

Centers for Primary Health Care Annual Report 2006



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Family Health Services

New Jersey Department of
Health and Senior Services

Division of Family Health
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*Serving the Uninsured and Underinsured:
Statistical Report on New Jersey Department of Health and Senior Services
Uncompensated Primary Care Program
For State Fiscal Year 2006*

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Introduction

Since 1991, the Department of Health and Senior Services (DHSS), Office of Primary Care has had fiscal oversight of the State's financial support to New Jersey's Centers for Primary Health Care (CPHCs).

In 2005, legislation was signed dedicating Health Care Subsidy funding generated by .53 assessment on hospital revenues to support reimbursement for uninsured client visits at CPHCs.

In addition to financial support from New Jersey's Health Care Subsidy fund, special State appropriations have been made available each year since FY 2004 to increase the capacity of existing CPHCs and to establish new access points in medically underserved areas. This financial investment has resulted in 19 new access points and 13 capacity expansion projects which have all been completed and are fully operational.

As of November 2006, due to the continued State support and fiscal oversight by the Office of Primary Care, there are 17 licensed CPHCs with 74 sites located strategically across the state. This supplemental State funding has served to expand the safety net for our citizens and has offset the cost of providing medical, dental and specialty services to the uninsured and underinsured clients treated at New Jersey's CPHCs.

Since State Fiscal Year (SFY) 2005, the Department of Health and Senior Services (DHSS) has begun to reap the benefits of its multiple investments in New Jersey's Centers for Primary Health Care (CPHC). These investments included grants to establish new delivery sites, or new access points, and to expand the capacity of existing CPHCs by instituting extended clinical service hours, adding new staff or renovating outmoded facilities. New access points that became operational in State Fiscal Year 2006 include:

- North Hudson Community Action Corporation Health Center at Garfield (Bergen County)
- Community Health Care at Cape May Court House (Cape May County)
- Community Health Care on Manheim Avenue at Bridgeton (Cumberland County)
- Community Health Care on Chestnut Avenue at Vineland (Cumberland County)
- Community Health Care at Glassboro (Gloucester County)
- Henry J. Austin Health Center on Ewing Street at Trenton (Mercer County)
- Eric B. Chandler Health Center on Church Street at New Brunswick (Middlesex County)
- Jewish Renaissance Medical Center on Fayette Street at Perth Amboy (Middlesex County)
- VNA of Central Jersey Community Health Center at Red Bank (Monmouth County)

Since May, 2006, two Mobile Vans with well-equipped, attractive units from Southern Jersey Family Medical Center have offered service to vulnerable populations at Absecon (Atlantic County) and Mount Holly (Burlington County) which are in high-need areas. Otherwise, certain services cannot be delivered in a timely manner or will perhaps never be delivered to persons in "pockets of poverty".

The investments also represent partial fulfillment of the Department's strategy to establish new access points in areas identified by the Secretary of the U.S. Department of Health and Human Services as Medically Underserved Areas (MUA) and where no Federally Qualified Health Center (FQHC) existed. Expanding and strengthening the Health Centers will continue to improve health outcomes for the medically vulnerable as well as reduce health disparities.

SFY 2006 CPHC Patient Visits

During SFY 2006, uninsured patient visits to CPHC totaled 344,668, an increase of 14.1 percent over SFY 2005. The New Jersey Health Care Subsidy Fund covered the cost of 279,860 of these uninsured visits, an increase of 23.4 percent over the previous year. Through a Letter of Agreement (LOA) between CPHCs and the DHSS, CPHCs are reimbursed for a share of eligible, uninsured patient visits, hereafter referred to as LOA visits.

In SFY 2002 only ten CPHCs participated in the Uncompensated Primary Care Program; these centers were reimbursed for 122,117 uninsured visits. In SFYs 2003 and 2004, the number of delivery sites and patients increased, and the number of reimbursed visits grew to 145,131 and 176,401 visits, respectively. SFY 2005 growth represents the sharpest increase in the recent years, at 28.6 percent. Meanwhile, growth rate for SFY 2006 was also impressive at 23.4 percent.

Table 1 presents comparative data of total uninsured patient visits and patient visits reimbursed by the Uncompensated Primary Care Program for SFYs 2005 and 2006.

Table 1

	<u>SFY 2005</u>	<u>SFY 2006</u>	<u>% Increase</u>
Total Visits	819,211	914,345	11.6
Uninsured Visits	302,017	344,668	14.1
LOA Visits	226,874	279,860	23.4

In SFY 2006 total patients were 272,116 and uninsured patients were 120,565. The average number of visits per year for all patients was 3.4; for uninsured patients, the average number of visits was 2.9.

As shown in Table 2, most CHPCs have experienced an increase in the frequency of uninsured visits in SFY 2006 compare to SFY 2005. Zufall Health Center (Formerly known as 'Dover Community Clinic') and Monmouth Family Health Center just participated in the program around the middle of SFY 2005. Northwest Community Action Corporation's health center joined the program in the beginning of SFY 2006. This center delivered 1,008 uninsured dental visits in SFY 2006, but is not included in Table 2 and also the rest of figures in this report, since the Center is not yet reporting electronically.

Table 2
Uninsured Visits by CPHCs.

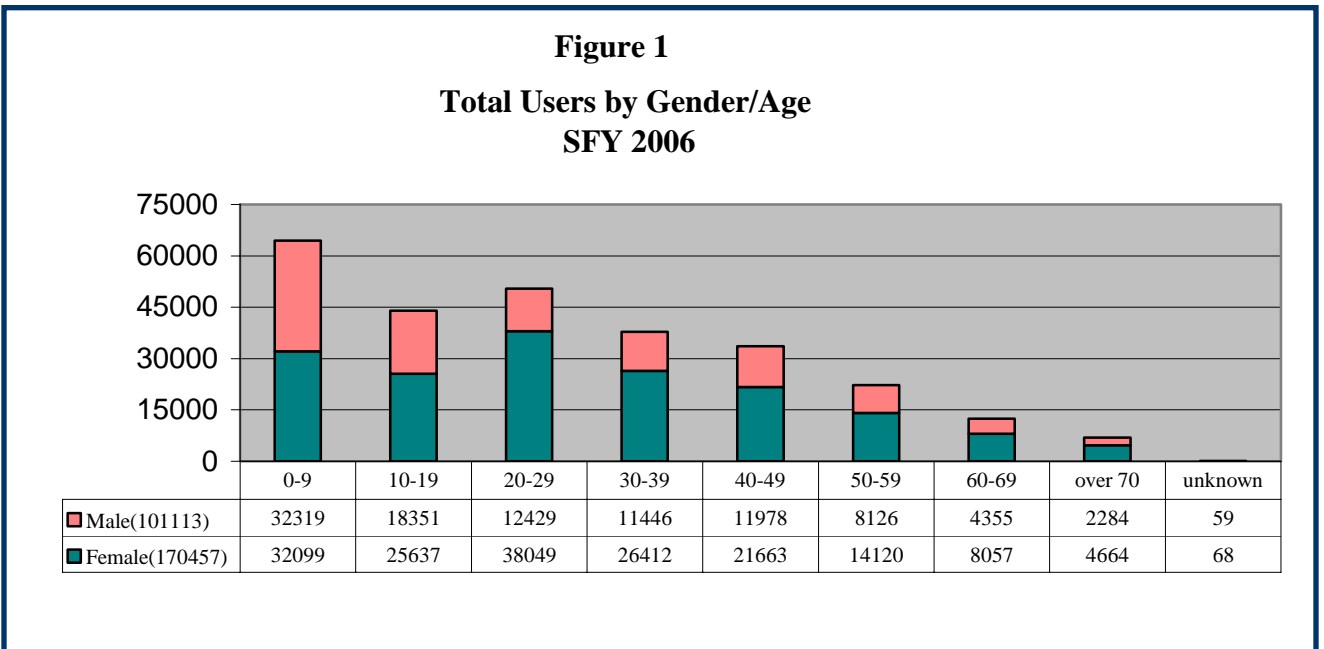
Centers for Primary Health Care	Uninsured Visits in SFY05	Uninsured Visits in SFY06	Percentage of Increase/Decrease
Atlantic Health Initiatives, Inc. (Atlantic)	1,842	2,136	16%
CAMcare Health Corporation (Camden)	30,964	32,259	4%
Community Health Care, Inc. (Cumberland)	20,238	25,582	26%
Zufall Health Center (Morris)	4,771	9,818	106%
Eric B. Chandler (Middlesex)	27,283	28,282	4%
Horizon Health Center (Hudson)	11,150	11,836	6%
Henry J. Austin Health Center, Inc (Mercer)	16,868	17,126	2%
Jewish Renaissance Medical Center, Inc. (Middlesex)	3,912	5,780	48%
Monmouth Family Health Center (Monmouth)	4,026	10,038	149%
North Hudson CAC Health Center (Hudson, Passaic)	61,206	61,291	<1%
Newark Community Health Centers, Inc. (Essex)	28,180	31,354	11%
Ocean Health Initiatives, Inc. (Ocean)	6,035	17,129	184%
Patterson Community Health Center (Passaic)	21,613	19,567	-9%
Plainfield Health Center (Union)	29,823	32,642	9%
Southern Jersey Family Medical Centers (Atlantic,Salem,Burlington)	27,717	33,424	21%
VNA of Central Jersey Community Health Center (Monmouth)	6,389	6,404	<1%
Total	302,017	344,668	14%

