The Value Proposition:
Evidence of the Health and Economic Contributions of Community Health Centers

Geiger Gibson / RCHN Community Health Foundation
Research Collaborative

Policy Issue Brief #68

August 2022

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy or at www.rchnfoundation.org.

Executive Summary

Community health centers are the backbone of safety net primary and preventive health care services for underserved communities. In 2020, 1,375 health centers served almost 29 million patients. The health center program rests on a financial base consisting of core grant funding under Section 330 of the Public Health Service Act, as well as insurance payments from Medicaid and Medicare. Over 90 percent of health center patients are low income, so health centers rely primarily on the blend of federal grant funding, Medicaid and Medicare.

This analysis reviews the body of evidence that has developed over decades about the health and economic value contributed by community health centers:

- *Targeting populations who would otherwise be underserved for primary care.* Community health centers focus on populations who are traditionally underserved, such as people with low incomes, racial and ethnic minorities, rural and inner-city populations, immigrants, and people experiencing homelessness. Studies document health centers' success in reaching these populations. A recent example is the role played by community health centers during the COVID-19 pandemic, where they have been a central source of medical care, testing, vaccinations, and care to address behavioral and substance use needs for patients in crisis.
- *Quality of care and cost savings.* The evidence shows that health centers are an effective source of primary and preventive care to high need patients, which can avert subsequent health problems and lower the demand for more expensive emergency and inpatient hospital services. Furthermore, numerous studies, spanning decades, demonstrate that health centers reduce overall costs of medical care, which can help stem health care cost growth.
- *Economic and employment effects.* Health centers also help their communities by increasing employment opportunities both inside and outside the health care sector and improving local economic conditions.

Introduction

Community health centers (also known as Federally Qualified Health Centers) are foundational elements of America's safety-net health care system, providing primary health care to about 30 million needy and vulnerable patients. By mission and by law (Section 330 of the Public Health Service Act), health centers provide comprehensive primary and preventive health services, including medical, dental and behavioral care as well as related social services, to children, adults and seniors living in medically underserved communities, regardless of their ability to pay. They offer high-quality comprehensive primary and preventive care to uninsured, Medicaid, Medicare, and other public and privately insured patients in non-profit health centers operating over 13,900 clinics or sites across the United States in 2022.

Community health centers form a health care safety net for patients who need affordable quality health services but because of their insurance status, income, location or health needs, face barriers to getting care from the regular private health care system. Health centers are designed to meet the needs of those who live in rural, suburban or urban areas with an inadequate supply of primary care clinicians, who are uninsured or on Medicaid, or who have complex combinations of health and social needs, such as those who are experiencing homelessness, are migrant agricultural workers, or live in public housing.

Health centers are supported by multiple sources, but core funding comes from grants under Section 330, administered by the Bureau of Primary Health Care, part of the Health Resources and Services Administration. This funding has two main components: a mandatory Community Health Center Fund, currently authorized through Fiscal Year 2023, and additional annual appropriations.[1,2] During the COVID-19 pandemic, Congress provided other supplemental grant funding to support health centers' mission and their pandemic response. Health centers also receive insurance payments for patient care, including Medicaid, CHIP, Medicare, other public insurance, and private health insurance payments, as well as self-payments from patients. Many provide services supported by other federal grants, such as Ryan White HIV/AIDS services, Title X family planning,

or Women, Infants and Children (WIC) nutrition services. State and local grants frequently provide additional funding to support health and social services. In 2020, grants from the Bureau of Primary Health Care covered 18% of total health center revenue, while Medicaid payments provided 40% of their total revenue; other patient revenue, grant/ contract funds, and other revenue financed the rest of the total $34.5 billion in health center revenue.[3]

This brief assesses the value proposition for community health centers in three areas:

