The Impact of Medicaid Expansion on Louisiana's Federally Qualified Health Centers (FQHCs)

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Executive Summary

Our report addresses the impact of Louisiana's recent decision to expand Medicaid access upon the state's network of federally qualified health centers (FQHCs). Representing over 1,200 institutions nationwide, FQHCs are structured to provide primary health care services to the medically underserved and uninsured, regardless of their ability to pay. They do so in both rural and urban locations and include such institutions as community health centers, migrant health centers, health care for the homeless centers, public housing primary care centers, and outpatient health programs.[1] Acting in the role of a safety net provider, FQHCs are funded primarily through a combination of Medicaid/Medicare reimbursements and grants from the Health Resources Services Administration (HRSA) to provide services to the uninsured.

In Louisiana there are approximately 34 health care providers that are designated as a FQHC, and these providers are located across the state, in both rural and metropolitan areas. Recent estimates show that FQHCs in Louisiana treat approximately 15% of state residents, fulfilling a range of healthcare needs from preventative care to mental health services. In light of the state's decision to expand Medicaid and its impact upon FQHCs in the state, ***we find no evidence of any structural or policy threats to the sustainability of state FQHCs in the near future***. Our conclusion is based upon a number of pertinent observations that we summarize below:

- First, while in existence in various forms since the 1960s, FQHCs have been viewed as an integral component of the Affordable Care Act (ACA). As such, they received major funding upon the Act's passage. Specifically, Congress initially dedicated $11 billion to strengthen and expand the nation's FQHC network following the passage of the ACA and recently extended this funding source through 2017.

- Second, while FQHCs were initially supported to provide health care services to the uninsured, they have also served as a key provider of services to those covered by Medicaid, Medicare and private insurance. In light this broader role, Louisiana's decision to expand Medicaid will, in all likelihood, increase the percentage of patients covered by Medicaid and decrease the percentage of uninsured patients receiving services at FQHCs. National data show that FQHCs operating in Medicaid expansion states have higher per patient revenues than those in non-expansion states due in large part to the Medicaid reimbursement levels. All things being equal, we have no reason to expect that FQHCs in Louisiana will not experience a similar benefit.

While we are optimistic about near-term prospects for FQHCs in the state, it is prudent to point out that there are a number of macro-level, national factors that could potentially impact the ability of FQHCs to continue to provide their existing services. Namely, any major changes to Medicaid eligibility under the ACA or decreases in federal and state grant funding could impact those FQHCs that disproportionately rely upon such revenue sources.

[1] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf

The Impact of Medicaid Expansion on Louisiana's Federally Qualified Health Centers (FQHCs)

Introduction

Building upon our earlier analysis of the impact of the Medicaid expansion upon Louisiana's rural hospital network, LPHI requested that we extend our analysis to address the impact of Louisiana's recent decision to expand Medicaid access upon the state's network of federally qualified health centers (FQHCs). Representing over 1,200 institutions nationwide, FQHCs are structured to provide primary health care services to the medically underserved and uninsured, regardless of their ability to pay. They do so in both rural and urban locations and include such institutions as community health centers, migrant health centers, health care for the homeless centers, public housing primary care centers, and outpatient health programs.[2] Acting in the role of a safety net provider, FQHCs are funded primarily through a combination of Medicaid/Medicare reimbursements and grants from the Health Resources Services Administration (HRSA) to provide services to the uninsured. In Louisiana there are approximately 34 health care providers that are designated as a FQHC, and these providers are located across the state, in both rural and metropolitan areas.

While having their historical roots in the health centers created as part of Lyndon B. Johnson's War on Poverty, modern FQHCs are rooted in the federal government's 1991 decision to qualify rural and urban health centers to provide health care to the underserved, namely the uninsured and those living in areas without easy access to health care providers.[3] While access is still a critical issue nationally and for many Louisiana residents, the subsequent passage of the Affordable Care Act (ACA) and the state's recent decision to expand Medicaid access under the ACA have the potential to significantly impact FQHCs. By substantially reducing the number of uninsured state residents, the ACA promises to address many of the concerns first addressed by FQHCs. But, as we will discuss in detail throughout the report, FQHCs have been a core component of the implementation strategy for the ACA and the impact of the ACA upon them will largely be influenced by (1) the federal government's ongoing commitment to funding FQHCs through HRSA, (2) the persistence of uninsured state residents and (3) the ability of FQHCs to meet the needs of the state's growing population of individuals covered by Medicaid.

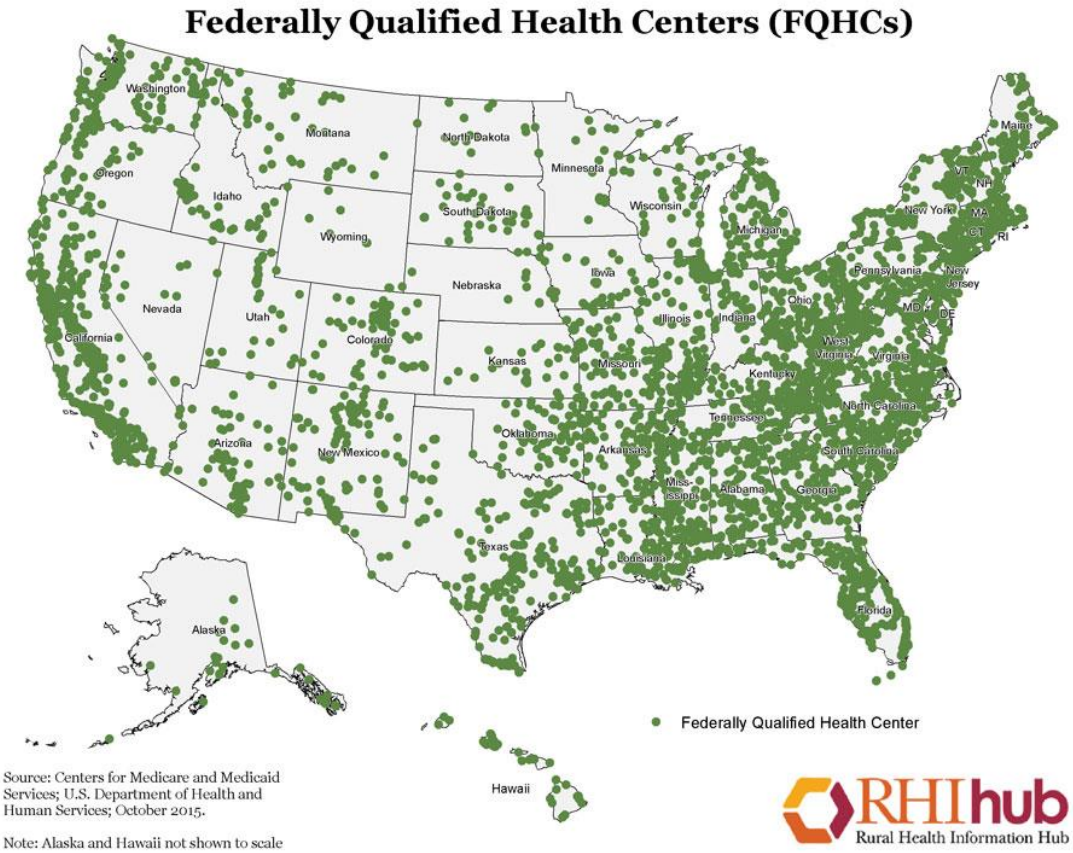
The report focuses upon the future role of FQHCs in the context of their historical position in the provision of health care. First, we provide a background description of the history, function and scope of FQHCs at the national level. Second, we address the likely impact of Medicaid expansion upon FQHCs, with particular attention paid to the current revenue sources for FQHCs. Third, we provide an analysis of Louisiana's existing FQHC network within the context of the state's demographic trends. Last, we conclude with summary remarks and conclusions regarding both the immediate and long-term prospects for Louisiana's FQHCs under Medicaid expansion.

