14.1 percent and by 12.7 percent in 2015 (Appendix Table 5). In 2015, Michigan FQHC revenue totaled $508.2 million, with $368.5 million coming from patient revenue and $139.7 million from other sources, including grants (Figure 5). Since 2012, approximately half of total FQHC revenue has come from Medicaid.

FIGURE:5

Total FQHC Revenue by Source and Year



Source: Author's analyses of Uniform Data System reports, 2008-2015

Despite gains from the ACA, financial challenges for FQHCs remain. Although a number of FQHCs have expanded services to help meet high patient demand, funding is insufficient for certain services. For example, several interviewees expressed concern about their ability to fund critical services provided by community health workers. Some FQHCs even provide some services, such as dental care, at a net loss because patient need is so high.

Patients who are underinsured or have high-deductible plans may face difficulty paying for FQHC services and may qualify for a sliding fee program. In 2015, sliding discounts totaled $31 million and bad debt write-off totaled $8 million. Between 2013 and 2015, sliding discounts decreased by an average of 19.7 percent per year (from $49 million to $31 million), while bad debt write-off[6] increased by an average of 19.4 percent per year (from $5 million to $8 million). Growth in bad debt is likely a result of the increase in the number of health centers, patients, and the volume of services provided, as well as the difficulty some patients have affording services, even if they are insured (Appendix Table 6). Together, the combined total of sliding discounts and bad debt write-off decreased by 15.1 percent per year between 2013 and 2015.

[6] Bad debt write-off reflects charges for which patients were responsible but have not paid.

Changes FQHCs Made in Response to the ACA

The ACA has enabled FQHCs to make changes to their centers without having to cut other efforts. The most common changes include increasing their workforce, expanding sites or services, and developing new partnerships with hospitals, community mental health organizations, and other providers and organizations.

Increasing Personnel, Sites, and Services

Many FQHCs expanded their workforce in response to the increases in available funding and newly insured patients with high health care needs. Full-time equivalent personnel at FQHCs increased on average 6.6 percent per year between 2008 and 2013, 9.2 percent in 2014, and 9.6 percent in 2015 (Appendix Table 7). In 2014 the growth rates for physicians and outreach and enrollment personnel were higher than in pre-expansion years. Then in 2015, growth in the number of physicians slowed, and the number of total outreach and enrollment personnel began to decrease with the reduction in funding for outreach and enrollment services.

From 2008 to 2015, both pre- and post-ACA, the number of mental health personnel increased by approximately 22.2 percent on average per year, by far one of the fastest rates of growth of all personnel. Various factors contributed to the large growth in the number of mental health personnel and patients, both over this entire period and between 2014 and 2015. Over the past few decades, there has been an increase in the number of patients with mental health disorders seeking treatment.[7] In addition, nationally, between 2000 and 2013, the number of FQHCs that provided mental health services rose by 81 percent due to more funding resources and increased demand for mental health care.[8] Since the ACA implementation, interviewees reported newly providing or expanding mental health services in response to the additional funding and coverage expansion. There were also several new FQHCs in 2015 that together had a sizable number of patients receiving mental health services compared with other centers. In addition to mental health services, there was also large growth in substance abuse personnel from 2008 to 2015, especially between 2014 and 2015.Several interviewees mentioned now being able to expand such services, given the additional funding available.