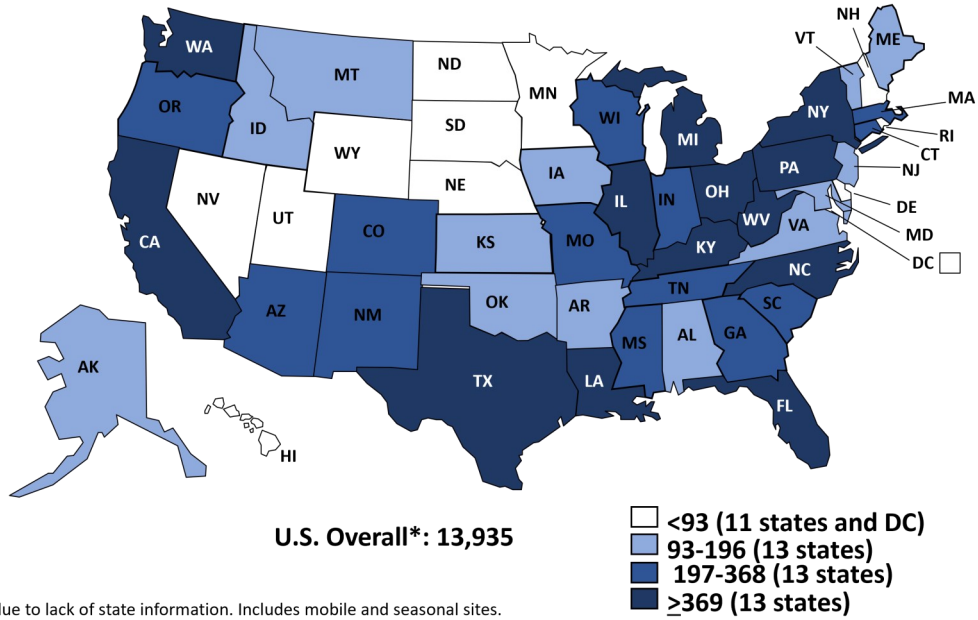
1. *Providing responsive services to meet health needs and promote equity;*
2. *Lowering health care costs by providing timely and efficient primary and preventive care services, thereby sparing the need for more expensive specialty, emergency or hospital care; and*
3. *Creating economic growth and employment opportunities to strengthen communities.*

Providing Responsive Services That Promote Health Equity

For more than a half-century, health centers have cared for tens of millions of vulnerable patients. In 2020, 28.6 million patients were served nationwide.[4]

- 28% are children under age 18, 10% are seniors age 65 or older, while 62% are working age adults ages 18-64; 58% are female.
- 38% are non-Hispanic Whites, 38% are Latinos, 18% are non-Hispanic Blacks, 4% are non-Hispanic Asians and 3% are other/multi-race persons.[5]
- 91% of patients have low incomes, at or below 200% of the federal poverty line.
- 46% are enrolled in Medicaid, 22% are uninsured,

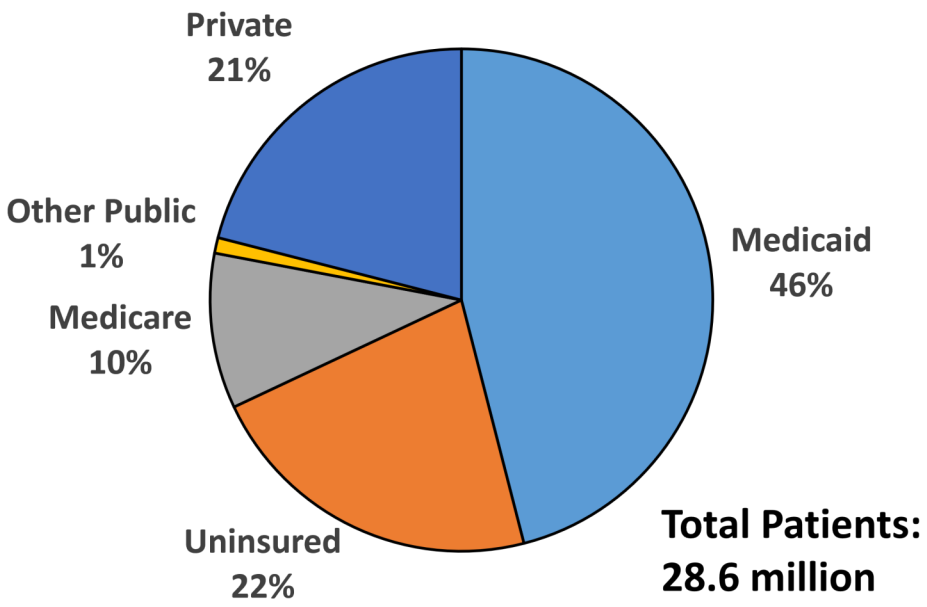
Number of Community Health Center Sites/Clinics by State, 2022



Notes: 20 sites excluded due to lack of state information. Includes mobile and seasonal sites.
Source: GW June 2022 analysis of HRSA grants to health center delivery sites, data available: https://data.hrsa.gov/tools/data-explorer
* There are additional sites in U.S. territories.

[1] National Association of Community Health Centers. Federal Grant Funding. https://www.nachc.org/focus-areas/policy-matters/health-center-funding/federal-grant-funding/
[2] Consolidated Appropriations Act of 2021, P.L. 116-20. https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf
[3] Analyses of Uniform Data System revenue data for 2020.
[4] Bureau of Primary Health Care, National Health Center Program Uniform Data System (UDS) Awardee Data. https://data.hrsa.gov/tools/data-reporting/program-data/national. Accessed June 9, 2022.