[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf
[3] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/FQHC-Text-Only-Factsheet.pdf

The Historical Function and Scope of FQHCs

The central role of FQHCs is to provide health care services to the uninsured and underinsured, as well as those without readily available healthcare options. While community health centers have evolved over a number of years, their history is rooted in the Johnson administration's efforts in the mid-1960s to combat poverty by providing healthcare services to underserved populations, including the poor. In 1975, community health centers were placed under the umbrella of Section 330 of the Public Health Service Act and have grown in function and scope since this time. In 1991, Congress amended the Social Security Act to include a federally qualified health center benefit under Medicare, which thus led to all health centers qualifying for this benefit to be deemed 'federally qualified health centers'. Presently, there are approximately 1,375 health centers in operation across the U.S., serving on an annual basis over 24 million patients, one-third of whom live in rural communities.[4]

Map 1. FQHCs in United States (Rural Health Information Hub)



[4] http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf

In order qualify as an FQHC, a health center must meet the following criteria:

- They must offer services to all customers, regardless of their ability to pay
- They must establish a sliding-fee scale for customers
- They must operate as a not for profit or public organization
- They must be community-based, which is defined has having a majority of the governing board comprised of patients/customers
- They must primarily target a medically underserved area / population
- They must provide primary care services
- They must operate a continuous quality assurance program[5]

Qualifying criteria also apply to FQHC services. As mandated by HRSA, all FQHCs must provide, either on-site or through another provider, the following:

- Preventative health services
- Dental services
- Mental health and substance abuse services
- Transportation services necessary for adequate patient care
- Hospital and specialty care[6]

Regarding the population of individuals served by FQHCs, 2013 estimates provided by the Kaiser Foundation showed that over 70% of individuals receiving services at FQHCs fell below 100% of the federal poverty level. Approximately 60% of those serviced at FQHCs were female and 60% were between the ages of 18 and 64. Additionally, approximately 40% of FQHC patients were covered by Medicaid, 14% by private insurance, 8% by Medicare and over 30% were uninsured.[7]

The Impact of the Affordable Care Act & Medicaid Expansion on FQHCs

As will be addressed below, assessing the existing and future impact of the ACA and Medicaid expansion upon FQHCs can be framed in both broad-based, national terms, as well as state-based, provider terms. In other words, there are components of the ACA that have and will continue to impact FQHCs nationally, while other impacts upon specific providers have and will be shaped by such state-level characteristics as uninsured rates, poverty levels and decisions related to Medicaid expansion.

National Impact

Given the goal of the ACA to target the nation's uninsured population, FQHCs have been directly influenced by the 2010 Act's implementation. Recognizing the need for a robust network of healthcare providers given the rapid expansion of the insured population, the ACA initially provided funding for the corresponding expansion of federal qualified health centers to accommodate the increasing number of individuals seeking health care services. While FQHCs have historically been provided discretionary

[5] Rural Health Information Hub, Federally Qualified Health Centers (FQHCs); https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers
[6] Rural Health Information Hub, Federally Qualified Health Centers (FQHCs); https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers
[7] http://kff.org/medicaid/issue-brief/community-health-centers-a-2013-profile-and-prospects-as-aca-implementation-proceeds/

funding by Congress, the ACA designated $11 billion of mandatory funding, through the Community Health Center Fund, over a five-year period for the "operation, expansion and construction" of FQHCs. Of this total, Congress reserved $9.5 billion to "support ongoing health center operations, create new health center sites in medically underserved areas," and "expand preventative and primary health care services."[8] Congress dedicated the remaining $1.5 billion to FQHC construction and renovation, with the total result being a significant expansion in presence and capabilities of the national FQHC network.

2013 estimates of FQHC funding nationally show that approximately 40% of center revenues come from Medicaid reimbursements, with only 6% coming from Medicare reimbursements. More germane to this analysis, 21% of 2013 revenues came from grants under the Public Health Service Act and other federal grants. This latter funding source received a great deal of attention this past fiscal year, given the anticipated 2015 sunset date for the initial influx of ACA related funding for FQHCs. However, much in the manner that Congress extended Disproportionate Share Hospital (DSH) payments that were scheduled to be significantly reduced following passage of the ACA, it also extended mandatory funding to FQHCs through September of 2017. In particular, Congress allocated $3.6 billion for fiscal years 2016 and 2017, and in fiscal year 2016 FQHCs received $1.4 billion in discretionary funding and $3.6 billion in mandatory funding. As such, it would appear that mandatory FQHC funding will remain stable for the immediate future, but nonetheless, FQHCs will need to prepare for the possibility of significant cuts to mandatory funding should Congress decide not to renew funding at current levels.

Provider Impact

Apart from national funding through Section 330 grants, estimates by the Kaiser Foundation show that nationally, approximately 40% of FQHC funding is derived from Medicaid reimbursements and 8% of revenues from private insurance plans.[9] As such, much of the impact of the ACA upon specific health centers has hinged upon state level decisions whether or not to expand Medicaid eligibility under the ACA. FQHCs operating in non-expansion states are much more likely to provide services to the poor and uninsured, and as a result, will rely more heavily upon existing revenue sources (federal, state, or local) to cover this population. On the other hand, FQHCs operating in states that have decided to expand Medicaid eligibility face reduced rates of uninsured patient visits and more generous reimbursements rates for Medicaid eligible patients.

The core differences in these two funding scenarios, between FQHCs located in expansion and non-expansion states, is further illustrated in 2013 estimates of patient, revenue and funding characteristics for qualified health centers. As Table 1, below, highlights, health centers in states with expanded Medicaid eligibility received a higher share of their annual revenues from Medicaid and a smaller proportion of their revenues from federal grants, as well as total grants.

[8] http://www.bphc.hrsa.gov/about/healthcentersaca/index.html
[9] http://kff.org/medicaid/issue-brief/community-health-centers-a-2013-profile-and-prospects-as-aca-implementation-proceeds/

Table 1. 2013 Health Center Characteristics: Expansion States vs. Non-Expansion States

	Medicaid Expansion States	Non-Expansion States
Patient Coverage Rates		
Uninsured	33%	44%
Medicaid	40%	27%
Medicare	9%	10%
Private Insurance	16%	17%
Revenue Shares		
Total per patient	$795	$723
Medicaid revenue share	36%	23%
Medicare revenue share	6%	7%
Private Insurance share	8%	8%
Self-pay share	6%	9%
Section 330 grants share	23%	35%
Total grants share	43%	52%

Source: The Kaiser Commisssion on Medicaid and the Uninsured / GWU analysis of 2013 UDS data on federall funded health centers

All things being equal, it is more beneficial, from a revenue standpoint, for FQHCs to treat patients under Medicaid than it is to cover the same population of patients with federal grants, as can be seen in the significantly higher per patient revenue estimates for FQHCs located in Medicaid expansion states. In addition, the ability to treat patients under Medicaid decreases the reliance upon grant revenue, the majority of which are subject to funding by Congress in a relatively inconsistent manner.