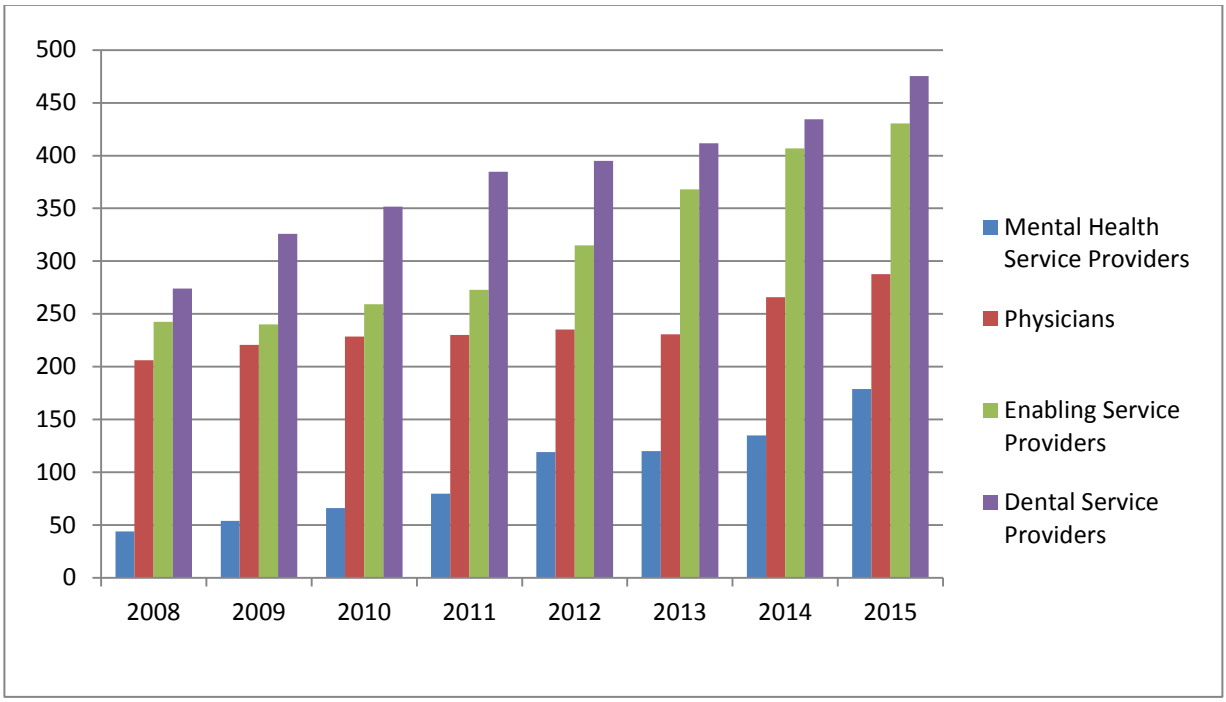
Between 2008 and 2015, there was sizable growth in the number of full-time equivalent providers across major service categories (Figure 6).

[7] D. Mechanic, "More people than ever before are receiving behavioral health care in the United States, but gaps and challenges remain," *Health Affairs*, August 2014, 33(8):1416–24.

[8] P. Shin, J. Sharac, and Z. Barber et al., Community Health Centers: A 2013 Profile and Prospects as ACA Implementation Proceeds (Menlo Park, CA and Washington, DC: Kaiser Family Foundation, March 2015): http://kff.org/medicaid/issue-brief/community-health-centers-a-2013-profile-and-prospects-as-aca-implementation-proceeds/ (accessed 7/16/2015).

FIGURE:6

Number of Full-Time Equivalent FQHC Personnel in Michigan, by Major Service Category and Year



Source: CHRT analyses of Uniform Data System reports, 2008-2015

FQHCs also expanded both their sites and the services offered in response to the ACA. Interviewees most frequently mentioned expansion of dental and behavioral health services.

> *"I think behavioral health was an unmet need for a long time here. And so now we're integrating. And the expansion of money, we're able to now put it in here. There's still a huge stigma, still a challenge, but we can have it at least accessible for people." —FQHC CEO*

A few also mentioned expansion of ophthalmology, pharmacy, or obstetrics care. With FQHCs newly offering or expanding mental health or substance abuse services, the number of mental health patients increased by 58.4 percent from 2014 to 2015, while the number of substance abuse patients increased by 214.3 percent. The number of substance abuse patients varied more year-to-year between 2008 and 2015 than the number of patients using other services. This may relate to fewer FQHCs offering substance abuse services and inconsistent reporting for such services.[9] In addition to expanding services in response to the ACA, some centers also extended their hours to improve patient access to services.