Health Insurance Coverage of Health Center Patients, 2020



10% have Medicare, 1% have other public insurance, and 21% have other insurance (e.g., private group or nongroup insurance, health insurance marketplaces, etc.). Low-income patients can get free or low-cost care based on sliding fee scales.

- 18% live in or near public housing, 5% are homeless, and 3% are agricultural workers or their dependents.
- Health center patients are more likely to have more complex health needs and are at higher risk of poor health compared to patients in other ambulatory care settings.[6]

Because they are located in underserved communities, health centers are increasingly tasked to address new threats to the public's health, such as COVID-19, the opioid epidemic and rising mental health problems.

Beginning in 2020, health centers rapidly mobilized to respond to urgent national needs during the COVID-19 pandemic. For example,

- As of June 2022, HRSA reported 20.8 million COVID-19 vaccinations were received by health center patients, of which 69% were administered to racial or ethnic minority patients.[7] Because of health centers' effectiveness in reaching minority patients – who tend to have lower vaccination levels but more serious COVID-19 illness rates – the Department of Health and Human Services relied on their care to support COVID-19 vaccination efforts. [8]
- Soon after the pandemic began, because of social distancing recommendations, health centers had to rapidly pivot to offer telehealth services. By April 2020, more than 50% of health center visits on average were being conducted via telehealth.[9]

[5] Sharac J, Jacobs R, Shin P, Rosenbaum S. The Toll Taken on Poor Communities: Community Health Centers in the First Year of the COVID-19 Pandemic. Geiger Gibson / RCHN Community Health Foundation Research Collaborative. October 2021. https://www.rchnfoundation.org/wp-content/uploads/2021/10/GG-IB-66-Final-October-2021.pdf

[6] Corallo B, Proser M, Nocon R. Comparing rates of Multiple Chronic Conditions at Primary Care and Mental Health Visits to Community Health Centers Versus Private Practice Providers. J Ambul Care Manage. 2020; 43(2):136-147

[7] https://data.hrsa.gov/topics/health-centers/covid-vaccination. Accessed June 9, 2022.

[8] Corallo B, Tolbert J. Biden Wants to Partner with Health Centers to Promote More Equitable Access to COVID-19 Vaccines. Kaiser Family Foundation. Feb. 9, 2021. https://www.kff.org/policy-watch/biden-wants-partner-with-health-centers-promote-more-equitable-access-covid-19-vaccines/

Since then, health centers have resumed in-person visits and as of June 2022, only 15% of visits were via telehealth, but telehealth capacity has become integral to meeting patients' needs.[10]

- Two-thirds (64%) of health centers added new substance use or mental health services, such as medication-assisted treatment for opioid use disorder, in response to these mental health and substance use disorder needs.[11]
- The expansion of behavioral health services enabled health centers to provide mental health services to 40% more patients and to more than twice as many patients needing substance use disorder treatment services in 2020, compared to 2016. [12]

Health centers have also been important in revitalizing health care services and providing other necessary relief to foster recovery for communities and populations hard-hit by other types of disasters, such as Hurricanes Maria or Katrina.[13, 14]

Despite these achievements, limited funding and staffing mean that the demand for care often outstrips the supply. Patients must often wait for scheduled appointments at health centers, although many can accommodate some patients as "walk-in" appointments for urgent or unexpected care needs.[15] While health centers have managed to recover from temporary closures and limits created by the COVID-19 pandemic, they have experienced difficulties maintaining adequate staffing during the period of the nationwide "Great Resignation." A March 2022 report found high levels of staff attrition: 68% of health centers reported losing 5 to 25% of their workforce in the previous six months.[16]

Lowering Health Care Costs Through Primary and Preventive Care

At its heart, the value proposition for community health centers is that timely, high-quality primary and preventive care provided to vulnerable, underserved patients prevents more serious conditions and the need for expensive acute care. Timely vaccinations can help to prevent COVID-19 or flu infections or reduce the severity of diseases when infections occur. Effective prevention, detection and management of chronic diseases like diabetes or asthma enable people to lead healthier, symptom-free lives and prevent emergency room visits or inpatient hospitalizations. Accessing critical contraception and family planning services promote reproductive health and overall health and wellbeing. Getting eyeglasses can help people with poor vision see better for school or work. Helping a person experiencing homelessness find behavioral care or housing can prevent serious health problems related to homelessness. Having access to preventive dental care can reduce the need for

[9] Sharac, J. et al. (2022). Data Note: Community Health Centers' Response to the COVID-19 Pandemic: Two-Year Findings from HRSA's Health Center COVID-19 Survey (April 2020—April 2022). https://www.rchnfoundation.org/?p=10041

[10] Sharac J, Stolyar L, Corallo B, et al. How Community Health Centers Are Serving Low-Income Communities During the COVID-19 Pandemic Amid New and Continuing Challenges. Kaiser Family Foundation. Jun. 3, 2022, https://www.kff.org/report-section/how-community-health-centers-are-serving-low-income-communities-during-the-covid-19-pandemic-amid-new-and-continuing-challenges-issue-brief/

[11] *Ibid.*

[12] Bureau of Primary Health Care. UDS Data Five-Year Summary. 2016-2020. https://data.hrsa.gov/tools/data-reporting/program-data/national. Accessed June 9, 2022.