However, as the Kaiser Foundation points out, there are challenges FQHCs will face regardless of their operation in an expansion or non-expansion state. First, FQHCs will need to meet the challenge of providing services to patients with health insurance whose plans may not cover the full costs of provided health care services. Given the relative size of this population, the need to cover uncompensated care costs could be substantial for some FQHCs. Second, existing federal health care policy does not require state Medicaid plans or other health insurance plans to include all FQHCs in their coverage networks. As such, there are no prohibitions for patients seeking care at a health center, when that care may not be eligible for reimbursement. Third, FQHCs will continue to treat patients that do not qualify for Medicaid and have elected not to purchase insurance on the marketplace. While this is a growing problem for the successful implementation of the ACA as a whole, the persistence of uninsured populations will also remain a concern for those FQHCs with sizeable uninsured patient rates.

Louisiana's FQHC Network & Medicaid Expansion

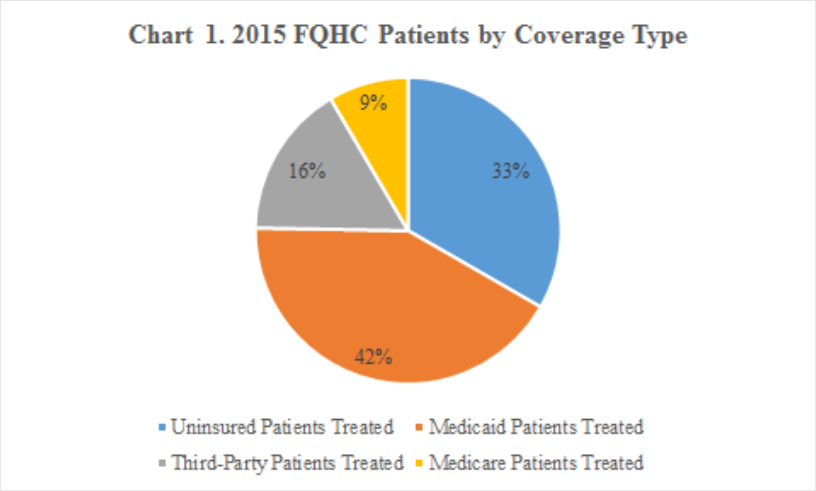
As highlighted in Table 2, below, there were 34 FQHCs operating in the state of Louisiana as of 2015.[10] The Kaiser Foundation estimated in 2013 that less than 15% of Louisiana residents received care through an FQHC. This estimate is reflective of the role and scope of the state's network of rural hospitals and safety net hospitals under the state's existing public/private partnerships, but as the table below highlights, local level FQHCs are providing services to those patients that would otherwise utilize the services of the state's safety net hospitals.

[10] http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=2015&state=LA#glist

Table 2. 2015 Louisiana Health Center Profile							
Health Center Name	**City**	**Patients at or below 200% of poverty**	**Patients at or below 100% of poverty**	**Uninsured**	**Medicaid/CHIP**	**Medicare**	**Other Third Party**
Access Health Louisiana	Luling	99%	90%	32%	41%	8%	19%
Baton Rouge Primary Care Collaborative, Inc.	Baton Rouge	97%	88%	36%	47%	8%	9%
C A S S E Dental Health Institute	Mansfield	82%	70%	13%	76%	3%	8%
Capitol City Family Health Center, Inc.	Baton Rouge	96%	73%	37%	40%	8%	15%
Catahoula Parish Hospital District # 2	Sicily Island	99%	87%	49%	19%	16%	16%
Common Ground Health Clinic	New Orleans	98%	84%	50%	36%	4%	10%
David Raines Comunity Health Center, Inc.	Shreveport	99%	93%	28%	49%	7%	16%
Excelth Inc.	New Orleans	97%	65%	41%	47%	6%	6%
H I V/ A I D S Alliance for Region Two Inc.	Baton Rouge	95%	75%	9%	39%	18%	33%
Hospital Service District No. 1-A of the Parish of Richland	Delhi	97%	66%	15%	36%	24%	25%
Iberia Comprehensive Community Health Center	New Iberia	79%	65%	36%	38%	10%	16%
Innis Community Health Center, Inc.	Innis	95%	75%	22%	38%	10%	30%
Jefferson Community Health Care Centers, Inc.	Avondale	99%	89%	54%	34%	4%	8%
Jefferson Parish Human Services Authority	Metairie	97%	90%	38%	42%	11%	10%
Marillac Community Health Centers	New Orleans	96%	74%	25%	54%	9%	12%
Morehouse Community Medical Centers, Inc	Bastrop	91%	63%	18%	50%	7%	25%
MQVN Community Development Corp	New Orleans	78%	64%	43%	34%	7%	16%
New Orleans Aids Task Force	New Orleans	88%	68%	40%	15%	10%	35%
New Orleans Health Department	New Orleans	99%	93%	51%	38%	1%	9%
Odyssey House Louisiana, Inc.	New Orleans	100%	98%	80%	11%	3%	7%
Out-Patient Medical Center	Natchitoches	98%	76%	31%	37%	11%	21%
Primary Care Providers for a Healthy Feliciana	Clinton	88%	41%	23%	39%	8%	30%
Primary Health Services Center	Monroe	98%	87%	30%	57%	4%	10%
Priority Health Care	Marrero	100%	100%	10%	19%	7%	63%
Rapides Primary Health Care Center, Inc.	Alexandria	100%	99%	24%	64%	4%	8%
Southeast Community Health Systems	Greensburg	94%	80%	27%	50%	8%	15%
Southwest Louisiana Primary Health Care Ctr, Inc.	Opelousas	97%	83%	33%	50%	8%	9%
St. Gabriel Health Clinic, Inc.	St Gabriel	96%	69%	50%	38%	2%	10%
St. Thomas Community Health Center, Inc.	New Orleans	95%	69%	28%	31%	8%	34%
START Corporation	Houma	100%	95%	4%	64%	29%	4%
SWLA Center for Health Services	Lake Charles	91%	77%	40%	44%	6%	9%
Teche Action Board Inc.	Franklin	95%	68%	46%	26%	16%	12%
Tensas Community Health Center, Inc.	Saint Joseph	99%	84%	35%	40%	6%	19%
Winn Community Health Center, Inc	Winnfield	93%	75%	22%	46%	10%	23%
Source: HRSA, Louisiana 2015 Health Center Profile							

Nearly 100% of patients utilizing the services of state health centers fell below 200% of the poverty level in 2015, and of this population, there was a great deal of variation in the percentage of patients that are uninsured, covered by Medicaid/Medicare or covered by a third party. Across all FQHCs, 33% of patients receiving services in 2015 (Chart 1 below) were uninsured, but there was a considerable range in uninsured patient rates between centers.[11] For example, nearly half of patients receiving services at the New Orleans' Health Department were uninsured in 2015, while only 4% of patients receiving services at the Start Corporation in Houma, LA were uninsured. At 42%, the percentage of health center patients covered by Medicaid is substantially higher, but again, there is considerable variation between centers. For example, nearly two-thirds of 2015 patients receiving services through the Rapides Primary Health Care Center in Alexandria were covered by Medicaid, but only 15% of patients receiving services through the New Orleans Aids Task Force were similarly covered. Last, only 16% of health center patients were covered by a third party, which would include private insurance, but in some cases, this coverage rate was exceptionally high, such as Marrero's Priority Health Care center with a third-party coverage rate of 63%.

[11] Estimates derived from HRSA patient totals.