One of the hallmarks of the CPHCs is an emphasis on comprehensive and preventive health care. The federal Bureau of Primary Health Care requires that FQHCs and FQHC Look-alikes, which comprise the vast majority of New Jersey’s CPHCs, deliver comprehensive primary care and enabling services on a continuing basis. The model of care CPHCs provide is premised on a patient selecting the CPHC to serve as a medical “home” and in so doing, regularly visiting his/her primary care provider for preventive and health maintenance services. This approach stands in contrast to episodic acute care where the main objective is to treat the acute condition(s) presented by the patient at the time.



CPHC Patients by Age and Gender

Figure 1 reflects the distribution for all patients by age and gender. Familiar patterns are in evidence here. Age and gender distributions for CPHCs are roughly comparable to the average community health center nationwide. The vast majority of patients are female and under 19. Females represent 63 percent of total patients while children (0-19 years) represent 39.8 percent of total patients. For the age group 0-9 years, the percentage of male and female patients is nearly equal; however, after age of 20 years the difference in percentage by gender widens sharply. For the age group 20-29 years, the largest adult group, females exceed males by a ratio of 3.1 to 1. There has been a steady decline of the number of males throughout the age groups except the group 40-49 years old. Elderly patients are under-represented compared to the general population. The number of New Jerseyans over 60 years of age is approximately 17 percent of the general population according to the annual estimates of the population from population division, U.S. Census Bureau, while the number of CPHC patients over 60 years of age was 7.1 percent of total patients.



CPHC Patients by Ethnicity / Race

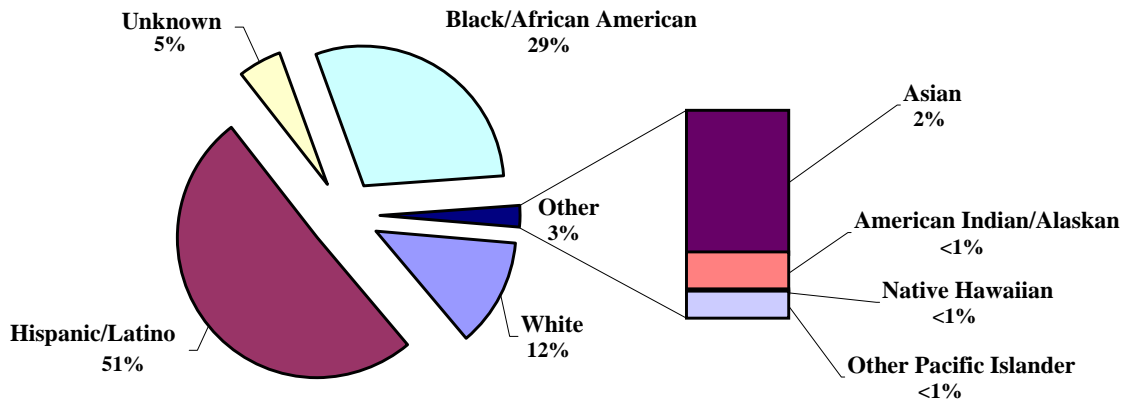


Patients by ethnicity underscore the rise in the State's Latino population over the past three decades. Relatively low wages, formidable barriers to gainful employment and a lack of health insurance has placed large numbers of this ethnic group at risk for poor health outcomes. In the northern part of New Jersey, Latinos are concentrated in Essex, Middlesex, Passaic, Hudson and Union counties

while in southern New Jersey Latinos are concentrated in parts of Camden, Salem, Cumberland and Atlantic counties. Figure 2 reflects CPHC patients by ethnicity. Latinos were the largest ethnic group served at 51 percent, followed by African Americans at 29 percent. The two groups together comprised 80 percent of total patients.