[13] Sharac J, Rosenbaum S, Tolbert J, et al. The Recovery of Community Health Centers in Puerto Rico and the US Virgin Islands One Year after Hurricanes Maria and Irma. Sep 19, 2018. https://www.kff.org/report-section/the-recovery-of-community-health-centers-in-puerto-rico-and-the-us-virgin-islands-one-year-after-hurricanes-maria-and-irma-issue-brief/

[14] Todd S. 10 years after Katrina, New Orleans has transformed primary care, behavioral health. Modern Healthcare. August 27, 2015. https://www.modernhealthcare.com/article/20150827/NEWS/150829878/10-years-after-katrina-new-orleans-has-transformed-primary-care-behavioral-health

[15] Sharac J, Stolyar L, Corallo B, et al. How Community Health Centers Are Serving Low-Income Communities During the COVID-19 Pandemic Amid New and Continuing Challenges. Kaiser Family Foundation. Jun. 3, 2022, https://www.kff.org/report-section/how-community-health-centers-are-serving-low-income-communities-during-the-covid-19-pandemic-amid-new-and-continuing-challenges-issue-brief/

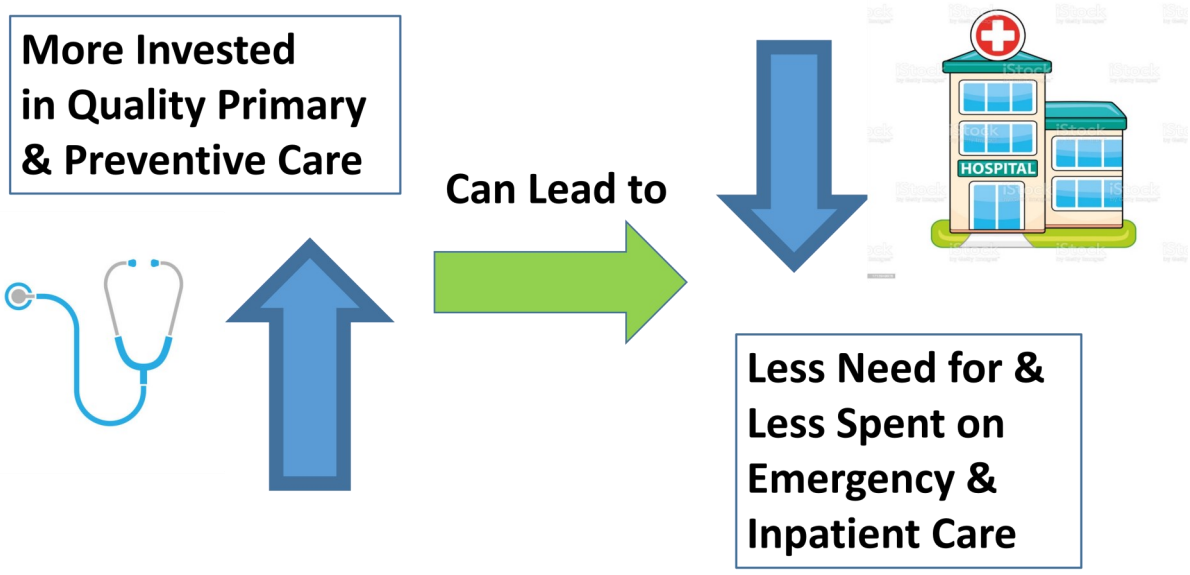
[16] National Association for Community Health Centers. Current State of the Health Center Workforce:
Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future. March 2022. https://www.nachc.org/wp-content/uploads/2022/03/NACHC-2022-Workforce-Survey-Full-Report-1.pdf

emergency care visits.[17]

Research about High-Quality Care

These services provided by health centers are particularly valuable because so many vulnerable health center patients would face substantial barriers to care if health centers were not available in their communities. Over the years, numerous researchers have documented that health centers provide high-quality care and that access to primary and preventive care can reduce the need for far more expensive emergency room or inpatient hospital services. The evidence from these studies consistently shows health centers' impact on access to quality care:

