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**Geiger Gibson /
RCHN Community Health Foundation Research Collaborative**

Policy Research Brief # 21

**The Health Care Access and Cost Consequences of Reducing
Health Center Funding**

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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 School of Public Health and Health Services 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, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of 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 www.gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Executive Summary

For over four decades, community health centers have served a critical role in providing affordable access to quality care to some of the nation's most vulnerable populations. Health centers have historically enjoyed broad bipartisan support, based on the evidence documenting their high quality care, crucial role in both urban and rural communities, and ability to "bend the cost curve."¹

On February 20, 2011, the U.S. House of Representatives voted to reduce discretionary health center funding by \$1.3 billion in FY 2011 alone. Although the spending bill was rejected by the U.S. Senate on March 10, 2011, final spending measures for health centers are yet to be determined. If other proposals to reduce health center funding are enacted into law, they would effectively undo health centers' ability to grow, as envisioned under the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA). This brief discusses the consequences on access and cost savings of reducing federal funding.

Building on our prior analyses of the impact of both ARRA and ACA on improving the ability of health centers to reach medically underserved communities, we conclude that the proposed \$1.3 billion reduction in health center funding for FY 2011 would significantly reduce health center capacity, eliminating access for between 10 to 12 million patients. Amid concerns of continuing threats to health center funding, we also find health centers are likely to reconsider some expansion efforts and may be unable to meet the increasing demand for care, particularly as coverage is expanded.

Federal investments in health centers under ARRA and ACA were intended to strengthen and expand primary care capacity. The proposed reduction in health center funding would undermine efforts to expand access to quality care for vulnerable populations, reduce health disparities, improve birth outcomes, protect local economies, and save federal and state health care costs. Moreover, we estimate that a \$1.3 billion reduction in FY 2011 health center funding would translate into a loss of approximately \$15 billion in cost savings; put another way, for every one dollar in health center funding reductions, \$11.50 in potential savings is lost as a result of reduced health center capacity to efficiently manage care and reduce avoidable costs.

¹ Ku L., Richard P., Dor A. et al., "Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform," Jun 30, 2010.

Overview

For 45 years, community health centers² have played a critical role in providing affordable access to quality care to some of the most vulnerable populations. Located in low-income communities across urban, rural, and frontier settings, health centers are often the only source of primary care for high-risk, uninsured, underinsured, and uninsurable Americans. In 2009, over 1,100 health centers served nearly 19 million patients, or 1 in 5 low-income persons nationally.³

Because of their location, emphasis on comprehensive, patient centered primary health care, and the populations they serve, health centers have had a particularly strong impact on certain populations and conditions, while also reducing costs:

- Health disparities: Two-thirds of all health center patients are nonwhite, and 90% have family incomes below twice the federal poverty level. The population served by health centers is at special risk for health disparities as a result of low family income, residence in communities with limited access to care, limited English proficiency, and chronic physical and mental health conditions that create a need for ongoing care.⁴ Even after controlling for socio-demographic factors, health centers have been demonstrated to reduce health disparities.⁵
- Children's health and education: Health centers serve as medical homes for nearly 7 million low-income children, or 1 in 5 low-income children nationally.⁶ Health centers also provide behavioral health services, dental, vision and hearing screening, and health education on or near school grounds to nearly 400,000 patients annually,⁷ with associated positive effects on health and behavior that

² The majority of community health centers consist of 1,132 federally-qualified health centers (FQHC) receiving Community Health Center, Migrant Health Center, and Public Housing grants. An additional 100 "look-alike" FQHCs qualify for federal grant funding but do not receive it.

³ In 2009-10, approximately 98 million people had incomes less 200% of the federal poverty level. U.S. Census.

⁴ 1996-2009 Uniform Data System, HRSA.

⁵ O'Malley AS, et al. "Health Center Trends, 1994-2001: What Do They Portend for the Federal Growth Initiative?" March/April 2005 *Health Affairs* 24(2):465-472.; Shin P, Jones K, and Rosenbaum S. *Reducing Racial and Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low-Income Communities*. Prepared for the National Association of Community Health Centers, September 2003; General Accounting Office (GAO). *Health Care: Approaches to Address Racial and Ethnic Disparities*. GAO-03-862R. July 8, 2003.