In light of the primary funding streams for FQHCs at the national level (grants, Medicaid/Medicare & private insurance), it would be safe to claim that those Louisiana FQHCs with relatively high rates for Medicaid covered patients are least vulnerable to any potential funding cuts to grants at the state and local levels. Likewise, given the recent expansion of Medicaid in the state, one would expect for the rate of uninsured patients to substantially decrease as more state residents take advantage of their new eligibility.

Locational Analysis of FQHCs in Louisiana

Given that the objective of FQHCs is to provide services to the underserved and the uninsured, we include a locational analysis of FQHCs in Louisiana. To provide better policy context, we divide the state into the existing Department of Health and Hospitals Administrative Regions (see Figure 1). We then mapped all currently operating FQHCs as well as provider-based rural health clinics, independent rural health clinics, and the only Amerindian 638 facility in Charenton, LA. Our objective in mapping these sites is to overlay them with statewide poverty thereby showing their location in relation to the density of impoverished persons. Using 2012 data, we generated a density map of poverty in the state (see Figure 2). Each dot on the map represents ten people living under the poverty line. We also included tract-level measurements of household income. The shading on the map illustrates the percentage of households in the tract with household incomes less than $25,000.

For this locational analysis, we assume that low income correlates strongly with uninsured status. It is also obviously connected with the availability of new Medicaid coverage with the ACA expansion adopted by the state. We do not have locational information on uninsured status at the level that we do for poverty (at the tract level). So, in order to better portray the location of persons, we relied upon the tract.