- Research conducted over 40 years ago showed that health centers were the usual source of care for many patients in low-income areas and reduced the need for care from more expensive hospital outpatient departments. Health center patients had lower rates of admission for inpatient hospital care than non-users.[18]
- In 1994, noted primary care expert Barbara Starfield of Johns Hopkins University found that the quality of care provided at health centers compared favorably with care received at private doctor's offices or hospital outpatient departments but was more affordable.[19]
- A 2001 study found that Medicaid patients receiving care at health centers had fewer emergency room visits and hospitalizations for conditions that could be prevented through adequate primary and preventive care (e.g., asthma, diabetes) than patients getting care elsewhere.[20] Subsequent research reinforced these findings.[21]
- Analyses of National Health Interview Survey data have found that, despite having poorer health, health center patients fared better than patients seen in other settings for services such as seeing a primary care doctor, receiving mammograms and getting advice about exercise, whether the patients were uninsured or covered by Medicaid.[22]



[17] National Association of Community Health Centers and Care Quest Institute for Oral Health. Oral Health Value-Based Care: The Federally Qualified Health Center (FQHC) Story. Boston, MA: August 2020.
[18] Okada LM, Wan T. Impact of community health centers and Medicaid on the use of health services. *Public Health Rep*. Nov-Dec 1980;95 (6):520-34.
[19] Starfield B, Powe N, Weiner J, et al. Costs vs quality in different types of primary care settings. *JAMA*. 1994 Dec 28;272(24):1903-8.
[20] Falik J, Needleman J, Wells B, Korb J. Ambulatory care sensitive hospitalizations and emergency visits: experiences of Medicaid patients using federally qualified health centers. *Med Care*. 2001 Jun;39(6):551-61.
[21] Falik J, Needleman J, Herbert R. et al. Comparative effectiveness of health centers as regular source of care: application of sentinel ACSC events as performance measures. *J Ambul Care Manage*. 2006, 29(1):24-35
[22] Shi L, Stevens G. The Role of Community Health Centers in Delivering Primary Care to the Underserved: Experiences of the Uninsured and Medicaid Insured. *J Ambul Care Manage*. 2007. 30(2): 159–170

- Research in Colorado found that Medicaid patients who regularly used community health centers had fewer emergency room visits, preventable admissions and inpatient hospitalizations than those using private fee-for-service physician offices. [23]
- Electronic health record data that followed the progress of health center patients over two years showed that their health status improved over time, and measures such as hemoglobin A1c or blood pressure readings documented that their diabetes and hypertension were better managed over time for both uninsured and insured patients. Those who also gained Medicaid coverage fared even better.[24]

Research about Health Care Cost Savings

While health center patients are often at higher risk, a number of studies document that care received at community health centers helps lower the total cost of medical care by providing the types of primary and preventive services that reduce the need for costlier medical care such as preventable emergency room and hospital care. Further increasing access to health centers can help "bend the cost curve" of ever-rising health care cost increases. Some of the evidence that health center patients have a lower total cost of care than patients who receive primary care elsewhere include:

- In 1993, Ben Duggar and his associates analyzed Medicaid patients in California and found that regular health center users showed 33% lower overall Medicaid expenditures than non-users, excluding maternity visits.[25] Similar analyses conducted for New York found that health center users had 26% lower Medicaid expenditures.[26]
- A 2006 report examining health center care for Michigan Medicaid patients found that health center patients had 10% lower per person per month health care costs than those served by traditional private providers.[27] A 2014 follow-up reached a similar conclusion and found that total cost of care for all services - including inpatient, outpatient, ER, and pharmacy - was 8.4% lower for Medicaid enrollees whose source of primary care was at a health center than for non-health center patients.[28]
- Robert Nocon and his colleagues examined Medicaid claims from 13 states.[29] They used sophisticated statistical methods (propensity score matching methods that seek to emulate the effect of randomized experiments) and found that when compared to patients getting primary care from other settings, health center patients had total health care costs that were 24% lower. More specifically, health center patients had fewer visits to specialists and required less inpatient care.
- Research by Mukamel et al. evaluated cost savings by Medicare patients using health centers compared to other types of care.[30] They found that median annual total medical costs for health center patients were 10% lower than for those receiving primary care at private physicians' offices and 30% lower than for those getting care at outpatient

[23] Rothkopf J, Brookler K, Wadhwa S, Sajovetz M. Medicaid patients seen at federally qualified health centers use hospital services less than those seen by private providers. *Health Affairs*. 2011 Jul;30(7):1335-42.