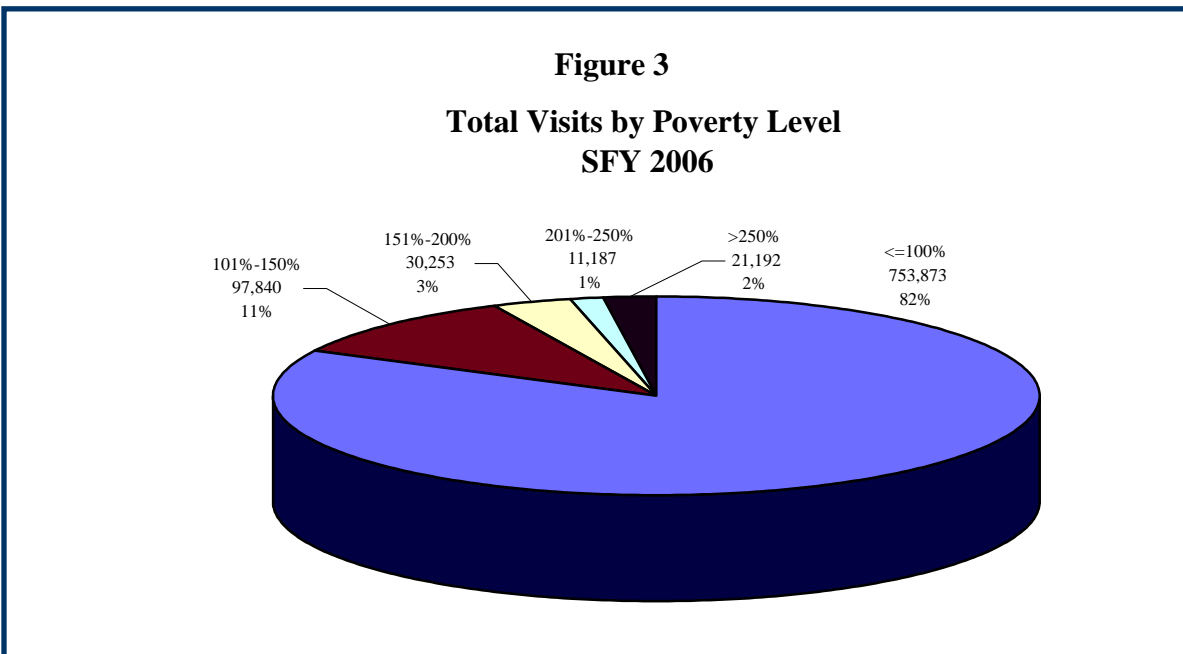
Figure 2

Total Users by Race/Ethnicity SFY 2006

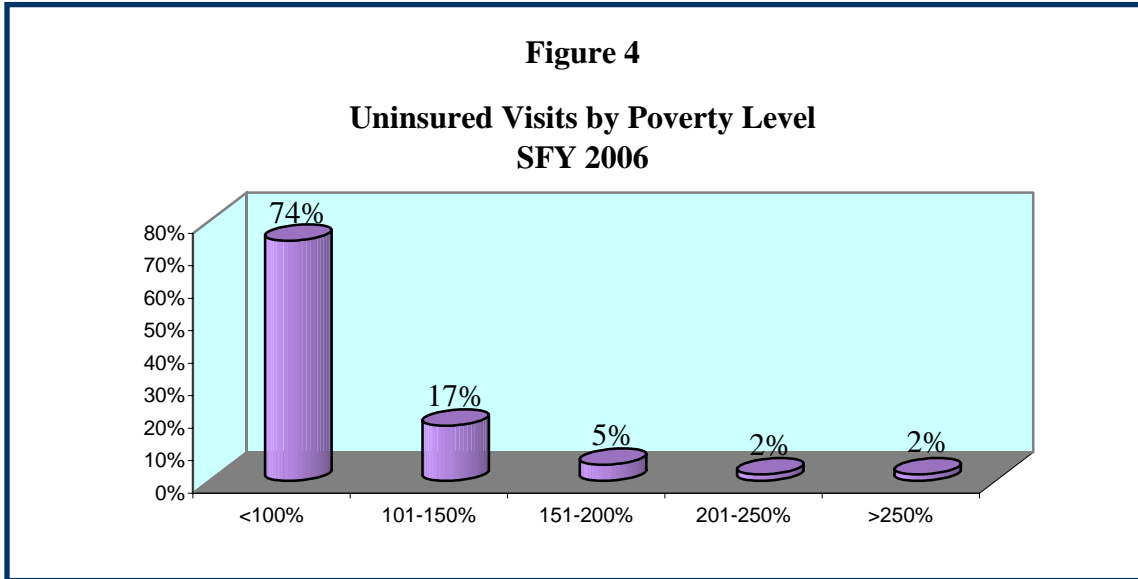


CPHC Patients by Poverty Level

Figure 3 indicates that New Jersey's CPHCs are, indeed, carrying out their mission to serve the economically vulnerable. In SFY 2006, 82 percent of total visits were by persons with incomes equal to or less than 100 percent of the Federal Poverty Level (FPL). When people with poverty income levels below 150 percent are grouped, the percentage of low income visits rises to 93 percent. Only two percent of all visits were to persons with income levels above 250 percent of poverty.



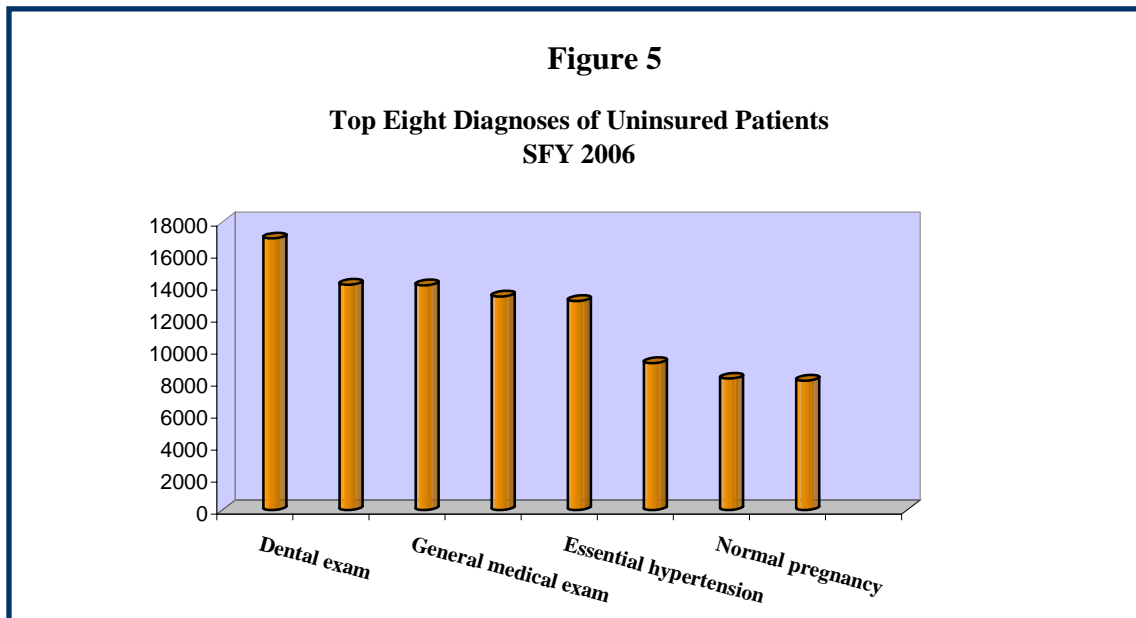
Low-income New Jerseyans with family incomes below 250% of the poverty level have the highest risk of being uninsured. As identified in Figure 4, at least 70% of the uninsured visits came from family incomes below 100% of the poverty level.