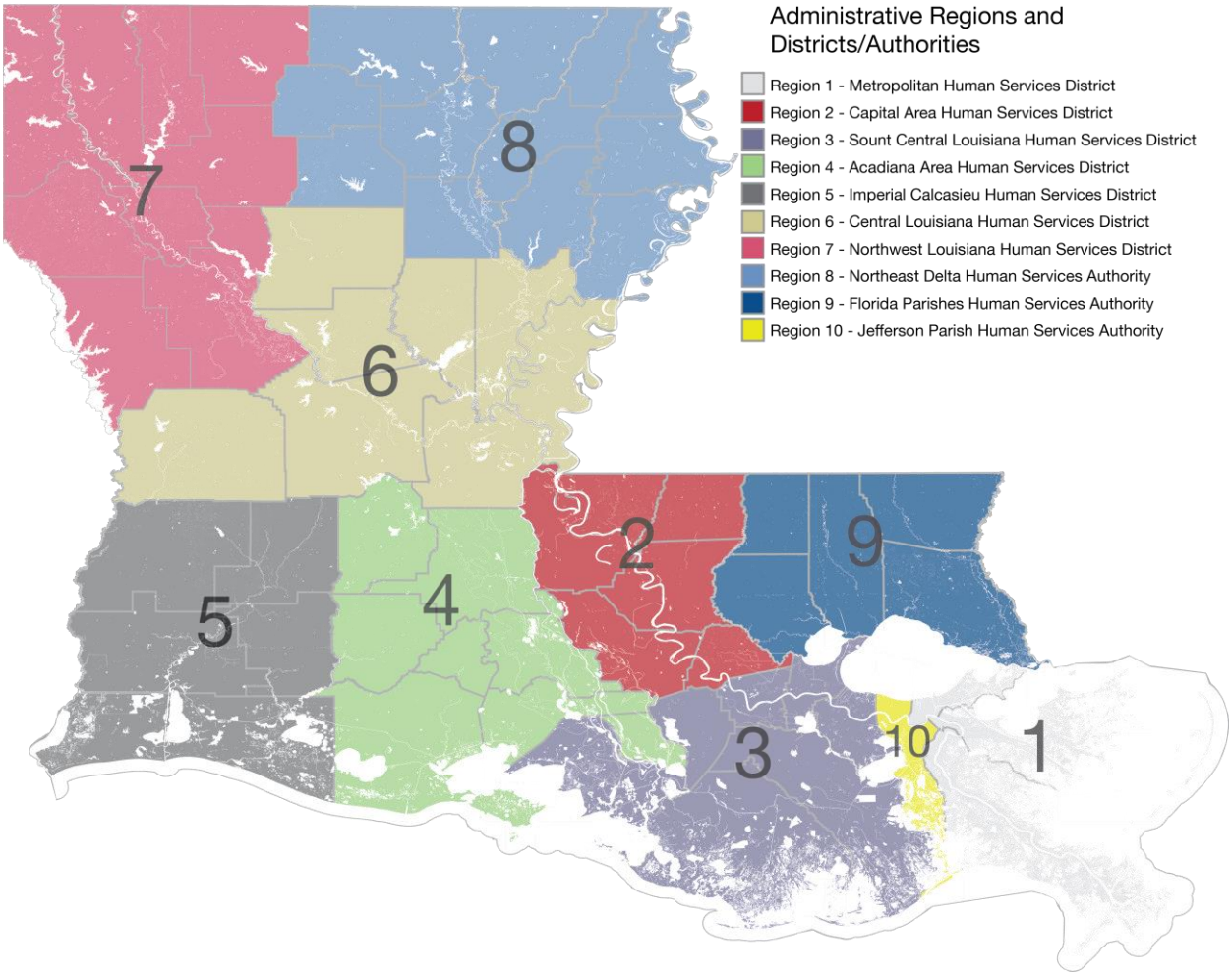


Figure 1. Louisiana DHH Administrative Regions

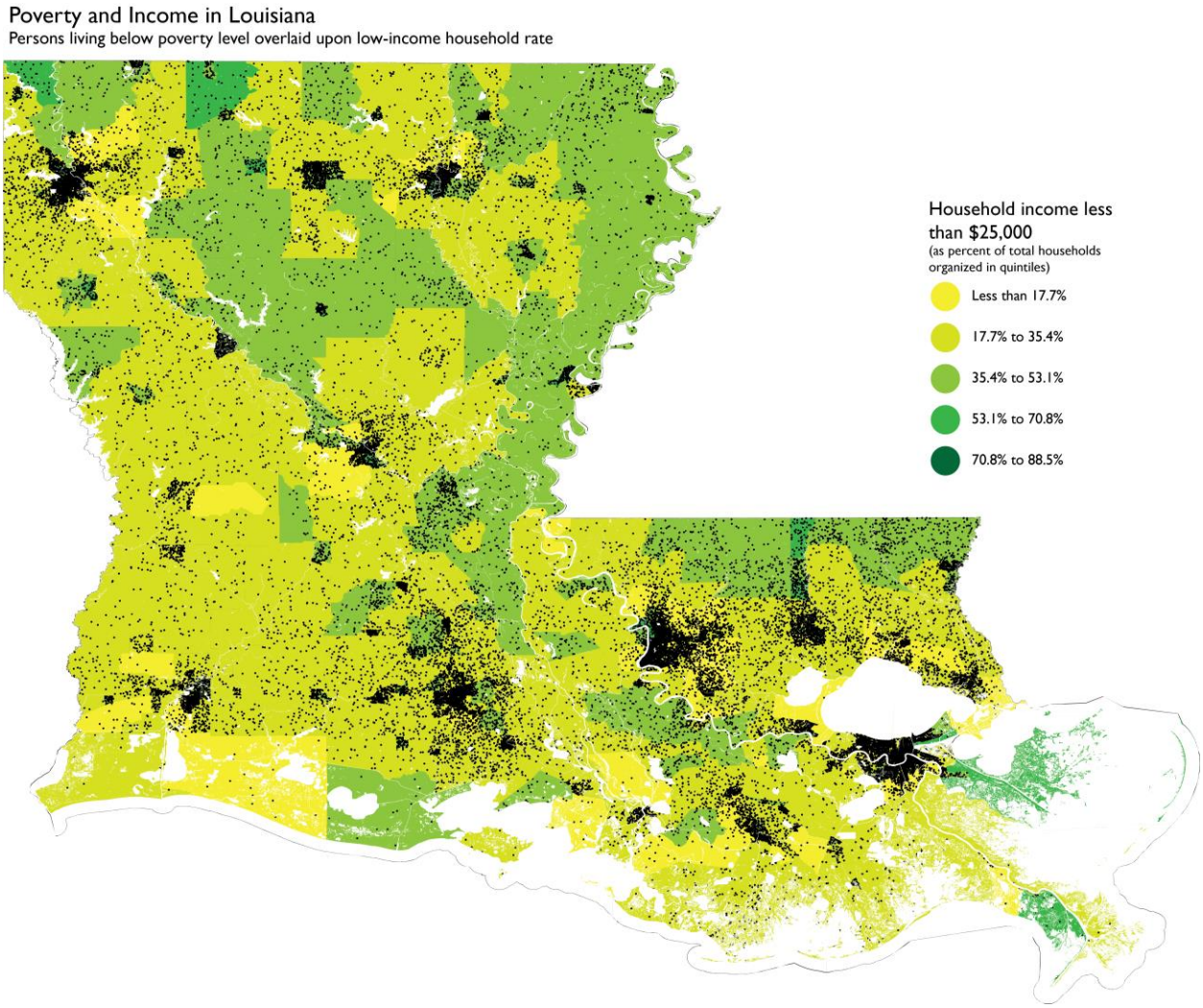


Figure 2. Poverty and Household Income in Louisiana

In order to make the maps more legible, we generated nine maps (Appendix 1) of the ten Administrative Regions (we combined Regions 1 and 10 into one map). Included in the maps are the locations of all FQHCs as well as the Rural Health Clinics throughout the state. A Rural Health Clinic (RHC) differs from an FQHC on five primary criteria.[12] First, an RHC must be located in a non-urbanized area, whereas an FQHC can be located in a rural or urban area. An FQHC must, though, be located so as to provide services to residents in a Medically Underserved Area (MUA) or to a Medically Underserved Population (MUP). A RHC requires current designation (at least three years) of an MUA or a Health Professional Shortage Area (HPSA). Additionally, RHCs can be created in areas that are designated by governors to be a shortage area. RHCs can be unincorporated, public, nonprofit, or for profit in their corporate structure, while an FQHC must be a tax-exempt non-profit or public organization. An RHC does not have any requirement for a Board of Directors, but an FQHC does. Finally, an FQHC does not have any specific

[12] This information is adapted from "Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs" published in revised for in June 2006 by the Health Resources and Services Administration under the U.S. Department of Health and Human Services

clinical staffing requirements, but an RHC requires a mid level provider (MLP) to be at the clinic for at least 50% of the time that the clinic is open.

FQHCs and RHCs also vary in the required scope of services. Table 3 shows that the FQHC requirements are more comprehensive than those of the RHC. This underscores the importance of FQHCs to the local population.

Table 3. Comparison of Required Scope of Services for FQHCs and RHCs

Required Scope of Services		
Criteria	Rural Health Clinic	Federally Qualified Health Center
Primary Health Care Services	Required	Required
Primary Care for All Life-cycle Ages	Not Required	Required on-site or under arrangement
Basic Lab	Six specified tests required on-site, others required on-site or under arrangement	Required on-site or under arrangement
Emergency Care	First response capabilities required	Required on-site or under arrangement
Radiological Services	Required on-site or under arrangement	Required on-site or under arrangement
Pharmacy	Not Required	Required on-site or under arrangement
Preventive Health	Not Required	Required on-site or under arrangement
Preventive Dental	Not Required	Required on-site or under arrangement
Transportation	Not Required	Required by the site or under arrangement
Case Management	Not Required	Required on site or under arrangement
Dental Screening for Children	Not Required	Required on site or under arrangement
After Hours Care	Not Required	Required
Hospital/Specialty Care	Required by clinic staff or under arrangement	Required by clinic staff or under arrangement

Source: "Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs"

Conclusion and Summary Remarks

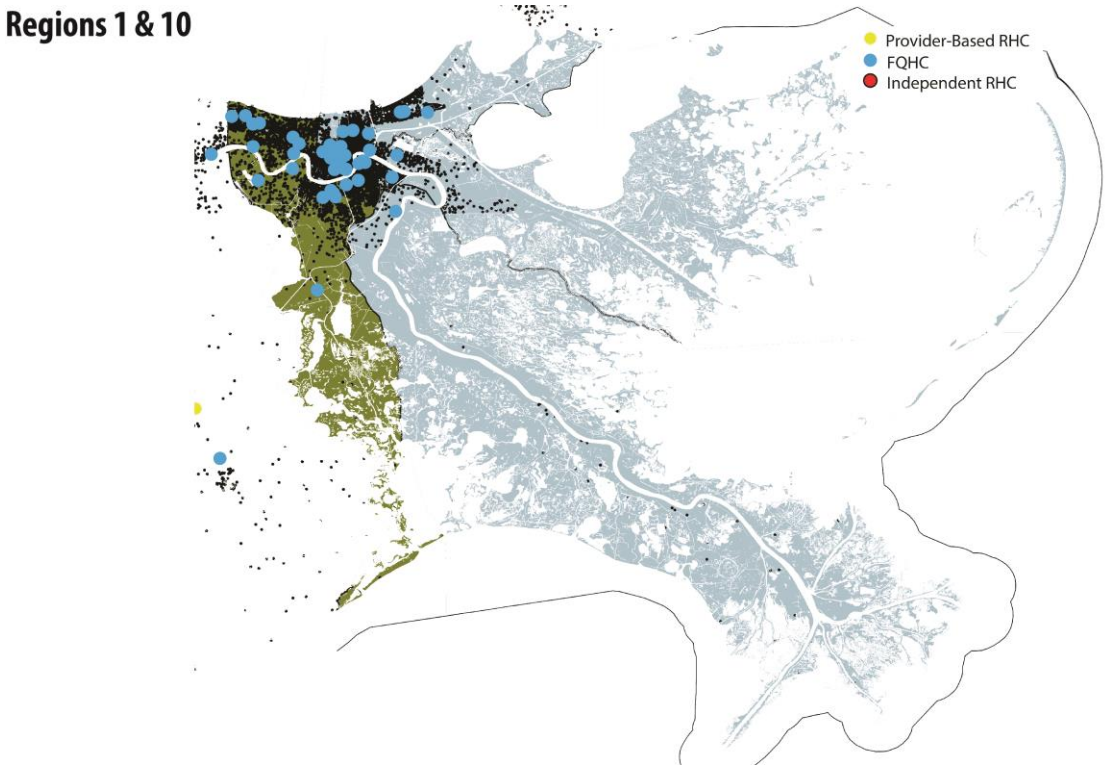
A requested by LPHI, our report has addressed the impact of Louisiana's recent decision to expand Medicaid access upon the state's network of federally qualified health centers (FQHCs). As described above, Louisiana's FQHCs are located across the state, in both rural and metropolitan areas. Overall, in light of the state's decision to expand Medicaid and its impact upon FQHCs in the state, ***we find no evidence of any structural or policy threats to the sustainability of state FQHCs in the near future***. Our summary conclusion is based upon a number of pertinent observations:

- First, while in existence in various forms since the 1960s, FQHCs have been viewed as an integral component of the Affordable Care Act (ACA), and such, received major funding upon the Act's passage. Specifically, Congress initially dedicated $11 billion to strengthen and expand the nation's FQHC network following the passage of the ACA and recently extended this funding source through 2017.