[24] Hatch H, Marino M, Killerby M, et al. Medicaid's Impact on Chronic Disease Biomarkers: A Cohort Study of Community Health Center Patients. *J Gen Intern Med*. 2017. 32(8):940–7

[25] Duggar B, et al. Utilization and Costs to Medicaid of AFDC Recipients in California Served and Not Served by Community Health Centers. Center for Health Policy Studies. Bureau of Primary Health Care. 1993. Cited by S Streeter, et al. The Effect of Community Health Centers on Healthcare Spending & Utilization. Avalere Health. 2009. http://nachc.org/wp-content/uploads/2015/06/CELitReview.pdf

[26] Duggar B, Keel K., Balicki B, Simpson E). Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers. Center for Health Policy Studies. Bureau of Primary Health Care. 1994. Also cited by Streeter, et al,. 2009.

[27] McRae T, Stampfly RD. An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan. East Lansing: Institute for Health Care Studies at Michigan State University. 2006. Cited by Mundt and Yuan, see next reference.

[28] Mundt C, Yuan S. An Evaluation of the Cost Efficiency of Federally Qualified Health Centers (FQHCs) and FQHC 'Look-Alikes' Operating in Michigan. Institute for Health Care Studies at Michigan State University. 2014. https://cdn.ymaws.com/www.mpca.net/resource/resmgr/cost_efficiency_study_2014/Cost_effectiveness_fullrepor.pdf

[29] Nocon R, Lee S, Sharma R, et al. Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings. *Am J Public Health*. 2016; 106:1981–1989.

Summary of Community Health Center Savings Studies

Study	CHC Population	Cost-Savings
Duggar et al, 1993	California Medicaid Patients	33%
Duggar et al, 1994	New York Medicaid Patients	26%
McRae & Stampfly, 2006	Michigan Medicaid Patients	10%
Richard et al, 2012	National Population	24%
Mundt & Yuan, 2014	Michigan Medicaid Patients	8%
Mukamel et al, 2016	14 States Medicare Patients	10%
Nocon et al, 2016	13 States Medicaid Population	24%
Bruen & Ku, 2019	National Population Children	35%
Nocon (not yet published)	Adult Medicaid Patients	15%

hospital settings.

- In 2012, George Washington University researchers examined medical expenditures for regular health center users in a nationally representative survey, including those covered by various forms of insurance. They found health center users' total annual health expenditures were 24% lower than non-users and that ambulatory care costs were 25% lower.[31]
- A 2019 follow-up by Bruen and Ku updated that study using more recent data and more sophisticated propensity score methods. The analysis found that children using health centers had 35% lower annual medical expenditures; analyses suggested that adults using health centers also had substantial savings, although those results were not statistically significant due to limited sample sizes.[32]
- At a conference in February 2022, Robert Nocon presented new (not yet published) findings from researchers at the University of Chicago about the financial performance of community health centers.[33] Using Medicaid claims data, they compared utilization and expenditures for health center patients and similar patients receiving care at physicians' offices and hospital outpatient clinics. For both child and adult patients, they found lower total costs and similar or better levels of quality. For adults, total costs were 15% lower for health center patients. Though health center patients used more primary care, they used less outpatient hospital, emergency room and inpatient care and had fewer preventable hospitalizations.

This body of research consistently shows that by providing timely and high-quality primary and preventive care to vulnerable patients living in medically underserved areas, health centers help avoid unnecessary high-cost care, including emergency room and hospital care, thus lowering total annual medical expenditures and contributing to efforts to

[30] Mukamel D, White L, Nocon R, et al. Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings. *Health Serv Res*. 2016; 51(2): 621-44.
[31] Richard P, Ku L, Dor A, Tan E, Shin P, Rosenbaum S. Cost Savings Associated with the Use of Com. *J Ambul Care Manage*, 2012; 35(1): 50-59.
[32] Bruen BK, Ku L. The Effects of Community Health Center Care on Medical Expenditures for Children and Adults: Propensity Score Analyses. *J Ambul Care Manage*. 2019; 42(2): 128-37
[33] Nocon R. Research on Health Center Value and Financial Performance. Presented at the NACHC Policy and Issues Virtual Conference. Feb. 14, 2022.

slow the growth of health care expenditures. More importantly, the research shows that effective primary care can help manage and reduce the occurrence of serious chronic diseases, like diabetes or hypertension, that create poor health and raise medical costs.

These studies do not include new data during the COVID-19 pandemic. The value of health centers' contributions to COVID-19 vaccinations, treatment, and testing likely further increases the medical cost savings attributable to health centers.[34]

What makes these cost-savings studies even more impressive is that their results are evident despite the fact that Medicaid, CHIP and Medicare pay health centers at an enhanced rate, using a special prospective payment system (PPS) rate required under law that approximates the cost of care and that can result in payment rates that may be higher than the rate for comparable services when furnished in traditional office settings.[35] Using PPS as an overall framework, states and health centers can create alternative payment methodologies that are designed to promote cost-efficiency while also giving health centers greater flexibility to adapt their care to address the wide range of medical, dental, behavioral, and health-related social needs and promote quality strategies such as greater use of group visits and telehealth.[36]

The PPS payment system was developed to ensure that grant funds intended to cover costs for uninsured patients, such as Section 330 funds, are not diverted to help pay for Medicaid patients, and also recognizes the broader scope of behavioral and other supportive services (such as health education, social, case management, and language services) often provided at health centers. These additional services are designed to help address social determinants of health by assessing and seeking to mitigate underlying causes of poor health such as poor nutrition or housing insecurity. Even accounting for the often-higher public insurance payment rates (compared to payments made to private physician offices), health centers are effective in reducing overall health care costs for their patients.