Developing New Partnerships

> *"There's really no reason for a hospital to be in the primary care business if there's a community health center that can do it in their community. The business metrics don't add up for them…So a good partnership and*

[9] C. Peters, J. Fangmeier, and M. Udow-Phillips, *Safety Net Providers in Michigan: 2014* (Ann Arbor, MI: Center for Healthcare Research & Transformation, Sept. 2015): http://www.chrt.org/publication/safety-net-providers-in-michigan-2014/

relationship between a health center and a hospital is good for the community, hospital, patients, the health center. It redirects the responsibility for primary care back to the community where it really should be." —FQHC CEO

Although some FQHCs had pursued partnerships with hospitals, community mental health organizations (CMHs), or other organizations before implementation of the ACA, some sought new partnerships as a direct result of the additional funding and insurance revenue available through the ACA. One interviewee said that since ACA implementation, more hospitals had approached FQHCs about partnering, particularly in light of hospitals' greater focus on population health. In addition, this interviewee noted that the ACA has fostered partnerships between FQHCs and CMHs, and increased the integration of primary care and behavioral health services.

"With FQHCs kind of getting a boost with money for primary care, integrative care with behavioral health, it's a real win I think to partner up with the CMHs." —FQHC CEO

Ongoing Concerns for FQHCs

FQHCs continue to face challenges in clinical workforce recruitment, funding services such as oral surgery, funding for needed personnel such as community health workers, and obtaining specialty referrals for patients. The extent of these problems varies substantially by FQHC location and by type of service. A 2016 National Association of Community Health Centers study found that on average, approximately 13 percent of clinical positions at health centers are currently vacant.[10]

"The ACA creates opportunities for more service locations and provided health insurance coverage for a lot of people,… [but]we're still not producing enough primary care doctors…And I don't know if the ACA necessarily addressed that as much as it could have or should have." —FQHC CEO

In Michigan, recruiting and funding psychiatrists and other mental health personnel can be particularly challenging. The Health Resources and Services Administration defines mental health professional shortage areas as regions with 30,000 or more people per psychiatrist.[11] In 2015, there were only eight full-time equivalent psychiatrists in total for the 638,735 patients served by FQHCs in the entire state of Michigan.

Although coverage expansion has made specialty referrals somewhat easier, referrals are still a major challenge for FQHC patients, including referrals to rheumatologists, orthopedists, and neurologists. Depending on the area and specialty, there may be a shortage of providers, an insufficient number of providers accepting Medicaid patients or providers sharply limiting the number of Medicaid (and sometimes Medicare) patients in their panels, or long wait times for appointments.

[10] National Association of Community Health Centers, *Staffing The Safety Net: Building the Primary Care Workforce at America's Health Centers.* (NACHC, March 2016): http://nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf (accessed 8/20/2016).
[11] Health Resources and Services Administration, *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations, N.d.*: http://www.hrsa.gov/shortage/ (accessed 8/20/16).

"There's a specialty issue—there sometimes aren't any specialists in our area that accept the insurance so patients have to travel two hours to get their issue addressed, and sometimes they don't travel because it's too big a burden for them." —FQHC CEO

Such access challenges have led some FQHCs to form partnerships with specialists outside their geographic area through telehealth arrangements or arrangements for specialists to periodically come to their FQHC to provide care.

The FQHC leaders that we interviewed recommended that policymakers ensure sufficient reimbursement for oral health care, for integrated behavioral and physical health care, and for critical personnel such as community health workers. They also called for allowance of a broader scope of practice for nurse practitioners, physician assistants, and hygienists, given the shortage of physicians and dentists in some areas. One interviewee mentioned Minnesota as a model for allowing broader scope of practice that also requires that these providers deliver care to an underserved population. Interviewees also discussed the need for additional primary care doctors and psychiatrists as well as improvements in the process of establishing successful health information exchange.

Conclusion

Many FQHCs in Michigan have benefited from the changes resulting from implementation of the ACA. The coverage expansion provisions and the additional FQHC funding have enabled FQHCs to make substantial changes, such as hiring more personnel, expanding their sites, and increasing services, without having to cut other efforts. Together, these changes have helped deliver care for more patients and increase access to necessary health care services.

One interviewee noted that previously some had feared that FQHCs would be less necessary after ACA implementation. However, FQHCs continue to be a critical source of care for many patients in Michigan, especially as timely health care access in other settings remains a challenge. It will be crucial to continue to study how well future grant funding and other revenue supports the services that FQHCs are providing to help address high health care needs.