Diagnoses of Patients/Visits

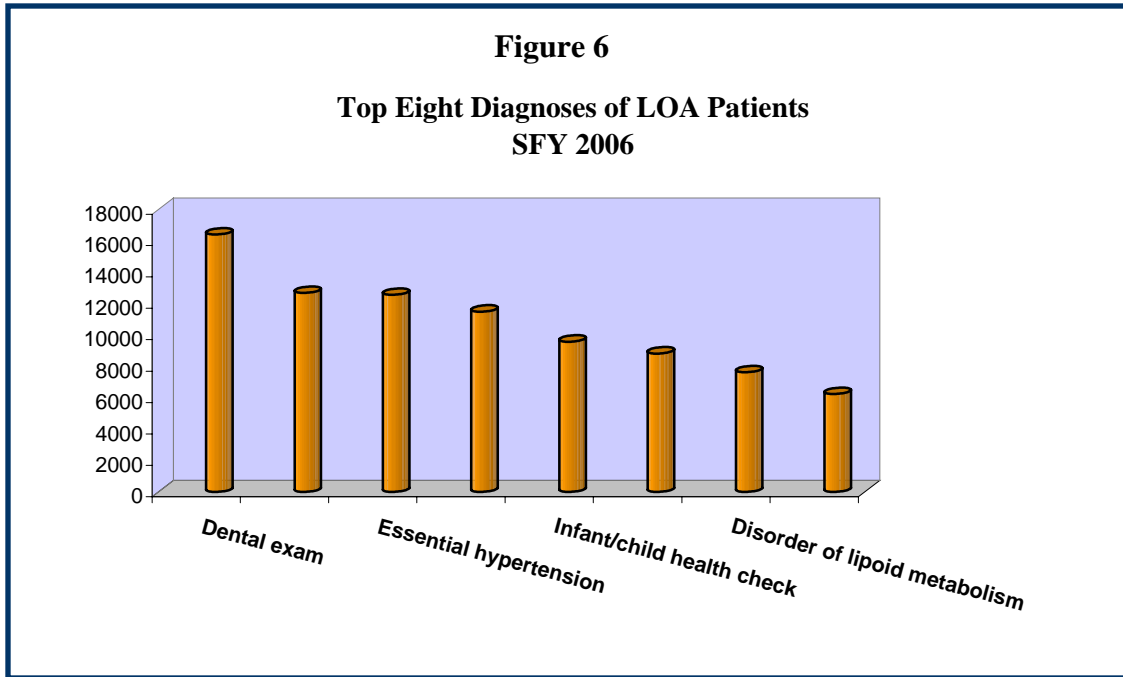
Figures 5 and 6 present the eight most frequent diagnoses for uninsured patients and LOA patients during SFY 2006. Clearly, the Uncompensated Primary Care Program played a significant role in addressing unmet dental care needs of the uninsured and underinsured populations. The high number of patients who sought dental care is a reflection of the dearth of dentists who provided care to the uninsured and underinsured through the use of a sliding fee scale. These populations, statewide, have few alternative sources of dental care.

Many CPHCs have seen patients with costly chronic conditions such as diabetes, asthma, and cardiovascular disease. They try to improve procedure to track treatments and reach out to patients and residents in the community, and encourage patients to take greater responsibility for monitoring their illnesses, which is more effective in reducing the burden of illness due to harm done by chronic diseases.



<u>Diagnosis</u>	<u>No. of Patients</u>
Dental Exam	16,973
Gynecologic exam	14,077
General medical exam	14,042
Infant/child health check	13,345
Essential hypertension	13,065
Dental caries	9,179
Normal pregnancy	8,209
Disorders of lipid metabolism	8,081

Hypertension is particularly prevalent among Blacks, which affects about 2 in 5 Blacks. People with higher educational and income levels are less likely to have hypertension. In New Jersey, age-adjusted hypertension mortality rates have increased in the last few years from 4.5 per 100,000 in 1999 to 5.3 per 100,000 in 2005. (Source: Health Data Fact Sheet 2006, Center for Health Statistics, New Jersey Department of Health and Senior Services).



<u>Diagnosis</u>	<u>No. of Patients</u>
Dental Exam	16,396
Gynecologic exam	12,662
Essential hypertension	12,544
General medical exam	11,472
Infant/child health check	9,562
Dental caries	8,810
Disorder of Lipoid Metabolism	7,620
Diabetes Mellitus	6,235

Other leading diagnoses include diabetes and disorder of lipid metabolism. Hypertension and diabetes are well-known diseases with significant race/ethnic health disparities that have been targeted for improvement at both the State and Federal levels. Healthy New Jersey 2010 cites as an objective the reduction of the age-adjusted mortality rate for diabetes per 100,000 standard populations. The targets for White, Black and Hispanic populations are 18.4, 24.5 and 18.4 respectively. Trends over five years for these sub-populations were as follows:

Mortality Rates from Diabetes

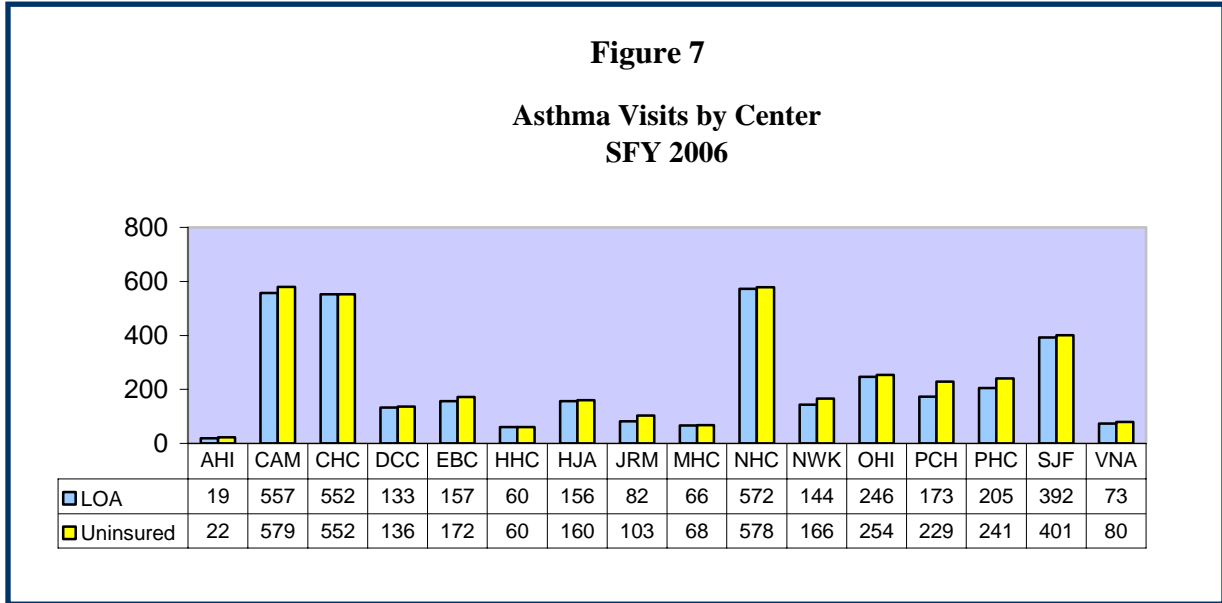
	<u>White</u>	<u>Black</u>	<u>Hispanic</u>
1999	25.4	53.8	28.7
2000	25.7	54.3	29.2
2001	25.4	59.0	31.7
2002	25.5	51.9	27.0
2003	24.2	55.4	31.9

(Source: Center for Health Statistics, New Jersey Department of Health and Senior Services)

Several of the larger CPHCs served a sizable number of diabetic patients. These centers also had large percentages of Latino and Black patients. For example, North Hudson Community Action Corporation Health Center served 901 diabetic, LOA patients and had a LOA population with 87 percent Latino; Community Health Care served 775 diabetic, LOA patients and had a LOA population with 61 percent Latino and 14 percent African American; and CAMcare Health Corporation served 1,060 diabetic, LOA patients and had a LOA population with 51 percent Hispanic and 31 percent African American.



Visits by center for asthma, pregnancy, and Pap smears are shown in Figures 7, 8 and 9. In Healthy New Jersey 2010, the Department has set goals for the reduction of asthma-related hospitalizations, infant mortality and cervical cancer.



The pregnancy graph reflects the large number of visits the Department reimburses for prenatal care. These visits have a direct bearing on pregnancy outcomes and are especially important in preventing pre-term labor, low birth weight delivery and infant mortality. Uninsured, low income pregnant women are initially qualified under the New Jersey Supplemental Prenatal Care Program (a Medicaid program). Only after these funds are exhausted may LOA agencies bill the Department for uninsured prenatal visits.