- Second, while FQHCs were initially supported to provide health care services to the uninsured, they have also served as a key provider of services to those covered by Medicaid, Medicare and private insurance. In light this broader role, Louisiana's decision to expand Medicaid will, in all likelihood, increase the percentage of FQHCs patients covered by Medicaid and decrease the percentage of uninsured patients receiving services. Given Medicaid reimbursement rate levels, national data show that FQHCs operating in Medicaid expansion states have higher per patient revenues than those in non-expansion states. All things being equal, we have no reason to expect that FQHCs in Louisiana will not experience a similar benefit.

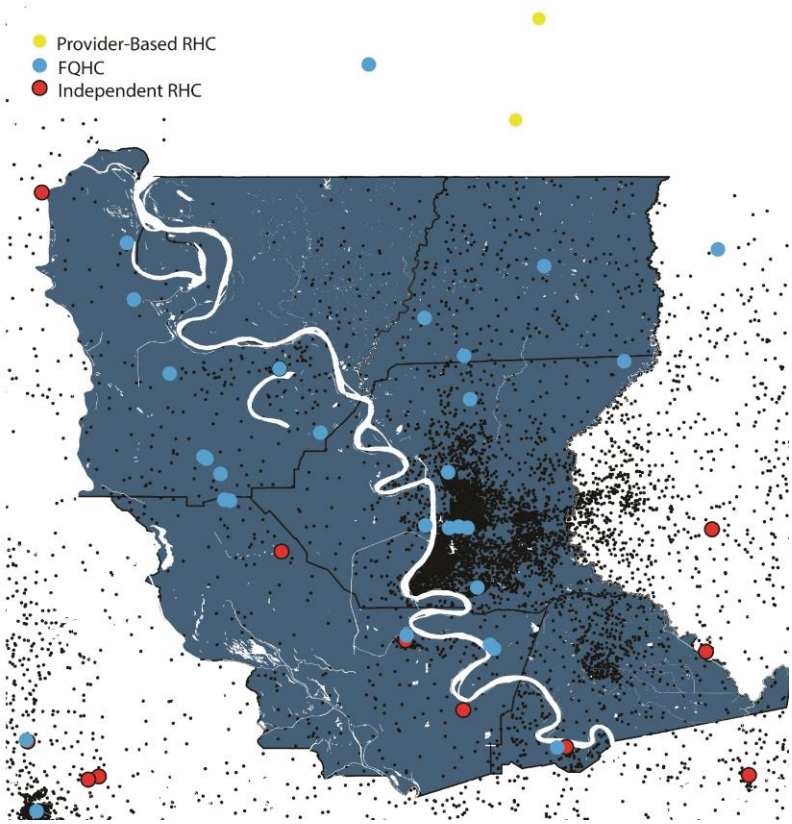
While we are optimistic about near-term prospects for FQHCs in the state, it is prudent to point out that there are a number of macro-level, national factors that could potentially impact the ability of FQHCs to continue to provide their existing services. Namely, any major changes to Medicaid eligibility under the ACA or decreases in federal and state grant funding could impact those FQHCs that disproportionately rely upon such revenue sources.

Appendix 1



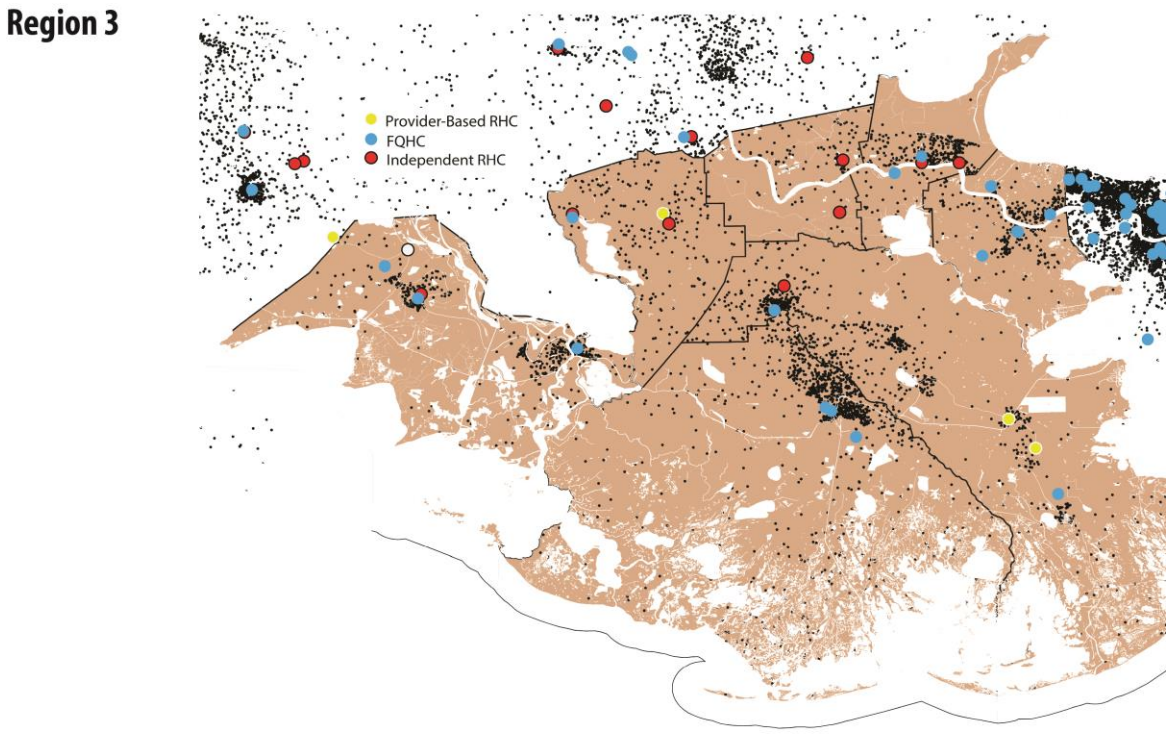
Regions 1 and 10 consist of the **New Orleans area, including Orleans , Plaquemines and St. Bernard Parishes, and Jefferson Parish**. There is a high density of poverty in this area and more FQHCs than any other area. The FQHCs are concentrated in the population centers, but because the parishes around Orleans are designated as urban, there are not any RHCs.