Methodology

Findings in this study are based on data analysis and interviews with FQHC leaders across Michigan. We conducted analyses of 2016 HRSA Delivery Site data and 2008–2015 Uniform Data System data for the state of Michigan. We restricted the 2016 HRSA Delivery Site data to all permanent or seasonal FQHC delivery sites in Michigan. In June and July of 2016, we conducted semi-structured hour-long interviews with senior personnel from five FQHCs. Since the changes that FQHCs have experienced with the ACA can differ by location and organizational characteristics, including size and type of FQHC, the sample was selected to include respondents from various sizes of FQHCs as well as differences in populations served, payer mix, and geographic area within the state. Interviews were recorded and transcribed. To promote candor, interviewees were guaranteed confidentiality for themselves and for their organization.

Appendix

Appendix Table 1: Variation Among Michigan FQHCs, 2015

		Average	Minimum	25th Percentile	Median	75th Percentile	Maximum
Total Patients	Total Number of Patients	16,809	1,038	6,058	14,083	24,486	66,234
	Total Number of Patients Ages 18-64	10,047	671	4,159	9,118	13,420	31,305
	Patients Ages 18-64 Percentage of Total	65%	41%	57%	63%	71%	93%
Patients with Known Race, Language	Racial and/or Ethnic Minority Percentage of Total	46%	2%	13%	47%	69%	98%
	Best Served in Another Language Percentage of Total	11%	0%	0%	2%	12%	68%
Patients with Known Income Level	Patients At or Below 200% of Poverty Percentage of Total	92%	58%	88%	97%	99%	100%
	Patients At or Below 100% of Poverty Percentage of Total	67%	18%	57%	73%	83%	94%
Payer Mix	Uninsured	16%	2%	8%	13%	20%	64%
	Medicaid/CHIP	53%	20%	39%	57%	66%	79%
	Medicare	12%	2%	7%	9%	15%	28%
	Other Third Party	19%	3%	10%	13%	27%	53%
Percent of Patients Receiving Service	Medical	80%	42%	68%	80%	95%	100%
	Dental	28%	0%	10%	32%	40%	87%
	Mental Health	9%	1%	3%	6%	8%	74%
	Substance Abuse	2%	0%	0%	0%	0%	19%
	Vision	1%	0%	0%	0%	0%	19%
	Enabling	10%	0%	1%	4%	11%	51%
Revenues and Costs	Health Center Service Grants	$2,370,446	$0	$1,177,615	$2,080,858	$2,989,984	$7,299,187
	Total Cost	$13,418,154	$1,371,853	$4,514,011	$9,952,758	$19,833,858	$59,172,730
	Total Cost Per Patient	$837	$405	$675	$786	$893	$2,097

Source: CHRT analyses of Uniform Data System report, 2015.

Appendix Table 2: Michigan FQHC Payer Mix and Number of Patients by Principal Insurance Type

	Percentage of Total / Payer Mix										
	2008	2009	2010	2011	2012	2013	2014	2015	2008-2013 Percentage Point Change	2013-2014 Percentage Point Change	2014-2015 Percentage Point Change
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**---**	**---**	**---**
None/Uninsured	32%	34%	34%	33%	32%	31%	21%	16%	-0.9%	-10.4%	-4.7%
Total Medicaid	40%	41%	42%	44%	45%	45%	52%	55%	4.6%	7.1%	2.8%
Regular Medicaid	40%	41%	42%	44%	45%	44%	51%	54%	3.9%	7.5%	3.4%
CHIP Medicaid	1%	0%	0%	0%	1%	1%	1%	0%	0.6%	-0.3%	-0.6%
Medicare	9%	9%	9%	9%	9%	10%	11%	11%	0.6%	0.7%	0.6%
Dually Eligible (Medicare and Medicaid)	---	---	---	---	---	---	---	4%	---	---	---
Other Public Insurance	1%	2%	1%	0%	0%	0%	0%	0%	-0.9%	-0.2%	0.0%
Private Insurance	17%	15%	14%	14%	13%	14%	17%	18%	-3.3%	2.8%	1.2%

Source: CHRT analyses of Uniform Data System reports, 2008-2015. Percentages may not total 100 because of rounding.