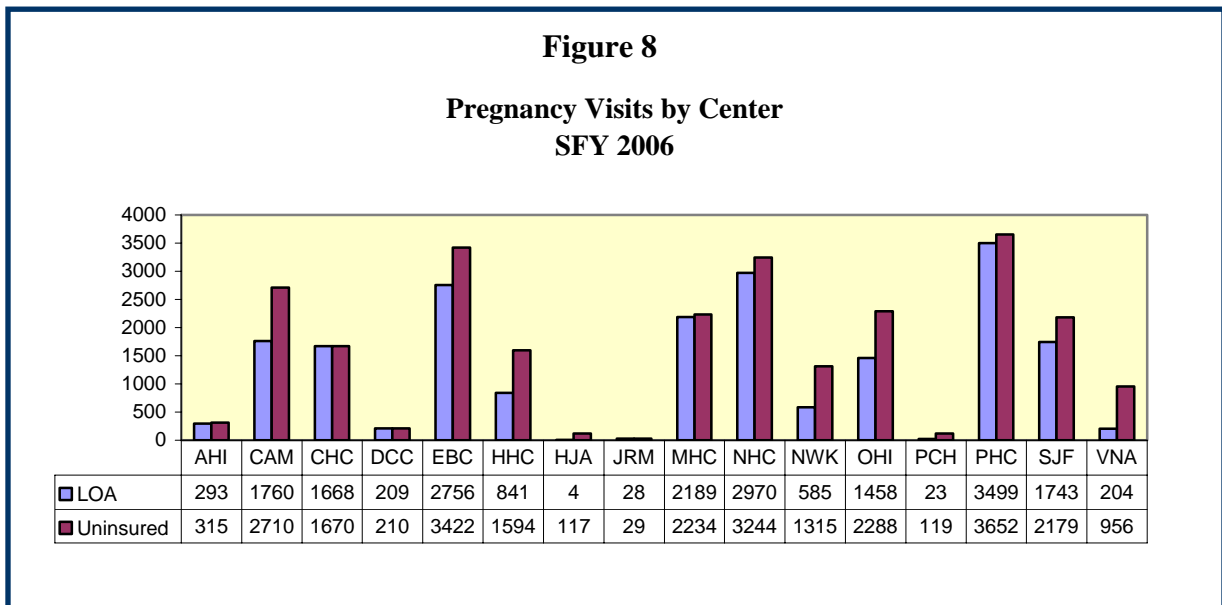
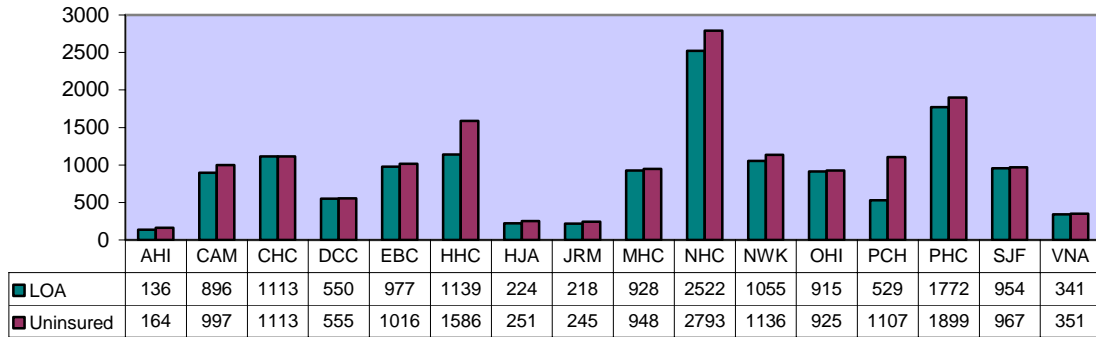


Figure 9

**PAP Smear Visits by Center
SFY 2006**

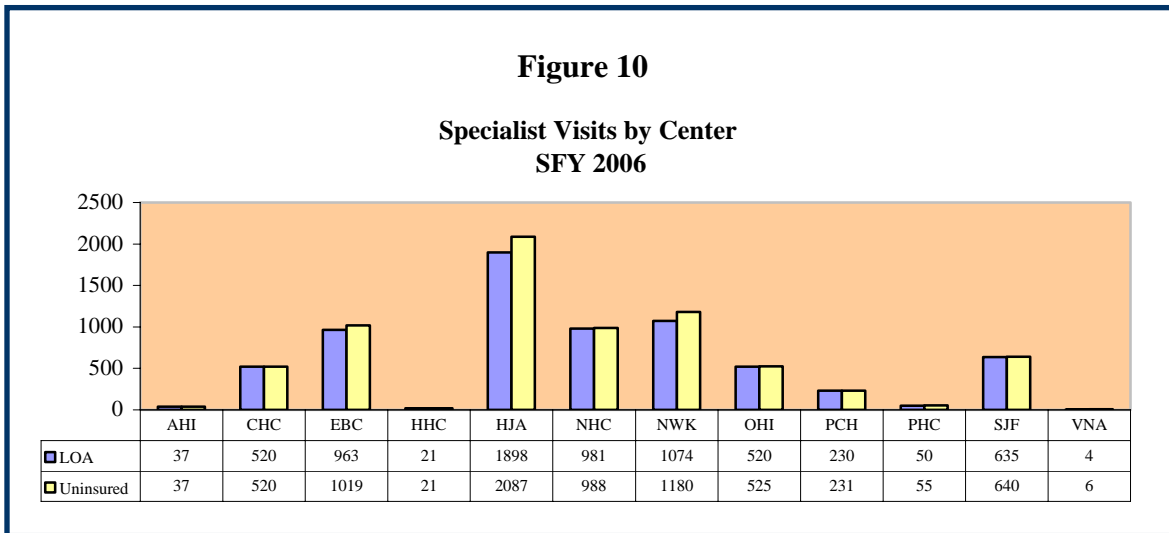


The data on Pap smears underscores the significant role the Uncompensated Primary Care Program played in providing access to cervical cancer screening. In addition, the New Jersey Cancer Education and Early Detection (NJCEED) program reimburses physician specialist services for low income men and women in the areas of breast, cervical, prostate and colorectal cancer detection under certain conditions. Healthy New Jersey 2010 data

indicates that Hispanic women 18 and over in 2003 are approximately six percentage points below the target (85.0) and approximately 11 percentage points below the preferred target for having received a Pap test.

Specialty Visits Served by CPHCs

In addition to core primary care services such as prenatal, pediatric and adult health care, the Uncompensated Primary Care Program reimburses CPHCs for care provided by eligible physician specialists. In so doing the spectrum of care is extended to include more complicated diagnoses. Figure 10 presents the number of specialist visits covered under the Uncompensated Primary Care Program by center from the electronic data system in SFY 2006.



Except Monmouth and Jewish health centers, most CPHCs have submitted uninsured specialty visits for reimbursement. Some CHPCs also submitted off site specialty visits for reimbursement which was not covered in the Figure 10, such as CAMcare Health Corporation submitted hard copies which included 913 visits and Zufall Health Center included 147 visits. Overall, Newark Community Health Centers provided over 3,500 specialist visits; Henry J. Austin Health Center, Eric B. Chandler Health Center and Southern Jersey Family Medical Centers each provided over 2,500 specialist visits.