An additional factor that may explain savings is that health centers efficiently use their most precious resource: health care staff. Because clinical and support staff recruitment and retention in medically underserved rural and urban communities is so challenging, health centers use innovative staffing approaches and more fully utilize the skills of less costly non-physician primary care providers, such as nurse practitioners and physician assistants, as well as other medical staff like nurses and medical aides, and amplify their role in providing care.[37, 38] Other research has found that non-physician clinical professionals working in health centers and caring for patients with health problems such as diabetes and hypertension furnish care equal in quality to, but less expensive than, physician care.[39] Other research has confirmed that effective use of non-physician staff helps to control health center costs.[40] Innovative health care staffing patterns contribute to the efficiency and cost-effectiveness of health centers.

[34] Schneider E, Shah A, Sah P, et al. Impact of U.S. COVID-19 Vaccination Efforts: An Update on Averted Deaths, Hospitalizations, and Health Care Costs Through March 2022. Commonwealth Fund. April 2022. https://www.commonwealthfund.org/blog/2022/impact-us-covid-19-vaccination-efforts-march-update

[35] Medicaid and CHIP Payment and Access Commission. Medicaid Payment Policy for Federally Qualified Health Centers. Dec. 2017. https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf

[36] Rosenbaum S, Sharac J, Shin P, Tolbert J. Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained. Kaiser Family Foundation. Mar. 26, 2019. https://www.kff.org/report-section/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained-issue-brief

[37] Ku L, Frogner B, Steinmetz E, Pittman P. Community Health Centers Use Diverse Staffing and Can Provide Lessons for Other Medical Practices. *Health Affairs* 2015; 34(1):95-103.

[38] Masselink L, Pittman P, Houterman C. Using a New Evidence-Based Health Workforce Innovation Research Framework to Compare Innovations in Community Health Center and Other Ambulatory Care Settings. GW Health Workforce Research Center. Nov. 2015. https://www.gwhwi.org/uploads/4/3/3/5/43358451/report_evidence-based_innovation_framework.pdf

[39] Luo Q, Dor A, Pittman P. Optimal staffing in community health centers to improve quality of care. *Health Serv Res*. 2021 Feb;56(1):112-122.

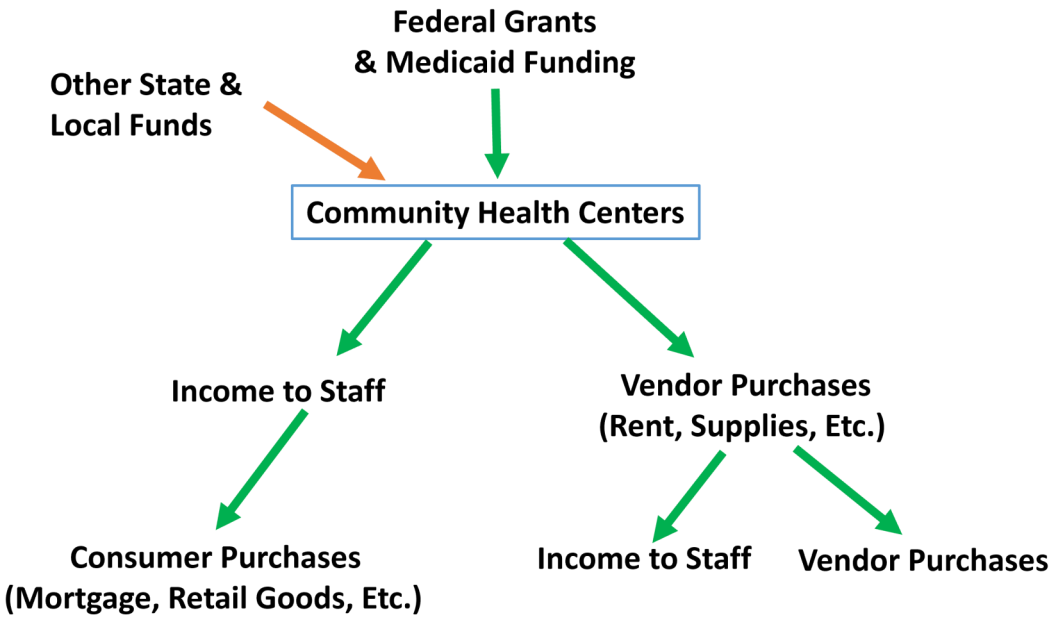
[40] Jung D, Huang E, Mayeda E, et al. Factors associated with federally qualified health center financial performance. *Health Serv Res*. 2022. DOI: 10.1111/1475-6773.13967