Appendix Table 3: Number of Michigan FQHC Patients by Gender and Age Group

		Total Number of Patients (In Thousands)										
		2008	2009	2010	2011	2012	2013	2014	2015	2008-2013 Average Annual Growth	2013-2014 Percent Change	2014-2015 Percent Change
Male and Female Patients	**Total**	**469**	**515**	**538**	**546**	**570**	**558**	**596**	**639**	**3.5%**	**6.7%**	**7.2%**
	Younger Than 18	164	180	188	190	204	195	202	207	3.6%	3.2%	2.7%
	Ages 18-34	114	128	133	133	132	127	136	147	2.3%	6.6%	8.1%
	Ages 35-64	158	172	181	189	198	199	217	235	4.7%	9.0%	8.6%
	Age 65 or Older	34	35	35	35	36	37	42	50	1.5%	13.2%	19.1%
Male Patients	**Total**	**196**	**215**	**228**	**232**	**242**	**237**	**257**	**278**	**3.8%**	**8.4%**	**8.2%**
	Younger Than 18	81	90	94	95	103	99	102	104	3.9%	3.1%	2.7%
	Ages 18-34	35	40	43	43	42	41	45	50	2.9%	11.7%	10.9%
	Ages 35-64	66	71	76	79	82	83	93	102	4.7%	11.8%	10.4%
	Age 65 or Older	14	14	15	14	15	15	17	21	1.2%	16.7%	22.0%
Female Patients	**Total**	**273**	**300**	**310**	**314**	**328**	**321**	**339**	**361**	**3.3%**	**5.5%**	**6.5%**
	Younger Than 18	83	90	94	94	101	97	100	103	3.2%	3.4%	2.8%
	Ages 18-34	79	88	90	90	90	86	90	96	1.9%	4.3%	6.7%
	Ages 35-64	92	101	105	109	116	116	124	133	4.7%	7.1%	7.2%
	Age 65 or Older	20	21	21	21	22	22	24	29	1.7%	10.9%	17.1%

Source: CHRT analyses of Uniform Data System reports, 2008-2015.

Appendix Table 4: Michigan FQHC Financial Costs by Category

	Accrued Cost (In Thousands)										
	2008	2009	2010	2011	2012	2013	2014	2015	2008-2013 Average Annual Growth[1]	2013-2014 Percent Change	2014-2015 Percent Change
Total Costs[2]	**$271,462**	**$303,865**	**$319,717**	**$348,020**	**$385,624**	**$396,065**	**$448,307**	**$509,890**	**7.8%**	**13.2%**	**13.7%**
Medical Staff	$83,054	$98,115	$103,648	$110,472	$116,304	$116,921	$133,403	$148,291	7.1%	14.1%	11.2%
Total Medical Care Services[3]	**$104,112**	**$122,078**	**$127,087**	**$133,533**	**$141,885**	**$144,077**	**$167,486**	**$185,840**	**6.7%**	**16.2%**	**11.0%**
Dental	$27,891	$32,231	$33,730	$38,192	$41,896	$42,990	$47,168	$56,094	9.0%	9.7%	18.9%
Mental Health	$3,020	$3,824	$4,762	$5,316	$8,182	$8,705	$10,986	$15,165	23.6%	26.2%	38.0%
Substance Abuse	$489	$502	$476	$834	$898	$1,606	$1,960	$2,761	26.9%	22.0%	40.8%
Pharmacy excluding pharmaceuticals	$8,433	$8,176	$8,575	$9,796	$11,064	$11,794	$12,816	$16,973	6.9%	8.7%	32.4%
Pharmaceuticals	$17,737	$20,540	$21,624	$21,596	$22,840	$23,061	$27,934	$34,579	5.4%	21.1%	23.8%
Other Professional	$6,671	$2,373	$2,079	$1,957	$2,026	$2,003	$2,054	$2,378	-21.4%	2.5%	15.8%
Vision				$533	$1,158	$1,809	$2,074	$2,156	84.2%	14.6%	4.0%
Case Management	$4,392	$3,795	$4,609	$4,827	$8,536	$8,171	$6,913	$8,445	13.2%	-15.4%	22.2%
Transportation	$527	$581	$590	$733	$881	$903	$843	$968	11.4%	-6.7%	14.9%
Outreach	$2,459	$2,790	$2,247	$2,224	$1,916	$3,114	$4,053	$4,284	4.8%	30.2%	5.7%
Eligibility Assistance	$1,480	$1,443	$1,599	$1,914	$1,691	$2,560	$4,263	$4,441	11.6%	66.5%	4.2%
Total Enabling and Other Services[4]	**$16,508**	**$16,522**	**$19,348**	**$20,819**	**$23,276**	**$24,767**	**$26,825**	**$29,198**	**8.5%**	**8.3%**	**8.8%**
Facility	$18,211	$19,926	$20,804	$21,839	$26,179	$29,410	$32,579	$36,133	10.1%	10.8%	10.9%
Non-Clinical Support Services	$68,391	$77,693	$81,233	$93,606	$106,221	$105,842	$116,426	$128,613	9.1%	10.0%	10.5%