Different types of medical specialty were delivered by CPHCs. Dermatology consults accounted for 13% of all LOA specialty visits; HIV accounted for 11%; allergic rhinitis and pain in limb each accounted for 8%; diabetes mellitus accounted for 7%; acquired deformities of toe and disease of nail each accounted for 6%; visual disturbances accounted for 5%.

CPHC Visits/Patients by Insurance Coverage

Figure 11 reflects the distribution of visits by payor source. At 47 percent, Medicaid (combined Mgd-A, Mgd-B, Mgd-C and Mgd-D) was the leading payor category. Uninsured visits were the second highest category of visits at 38 percent. Medicare and private insurance completed the balance of visits at 16 percent. According to the Kaiser Commission on Medicaid and the Uninsured, since 2000 the number of uninsured Americans under 65 increased significantly, driven largely by continuing declines in employer-sponsored health insurance. While increases in the State Children’s Health Insurance Program and Medicaid offset, to some extent, employer-sponsored declines for low income children, the situation for adults remains problematic. For the State of New Jersey, data from Current Population Survey conducted by Bureau of the Census indicates that the uninsured number for non-elderly adults (aged 19-64) increased by 11% from 927,308 in 2003 to 1,032,101 in 2005, while it decreased by 2% from 264,129 in 2003 to 258,536 in 2005 for the children under 19.

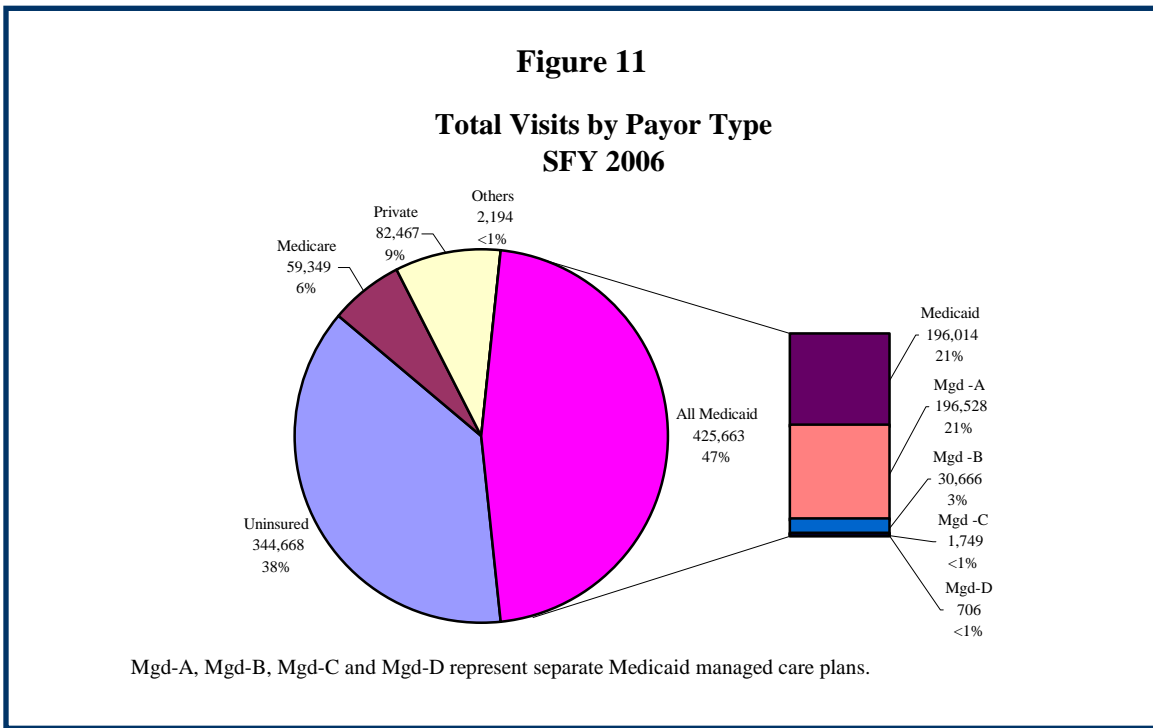


Table 3 reflects the total number of patients served by insurance coverage. The number of uninsured was by far the largest category followed by Medicaid. The total number of uninsured nearly equals the combined total for Medicaid and Medicare patients. This data underscores the critical role the Department's assistance to CPHCs along with federal support plays in meeting the needs of uninsured New Jerseyans served by CPHCs.

Table 3**Patients by Insurance Type in SFY 2006**

	Medicaid	Medicare	Uninsured	Other	Total
AHI	4,306	548	849	1,505	7,208
CAMcare	22,096	3,577	12,331	2,435	40,439
CHC	10,413	1,015	10,085	1,546	23,059
DCC	279	1	6,328	0	6,608
EBC	4,705	443	6,071	104	11,323
HHC	6,347	138	4,318	1,240	12,043
HJA	6,709	593	5,239	784	13,325
JRMC	2,124	117	2,291	398	4,930
MFHC	6,525	369	2,941	0	9,835
NHCAC	15,104	796	20,602	2,320	38,822
NWK	5,889	954	8,886	1,238	16,967
OHI	3,590	404	5,806	3,052	12,852
PCHC	266	1,779	6,334	6,036	14,415
PHC	9,605	787	11,972	1,642	24,006
SJFMC	12,135	841	13,488	3,113	29,577
VNA	2,977	310	3,024	396	6,707
TOTAL	113,070	12,672	120,565	25,809	272,116

Reimbursement to CPHCs for Uninsured Care

During SFY 2006, New Jersey CPHCs were reimbursed \$27,387,046. This reimbursement included visits that were ultimately found to be ineligible for Medicaid reimbursement under Medicaid denial codes 301, 305 and 875.

Table 4 shows the uninsured visits by CPHC. North Hudson CAC Health Center had the largest number of LOA visits (54,545) followed by CAMcare Health Corporation (29,274), Plainfield Health Center (27,633), Southern Jersey Family Medical Centers (26,631) and Community Health Care Inc. (25,567). Each of these centers had uninsured visits equaling or exceeding 26 percent of total visits. For North Hudson and Plainfield the percent of uninsured visits was 46 percent and 43 percent, respectively.

Table 4

Uninsured Patient Visits by CPHCs July 1, 2005 – June 30, 2006			
Centers for Primary Health Care	Total Uninsured Visits	Total LOA Visits	
Atlantic Health Initiatives, Inc.	2,136	1,708	(80%)
CAMcare Health Corporation (Camden)	32,259	29,274	(91%)
Community Health Care, Inc. (Cumberland)	25,582	25,567	(100%)
Zufall Health Center (Morris)	9,818	9,527	(97%)
Eric B. Chandler (Middlesex)	28,282	18,931	(67%)
Horizon Health Center (Hudson)	11,836	8,210	(69%)
Henry J. Austin Health Center, Inc (Mercer)	17,126	12,938	(76%)
Jewish Renaissance Medical Center, Inc. (Middlesex)	5,780	4,973	(86%)
Monmouth Family Health Center (Monmouth)	10,038	8,755	(87%)
North Hudson CAC Health Center (Hudson, Passaic)	61,291	54,545	(89%)
Newark Community Health Centers, Inc. (Essex)	31,354	18,260	(58%)
Ocean Health Initiatives, Inc. (Ocean)	17,129	15,655	(91%)
Paterson Community Health Center (Passaic)	19,567	13,043	(67%)
Plainfield Health Center (Union)	32,642	27,633	(85%)
Southern Jersey Family Medical Centers (Atlantic, Salem, Burlington)	33,424	26,631	(80%)
VNA of Central Jersey Community Health Center (Monmouth)	6,404	4,210	(66%)
Total	344,668	279,860	(81%)