Appendix 1



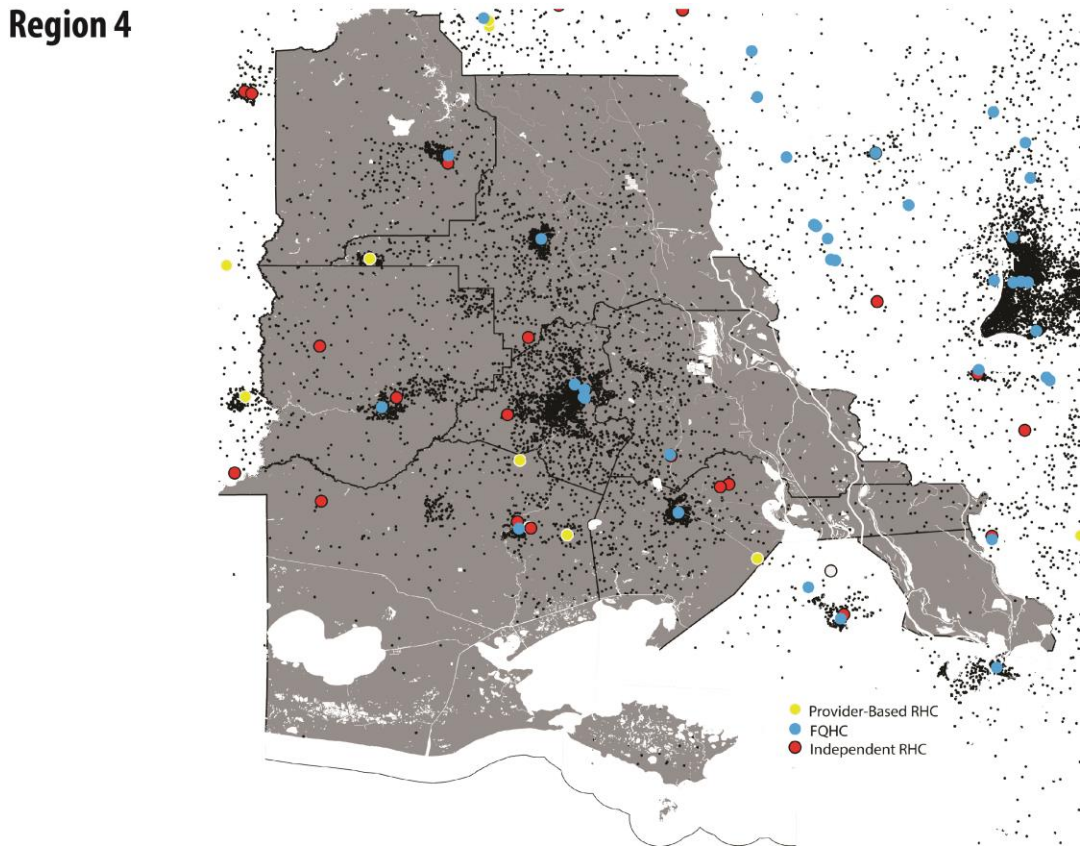
Region 2 covers most of the **Baton Rouge area with the heavily populated areas being Ascension and East Baton Rouge parishes**. Although there is a large population that rivals the New Orleans area, the number of FQHCs is noticeably less dense. Accessibility, especially in the large pockets of poverty in and around the city of Baton Rouge, is questionable in comparison to the services of New Orleans.

Appendix 1



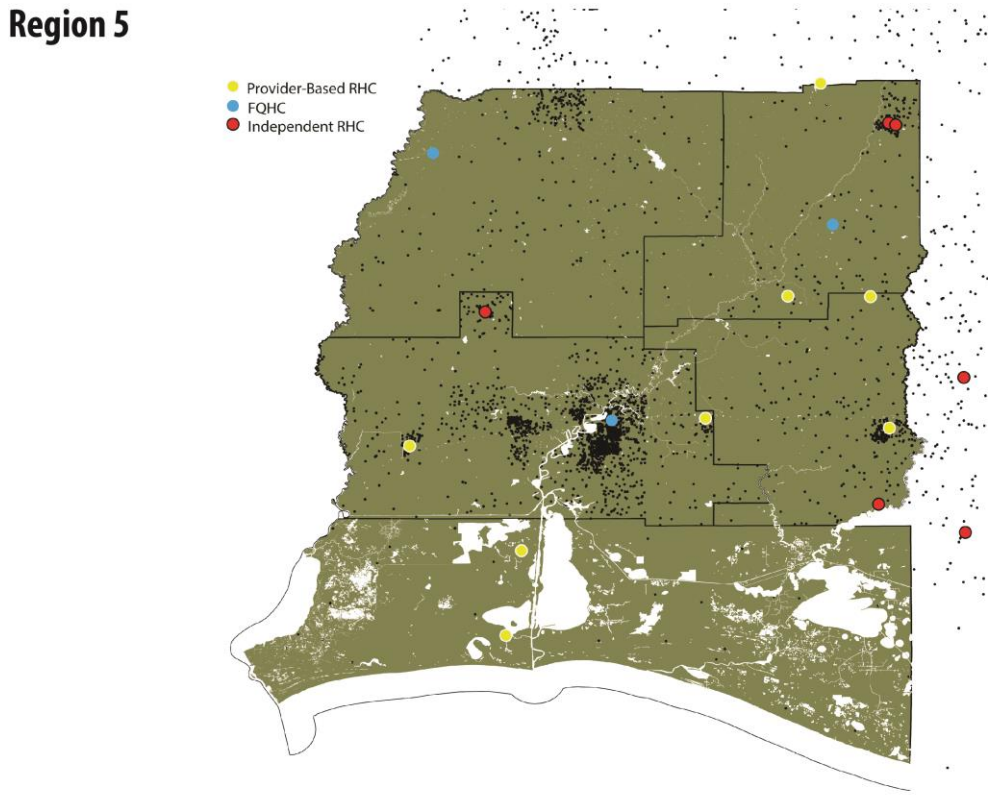
The **Houma-Thibodaux** region, Region 3, is more scattered than the two primary urban areas of the state, Baton Rouge and New Orleans. It consists of more RHCs with FQHCs located near pockets of poverty.

Appendix 1



Region 4, which contains the city of **Lafayette**, is less well served by FQHCs than by RHCs. This suggests a potential, though not necessary, restriction on services available to qualified persons. This is especially evident in the city of Lafayette, where only three FQHCs currently operate.

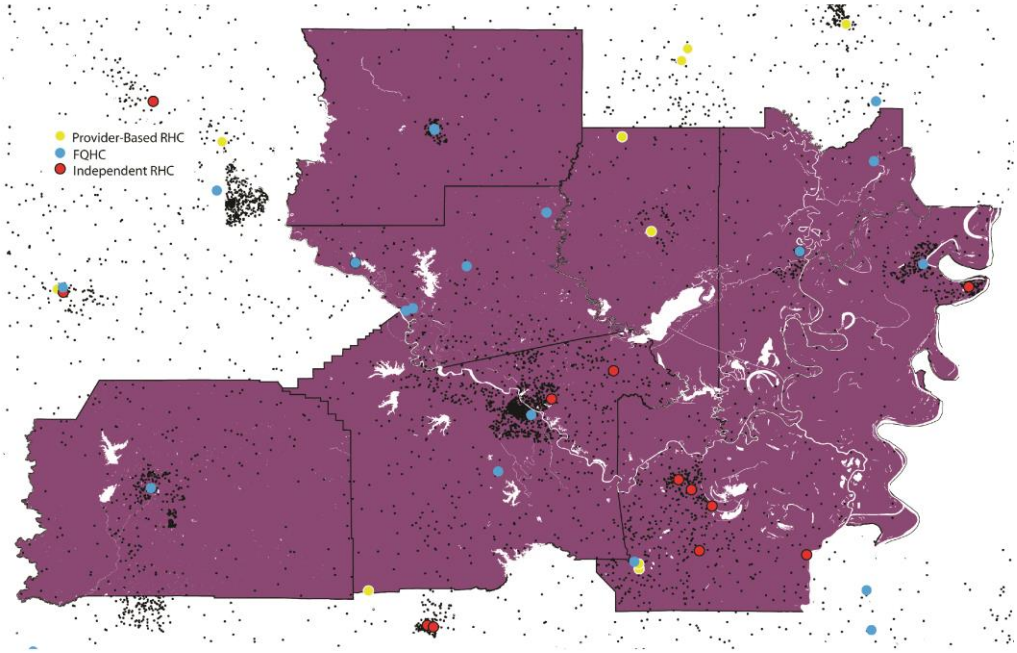
Appendix 1



Region 5 includes the city of **Lake Charles in Calcasieu Parish**. This is an area that is noticeably underserved by FQHCs with very little density of services provided in the pockets of poverty. Most of the area is reliant on RHCs, both provider-based and independent.