Source: CHRT analyses of Uniform Data System reports, 2008-2015.

1. There were no vision costs reported separately prior to 2011. The average annual growth for this service was calculated for the 2011 to 2013 time frame.

2. Includes direct costs associated with each service as well as facility costs and non-clinical support service costs.

3. Includes Medical Staff, Lab and X-Ray, and Medical/Other Direct.

4. Includes Case Management, Transportation, Outreach, Patient and Community Education, Eligibility Assistance, Interpretation Services, Other Enabling Services, and Other Related Services.

Appendix Table 5: Amount of Michigan FQHC Revenue Collected This Period by Source

	Amount Collected This Period (In Millions)										
	2008	2009	2010	2011	2012	2013	2014	2015	2008-2013 Average Annual Growth	2013-2014 Percent Change	2014-2015 Percent Change
Overall Total Revenue	**$263**	**$302**	**$336**	**$365**	**$390**	**$395**	**$451**	**$508**	**8.5%**	**14.1%**	**12.7%**
Total Patient Revenue	**$185**	**$204**	**$221**	**$246**	**$285**	**$290**	**$318**	**$369**	**9.4%**	**9.7%**	**15.9%**
Medicaid	$113	$124	$138	$162	$192	$198	$220	$245	11.9%	10.9%	11.5%
Medicare	$24	$25	$26	$24	$28	$29	$29	$40	4.0%	2.8%	37.3%
Other Public	$1	$3	$1	$1	$3	$4	$3	$2	24.7%	-31.1%	-41.0%
Private	$31	$33	$34	$36	$39	$35	$47	$63	2.8%	32.3%	34.9%
Self Pay	$16	$19	$22	$23	$23	$24	$19	$18	7.9%	-19.1%	-5.1%
Total Other Revenue	**$79**	**$98**	**$115**	**$119**	**$105**	**$105**	**$133**	**$140**	**6.0%**	**26.2%**	**5.2%**
Federal Grants	$45	$62	$73	$83	$74	$71	$91	$99	9.3%	29.0%	8.2%
State or Local Programs, Grants, and Contracts	$15	$21	$28	$24	$19	$18	$19	$17	4.0%	5.6%	-8.0%
Foundation/Private Grants and Contracts	$7	$7	$8	$4	$7	$9	$11	$15	4.1%	21.8%	36.5%
Other Revenue[1]	$11	$9	$6	$7	$5	$8	$12	$9	-7.3%	53.3%	-26.5%

Source: CHRT analyses of Uniform Data System reports, 2008-2015. Percentages may not total 100 because of rounding.

1. Reflects non-patient related revenue not reported elsewhere.

Appendix Table 6: Michigan FQHC Self-Pay Sliding Discounts and Total Bad Debt Write-Off (In Millions)

	2008	2009	2010	2011	2012	2013	2014	2015	2008-2013 Average Annual Growth	2013-2014 Percent Change	2014-2015 Percent Change
Total	**$42**	**$52**	**$57**	**$54**	**$52**	**$54**	**$46**	**$39**	**5.1%**	**-15.1%**	**-15.1%**
Sliding Discounts	$38	$47	$52	$48	$47	$49	$39	$31	5.0%	-19.2%	-20.3%
Bad Debt Write Off	$4	$5	$5	$6	$5	$5	$6	$8	6.3%	22.2%	16.6%

Source: CHRT analyses of Uniform Data System reports, 2008-2015.