Creating Economic Growth and Employment Opportunities in Communities

In addition to providing health services, health centers are major employers and contribute to the economies of their communities. In 2020, health centers nationwide employed 255,000 full-time-equivalent people (even more individuals are employed, since some work part-time).[41] They employ highly-skilled clinical staff, such as physicians, dentists and nurse practitioners, as well as non-clinical staff, such as receptionists, patient support staff, enabling services staff like community health workers, case managers and interpreters and finance and information technology staff. Health centers often offer career development or career ladder programs to advance the skills and credentials of their staff, which creates better jobs and employment opportunities in their communities.[42]

Because community health centers attract a substantial amount of federal funding to their communities and because of the "economic multiplier" effect, health centers strengthen both employment and economic growth.[43] One level of direct impact is the revenue to the health centers and their employment of over a quarter of a million personnel. These staff members use their incomes to pay rent or mortgages, and to purchase transportation, food, and other consumer goods, providing a second level of economic impact in their communities as revenue flows to real estate firms, manufacturers, grocery stores and other businesses. Health centers also purchase goods and services in their communities, providing revenue to other vendors who, in turn, use that revenue to pay their

The Multiplier Effect: Community Health Centers Boost Local Economies & Employment



Health centers attract federal and other funds for health care.

Centers hire staff and purchase goods & services from other community businesses, who also hire workers.

Workers buy consumer goods that support yet other businesses, bolstering jobs and local economies.

[41] Analyses of Uniform Data System revenue data for 2020.

[42] Aysola J, Groves D, Hicks LS. Health Center Professional Programs and Primary Care Workforce. J Fam Med Community Health. 2015;2 (8):1063.

[43] Whelan E. Testimony to the House Democratic Steering and Policy Committee. Community Health Centers: Engines of Economic Activity and Job Creation. March 31, 2011. https://www.americanprogressaction.org/article/community-health-centers-engines-of-economic-activity-and-job-creation/

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workers, and so on.

The cumulative impact is substantial. For example, in 2017, an economic impact study estimated that if $3.6 billion in mandatory federal funding for health centers was not provided, this would have led to $7.4 to $15.6 billion in economic losses (state gross product) to states and their communities, as well as the loss of 76,000 to 161,000 jobs.[44] The analysis indicated that more than half of the jobs lost are outside the health sector; that is, the jobs lost occur in retail stores, construction companies, financial firms, and other sectors in those communities, not just in the health centers themselves.

Other analyses yielded similar findings. Capital Link estimated that, in 2014, health centers accounted for 170,000 jobs in health centers plus 169,000 more in other sectors. Collectively, they generated $45.6 billion in state and local economic impact and helped raise $5.8 billion in federal, state and local tax revenues. [45]

An analysis of the economic impact of a single health center in Kansas offers insights into how these impacts are felt within a single community. In 2018, Mercy Hospital, the sole hospital in rural Fort Scott, Kansas closed its doors.[46] In the wake of its closure, a nearby community health center, Community Health Center of Southeast Kansas, stepped in to expand health services in Fort Scott, taking over the hospital building and many of its clinics. Not only did the health center's expansion preserve health care access for the residents of that rural town, the transformation allowed the health center to increase its patient caseload from 47,000 in 2018 to 65,000 by 2021 and to contribute $12.4 million in economic growth to the community, adding 109 jobs in health care and 40 other community jobs.

Conclusion

For decades, community health centers have demonstrated their value to the nation, to the communities they serve, and to millions of health center patients. They provide a much-needed health care safety net for patients by providing vital services to vulnerable Americans in rural, suburban and urban communities across the nation. Health centers have also proven resilient and innovative in responding to changing health needs, such as the opioid epidemic, the COVID-19 pandemic and even natural disasters like hurricanes.

Through a carefully developed and managed system, these nonprofit health centers provide efficient and necessary care to almost 30 million patients nationwide. At the core of this system is federal funding provided under Section 330 of the Public Health Service Act, supplemented by insurance payments from Medicare, Medicaid, CHIP, other public insurance, and private health insurance.

Continued support for community health centers not only helps the millions of patients served nationwide, improves health and enhances health equity, but also helps to lower total health care costs and invigorates the economies of their communities.

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