Appendix 1

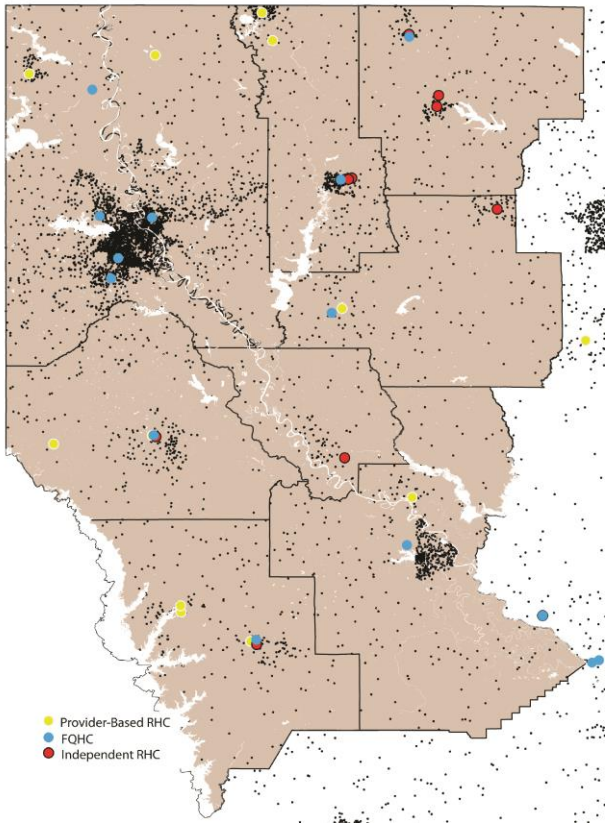
Region 6



Region 6 shows a scattering of FQHCs across the central part of the state, including **Alexandria**. Services in the areas of dense poverty appear to be adequately served and complemented well by the RHCs.

Appendix 1

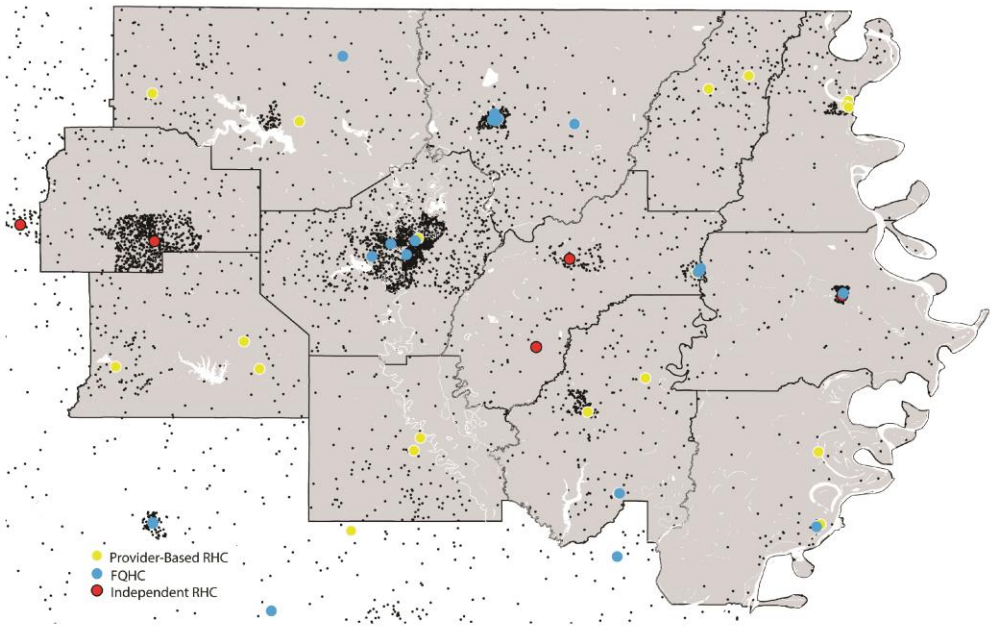
Region 7



Region 7 is another contrast with the high density of clinics in New Orleans. The **Shreveport-Bossier** area has highly dense pockets of poverty with relatively few FQHCs available. Other areas include access to FQHCs along with RHCs.

Appendix 1

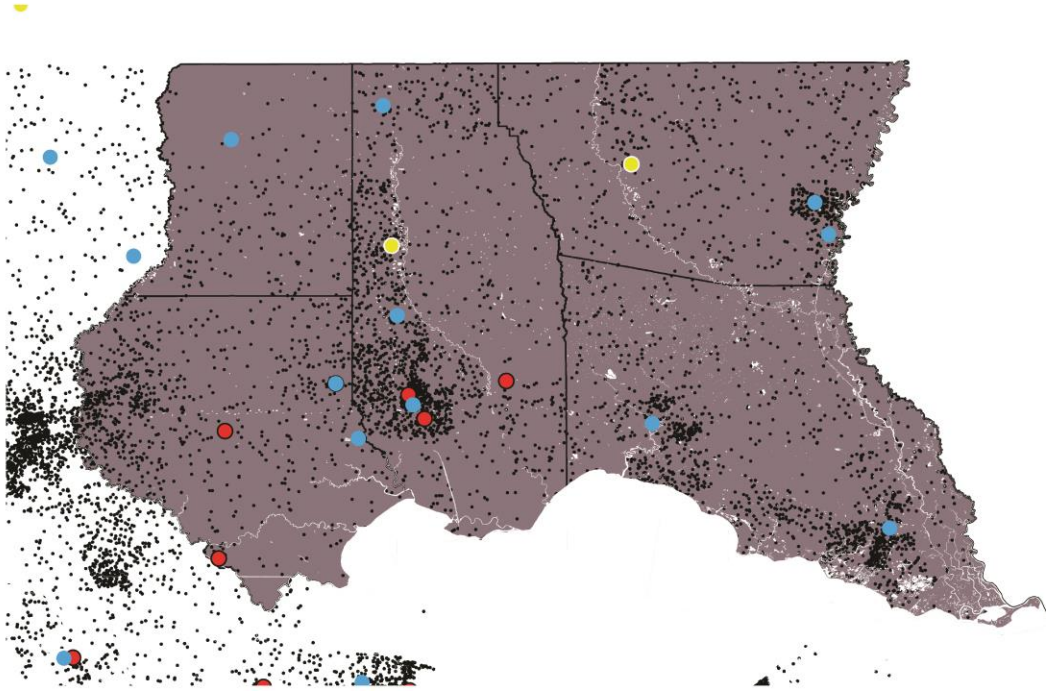
Region 8



Region 8 offers an interesting contrast in itself. The **Monroe** area appears to be fairly well served by FQHCs, but to the west in Ruston, high pockets of poverty are served by a single RHC. Overall, the area is covered by a number of clinics.

Appendix 1

Region 9



Region 9, the **Northshore** area, is a high growth part of the state. Poverty is scattered in the area with some exceptions of relatively dense pockets. The area around Hammond is served variously by RHCs and FQHCs, while parts of St. Tammany are clearly underserved by such clinics, especially compared to the availability across Lake Pontchartrain.

Appendix 1

Map 2. FQHCs in Louisiana (Louisiana Primary Care Association, Inc.)