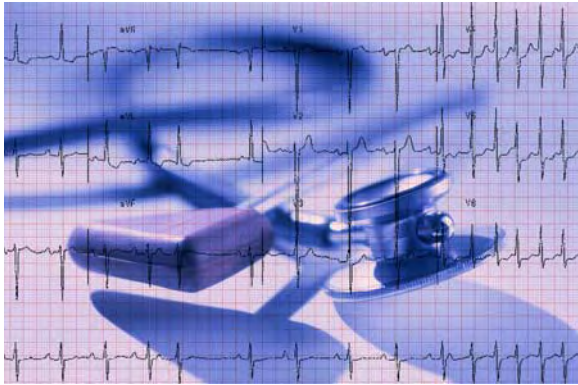
The middle tier of centers by volume of LOA visits included Eric B. Chandler Health Center (18,931), Newark Community Health Centers (18,260), Ocean Health Initiatives (15,655), Paterson Community Health Center (13,043) and Henry J. Austin Health Center (12,938).

The third tier of centers consisted of those with the smallest number of LOA visits such as Zufall Health Center (9,527), Monmouth Family Health Center (8,755), Horizon Health Center (8,210), Jewish Renaissance Medical Center (4,973), VNA of Central Jersey (4,210) and Atlantic Health Initiatives (1,708). Generally, these centers had fewer and/or smaller facilities.

The numbers in parenthesis reflect the percentage of total LOA visits over total uninsured visits, ranging from 58% to 100%. Almost 100% of uninsured visits from Community Health Center Inc. and the Zufall Health Center received reimbursement from the state. More than 80% of uninsured visits had been reimbursed in ten health centers. All uninsured visits shall be assessed to determine eligibility for reimbursement under the letter of agreement and uninsured care application must be completed. Visits provided by nurse, psychiatrist, case manager and lab personnel are not eligible for reimbursement.



CPHC Electronic Billing Data



Early in SFY 2005, the Department implemented a new computer-based billing and reporting system. The new system replaced an inadequate manual billing system for the New Jersey Uncompensated Primary Care Program. Over subsequent months, the new electronic billing and data collection system was enhanced to “adjust” to the variety of Patient Management Systems (PMS) used by the

CPHCs. Upgrades were made to include data sets for patient diagnoses, the elimination of ineligible patient visits, and various other data elements recommended by centers and program staff.

Extensive training and on-site technical assistance were provided to CPHC management and staff on the use of the system, especially reconciliation and re-submission features. In part due to varying computerized claim and data submission capabilities, many centers struggled to meet the new requirements. However, in SFY 2006, 16 of 17 centers had successfully employed the computerized billing and reporting system with the exception of the new center from Northwest New Jersey Community Action Corporation.

With this new system, program staff had data upon which more accurate projections could be developed. Computerized information on patient diagnoses, visits, age, gender, ethnicity and more is now available for analysis, and program and fiscal planning. Moreover, it is much easier to ensure the reimbursement eligibility of uninsured visits and it is much faster to identify/eliminate sources of trouble or take steps to minimize their effects. In SFY 2006, on-site compliance audits and some subsequent comprehensive audits were completed for all 17 health centers.

Health Care for the Homeless (HCH) in NJ

Nationally, the HCH programs provided services to more than 600,000 homeless people in 2004 through 50 states, the District of Columbia, and the Commonwealth of Puerto Rico. The majority of the participants were male (59%); more than half (53%) were ages 20-44 years and 28% were ages 45-64; 71% had no insurances and 22% were Medicaid eligible. (Source: National Coalition for the Homeless, Health Care for the Homeless Program, October 2005)

In New Jersey, there are five federally funded Health Care for the Homeless Programs. They deliver primary care, dental care, mental health and substance abuse services, and case management to homeless persons. Since SFY 2005, each HCH Program in New Jersey received a grant from the New Jersey Department of Health and Senior Services to strength their service to homeless individuals and families.

Nearly 1,500 homeless were served in New Jersey in SFY06. About 68 percent were male; more than half (56%) were ages 31-50 years and 20% were ages 51-60; 59% had no insurance and 32% were Medicaid eligible; 23% had mental and substance abuse problems and 42% had seen counselors. The most common places homeless persons stayed at night were transitional housing (27%), a shelter (26%) and doubled up (24%). (Doubled up refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members.)



SFY 2006 Other Issues

New Methodology of Reimbursement

The system for reimbursing CPHCs for uninsured patient visits was developed in 1992 with several modifications over the years. In an effort to redesign the reimbursement methodology, a major initiative was undertaken in SFY 2004.

The Department of Health and Senior Services commissioned the Rutgers University Center for State Health Policy to (1) review New Jersey's existing Uncompensated Primary Care Program relative to other states; (2) analyze the existing reimbursement methodology; (3) consult with financial analysts and auditors; and (4) develop options for reform of the system of payment to participating health centers.

The reimbursement methodology dating from the early 1990s was premised on paying only for uninsured visits above a pre-existing level of uninsured visits for health centers entering the program at that time. The intent was not to displace federal funds with new State funds. The pre-existing uninsured visit threshold came to be called the "baseline" deduction.

With the inclusion of new centers into the program, this approach became inequitable. For new centers, baselines were often set arbitrarily and were not subsequently adjusted. Moreover, it is difficult to recognize current CPHC performance in providing services to the uninsured. In proffering multiple options for reform, Rutgers recommended elimination of baselines.

For SFY 2006 baselines have been eliminated. Also because of the fixed amount of funding available for uninsured visits and to account for federal grant support and enhanced Medicaid reimbursement rates to federally qualified health centers (FQHCs) and FQHC Look-alikes, the amount reimbursed per eligible uninsured visit was established at \$95 instead of previous \$104.



New Legislation

In September 2005, Governor Richard Codey signed into law Senate Bill 2260 sponsored by Senators Wayne Bryant and Nia Gill. This landmark legislation established for the first time a dedicated source of funding for CPHCs. Since 1992, CPHCs have received funding from an annual .53 assessment on the operating revenue of New Jersey's hospitals. In recent years, this assessment has been level at \$11 million annually. The new legislation has sharply increased annual funding from \$11 million to \$35 million for fiscal years 2006 and 2007. In addition to sustaining basic medical and dental services to New Jersey's uninsured population, the new legislation maintains the momentum of previous years by establishing the financial basis for the creation of more new access points and provides additional protection of major investments made in 2004 and 2005. The legislation was timely. The ranks of New Jersey's medically uninsured grew significantly since the beginning of this decade. Currently, over 1.3 million New Jerseyans are uninsured at any given time.

New Access Point Development

At the beginning of SFY 2007, the Department awarded \$4.7 million in funding to establish nine new access points throughout New Jersey. The latest round of expansion includes the establishment of new delivery sites at Clementon, Paulsboro, Burlington City and Keansburg.

CAMcare Health Corporation's four sites currently provide ample access to care for the residents of Camden City. However, the majority of Camden County's low income population resides outside of Camden City. The new access point for Clementon on the Route 30 Corridor (White Horse Pike) will extend CAMcare's presence 15 miles south and eastward. CAMcare's second new access point will be located in Paulsboro (Gloucester County).