Appendix Table 7: Number of Michigan FQHC Full-Time Equivalent Personnel by Major Service Category

	Full-Time Equivalents										
	2008	2009	2010	2011	2012	2013	2014	2015	2008-2013 Average Annual Growth[1]	2013-2014 Percent Change	2014-2015 Percent Change
Overall Total[2]	**2,978**	**3,276**	**3,430**	**3,674**	**4,009**	**4,094**	**4,470**	**4,901**	**6.6%**	**9.2%**	**9.6%**
Family Physicians	127	127	130	127	123	122	146	171	-0.7%	19.5%	17.0%
Internists	23	25	26	30	35	32	39	40	6.9%	21.8%	2.9%
Obstetrician/Gynecologists	21	23	26	26	27	26	34	30	4.3%	28.8%	-12.3%
Pediatricians	25	30	34	35	43	42	40	41	10.3%	-3.1%	0.7%
Total Physicians[3]	**206**	**221**	**229**	**230**	**235**	**231**	**266**	**288**	**2.3%**	**15.1%**	**8.2%**
Total NPs, PAs, CNMs	138	159	172	190	202	210	244	268	8.7%	16.1%	9.8%
Nurses	265	303	288	305	318	297	362	364	2.3%	21.9%	0.6%
Total Medical Services[4]	**1,040**	**1,159**	**1,208**	**1,289**	**1,371**	**1,374**	**1,532**	**1,695**	**5.7%**	**11.5%**	**10.6%**
Total Dental Services	**274**	**326**	**352**	**385**	**395**	**412**	**434**	**475**	**8.5%**	**5.5%**	**9.4%**
Psychiatrists	2	2	2	3	6	8	6	8	33.5%	-25.9%	34.3%
Licensed Clinical Psychologists	3	4	4	3	7	4	5	8	6.1%	16.2%	63.6%
Licensed Clinical Social Workers	17	25	34	47	70	69	83	109	31.8%	19.7%	31.3%
Total Mental Health Services[5]	**44**	**54**	**66**	**80**	**119**	**120**	**135**	**179**	**22.2%**	**12.3%**	**32.7%**
Substance Abuse Services	8	7	8	10	17	19	22	32	19.5%	17.2%	48.4%
Total Vision Services			5	6	11	19	24	29	62.7%	24.0%	21.0%
Pharmacy Personnel	65	69	76	90	117	125	128	143	13.8%	2.7%	11.4%
Case Managers	79	71	89	85	125	133	124	146	10.9%	-6.2%	17.3%
Outreach Workers	63	69	50	54	53	75	90	85	3.6%	20.8%	-6.2%
Transportation Staff	12	12	12	13	16	17	17	17	7.3%	-2.6%	0.4%
Eligibility Assistance Workers	32	33	46	55	55	75	108	105	18.4%	44.0%	-3.3%
Total Enabling Services[6]	**242**	**240**	**259**	**273**	**315**	**368**	**407**	**431**	**8.7%**	**10.6%**	**5.8%**

Source: CHRT analyses of Uniform Data System reports, 2008-2015.

1. There was no vision personnel reported separately prior to 2010. The average annual growth for this service was calculated for the 2010 to 2013 time frame.
2. Includes Clinical Personnel as well as Facility and Non-Clinical Support Services.
3. Includes Family Physicians, General Practitioners, Internists, Obstetrician/Gynecologists, Pediatrians, and Other Specialty Physicians.
4. Includes Family Physicians, General Practitioners, Internists, Obstetrician/Gynecologists, Pediatrians, and Other Specialty Physicians, NPs, Pas, CNMs, Nurses, Other Medical Personnel, Laboratory Personnel, and X-Ray Personnel.
5. Includes Psychiatrists, Licensed Clinical Psychologists, Licensed Clinical Social Workers, Other Licensed Mental Health Providers, and Other Mental Health Staff.
6. Includes Case Managers, Patient/Community Education Specialists, Outreach Workers, Transportation Staff, Eligibility Assistance Workers, Interpretation Staff, and Other Enabling Services.