The VNA of Central New Jersey will expand access to primary care health services for low income persons residing in Monmouth County's shore communities. Their new site will be located at Keansburg.

After several months' negotiation, Plainfield Health Center finally assumed full ownership of two sites from the Northwest New Jersey Community Action Corporation. One is in Phillipsburg (Warren County) and the other is in Newton (Sussex County). Phillipsburg began to operate in September, 2006. Newton has delivered dental service for one year and will offer medical service sometime in 2007.

Further, additional expansions are anticipated in SFY 2007. They include a new dental facility on Baltic Avenue in Atlantic City, Newark Community Health Centers' new center in Orange (Essex County).

When these sites are completed and placed into operation, the total number of CPHC delivery sites will be more than 75 statewide.

Projected Reimbursements for SFY07 to SFY09

Table 5 reflects projected patients, uninsured visits, growth rate of visits and the cost of reimbursing visits for the next three years.

Table 5

Projected Growth in Patients and Visits

SFY	Uninsured Patients	Uninsured Visits	Visit Growth Rate	Cost
2007	146,769	410,953	20%	\$35.53 million
2008	154,108	431,501	5%	\$37.30 million
2009	158,731	444,446	3%	\$38.42 million

Asthma Initiative

In addition to expanding access to care by establishing new delivery sites, the Department is interested in assisting CPHCs to improve the delivery of care and care outcomes. In this regard, the Department sponsored a statewide asthma collaborative in 2005. The New Jersey Asthma Collaborative builds upon the federal Bureau of Primary Health Care's goal to eliminate health disparities among the nation's underserved racial/ethnic groups by encouraging federally qualified health centers to participate in groups focusing on a particular disease. The new groups, termed collaboratives, seek to improve the treatment of a specific chronic disease through the implementation of a new care model that includes systemic data collection, measurement of care against established standards and dissemination of results.

In September 2005, at the Department's first asthma summit, Commissioner Fred M. Jacobs, M.D., J.D. introduced the promising initiative. The summit served both as an orientation and kick-off event. Sixteen health centers subsequently agreed to participate in the new collaborative. By early December 2005, center teams had been formed and the first major activities undertaken. A grant of Prospective Equivalency from Clinical Quality Improvement Branch, HRSA/BPHC has been awarded for the Asthma Collaborative Phase I process. Fifteen health centers have successfully completed the equivalent collaborative activity and transitioned to National Phase II Teams. As of July 1, 2006, the teams were tracking approximately 2,553 patients with asthma.

Asthma continues to be a major health disparity in the State of New Jersey. The Healthy New Jersey 2010 reports that the hospital admission rate per 100,000 populations for asthma between 1998 and 2003 fluctuated from 370.5 to 447.6 for Black and 214.9 to 269.1 for Latinos. In 2003, the hospital admission rates for Blacks and Latinos are 1.7 and 1.8 times above the 2010 objective.

Pharmacy Discount Initiative

Much of the current practice of medicine involves the use of prescription drugs either to cure acute infections or to better manage chronic diseases. Yet for the poor or uninsured patient, simply acquiring needed medications can prove to be a daunting task. The cost of prescription medications continues to rise at a rate that well exceeds the consumer price index and their high cost has become a systemic problem that defies easy resolution.

To address the inability of the medically underserved to obtain prescription medications through federal programs, in 1992 Congress enacted Section 340-B of the Public Health Service Act. This act enabled certain providers including CPHCs to acquire outpatient drugs at a steep discount. However, participation in the program is not automatic. To be enrolled, eligible providers known as “covered entities” must apply to the Pharmacy Affairs Branch of the U.S. Department of Health and Human Services.

While the program offers such benefits as reduced prices for medications, an expanded drug formulary and improved treatment plan compliance, as of early 2005 only five health centers participated in the 340-B discount pharmacy program. Implementing a 340-B program does require substantial effort on the part of the applying organization including deciding which operating model is best (in-house, contract pharmacy or other model), meeting 340-B compliance requirements and avoiding program prohibitions, as well as developing procedures and policies for formulary management, quality improvement and price setting.

In October 2005 the Department hosted a workshop designed to sharply increase the number of CPHCs participating in the 340-B Program. At this workshop, Commissioner Fred M. Jacobs, M.D., J.D. announced the goal of having each CPHC not currently participating in the program to begin doing so within the current fiscal year. To facilitate participation the Department in collaboration with the Health Resources and Services Administration provided each CPHC with free consulting services. At the October workshop CPHCs met with assigned consultants and began the process of understanding their patient mix and analyzing the program model that is likely to work the best.

As of September 1, 2006, eight health centers have participated in the 340-B Program. They are Atlanticare Health Services, CAMcare Health Corporation, Community Health Care, Henry J. Austin Health Center, Horizon Health Center, Metropolitan Family Health Network, Newark Community Health Center and North Hudson CAC Health Center. Another four health centers are expected to participate in the 340 B Program by the end of 2006.

Conclusion

In summary, the number of uninsured across the nation has grown from just under 36 million in 1990 to 43 million in 2004, while 1.3 million of those uninsured reside in New Jersey. New Jersey is seen as a national leader to increase both the affordability and accessibility of health insurance coverage to the vulnerable populations. Since 1992, the number of CPHCs in New Jersey has grown from 10 to 17 (see the following list of CPHCs). New access points continue to be established in SFY2007. By June 30, 2006, 19 of 21 counties (except Hunterdon and Somerset) in New Jersey already have access to CPHCs.

Centers for Primary Health Care are non-profit, community-owned health care centers which serve low-income and medically underserved communities. For more than 10 years, CPHCs in New Jersey have provided high-quality, affordable primary care and preventive services to the New Jersey's most vulnerable populations no matter who they are, where they live and what language they speak.

17 CPHCs in SFY 2006:

Atlantic Health Initiatives, Inc.
CAMcare Health Corporation
Community Health Care
Eric B. Chandler Health Center
Henry J. Austin Health Center, Inc.
Horizon Health Center
Jewish Renaissance Medical Center, Inc.
Monmouth Family Health Center
Newark Community Health Center, Inc.
North Hudson Community Action Corporation Health Center
Northwest New Jersey Community Action Corporation Health Center
Ocean Health Initiatives, Inc.
Paterson Community Health Center
Plainfield Health Center
Southern Jersey Family Medical Centers
VNA of Central Jersey Community Health Center
Zufall Health Center (previously called the Dover Community Clinic)

Health Center Location and Sites:

As of November, 2006, there are 74 sites that are operational and licensed; three sites have pending licensures; sixteen sites are outreach with no licensure.

Definitions:

FQHC: Federally Qualified Health Center – designation by the Federal Bureau of Primary Care

FQHC 330: Designation with Federal funding.

330E: Community Health Centers (CHC)

330G: Migrant Health Centers (MHC)

330H: Health Care for the Homeless (HCH)

330: School-Based Health Centers (SBHC)

FQHC – LAL: Look-a-Like designation which allows an agency to receive enhanced reimbursement rates and to bill at the approved FQHC Medicaid rate. The approval of an agency as a LAL will be viewed more favorably for future funding. A LAL does not receive federal funding like a 330.

Satellite: Licensed satellite ambulatory care facility that is a subsidiary of the parent FQHC organization.

Outreach: Providing services – but is not a licensed ambulatory care facility.

Contract: School-based services that are provided by a licensed ambulatory care facility.