⁶ In 2009-10, there were approximately 31 million children under 18 years of age living in households with incomes less 200% of the federal poverty level. U.S. Census.

⁷ Juszczak, L., Schlitt, J., & Moore, A. (2007). *National Census School Year 2004-2005*. Washington, DC: National Assembly on School-Based Health Care.

can improve educational indicators and performance while reducing health care costs.⁸

- High-risk pregnant women: Health centers improve access to comprehensive prenatal care and reduce the rate of low birth weight and other pregnancy complications;⁹ in the first year alone, approximately \$15,000 in health care costs are saved for each low-birth weight infant averted.¹⁰ Additionally, prevention of poor birth outcomes helps reduce costs for other services, including long term educational and social costs.¹¹
- Economic security: Health centers help promote a healthy workforce and mitigate the effects of severe economic downturns. In 2009, health centers served over one million homeless families, families suffering from prolonged unemployment and foreclosure, nearly 865,000 seasonal and migrant seasonal farmworkers, and 230,000 veterans.¹² Despite the economic downturn, health centers generated nearly a two-fold return in new economic activity on federal investments in 2009.¹³
- Savings to the health system: Health centers provide access to preventive services and effective management of chronic conditions and, as a result, reduce the use of costly emergency room visits and hospital (re)admissions.¹⁴ In 2009, health centers saved approximately \$24 billion in health care costs.

⁸See the National Assembly on School-based Health Care's fact sheets on School-based Health Centers and Academic Success (at <http://www.nasbhc.org/atf/cf/%7BCD9949F2-2761-42FB-BC7A-CEE165C701D9%7D/Academic%20Outcome%20Fact%20%28FINAL%29.pdf>) and Benefits of School-based Health Centers (at http://ww2.nasbhc.org/RoadMap/PUBLIC/advocacy_factsheetbenefits.pdf)

⁹ Shi, L et al. (2004). "America's Health Centers: Reducing Racial and Ethnic Disparities in Prenatal and Birth Outcomes" *Health Services Research*, 39(6), Part I, 1881-1901.

¹⁰ United States Department of Health and Human Services, Centers for Disease Control and Prevention. *An Ounce of Prevention, What Are The Returns*. 1999 (at <http://www.cdc.gov/mmwr/PDF/other/ozprev.pdf>).

¹¹ Kessenich M., Developmental outcomes of premature, low-birthweight, and medically fragile infants. *Newborn and Infant Nursing Reviews*, 2003; 3(3): 80-87; Chaikind, D. and Corman H., The impact of low birthweight on special education costs, *Journal of Health Economics*, 1991; 10, 291-311.

¹² 2009 Uniform Data System, HRSA.

¹³ Shin P., Bruen B., Jones E. et al., "The Economic Stimulus: Gauging the Early Effects of ARRA Funding on Health Centers and Medically Underserved Populations and Communities," Feb 16, 2010. http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_C41AE130-5056-9D20-3D65728F2361CFAF.pdf

¹⁴ Shin P., Ku L., Jones E. et al., "Financing Community Health Centers as Patient- and Community-Centered Medical Homes: A Primer," *The Commonwealth Fund*, May 27, 2009 http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_A186E838-5056-9D20-3D9EA92EB75DAC24.pdf; Dor A., Pylypchuck Y., Shin P. et al., "Uninsured and Medicaid Patients' Access to Preventive Care: Comparison of Health Centers and Other Primary Care Provider," George Washington University, Aug 2008.

Given their economic value and well-documented ability to provide significant cost-savings, health centers have garnered broad bipartisan support.

In 2009, when unemployment levels rose to 10%, Congress included in the American Recovery and Reinvestment Act (ARRA) more than \$2 billion for health centers, of which \$500 million were made immediately available in response to rising demand for care in communities hardest hit by the recession.¹⁵ The ARRA funding also provided \$1.5 billion to build and improve health center facilities and helped create and save nearly 7,500 health care jobs and approximately 2,100 construction jobs; overall, nearly \$2 billion invested in health centers generated at least \$3.2 billion in new economic activity.¹⁶ Although ARRA funding was intended as an additional resource for expanding access to care, it also helps to offset decreasing state and local grants, which generally account for 10 percent of health center revenues.¹⁷ Based on historical growth, funding patterns, and coverage expansions, we estimated that ARRA would double health center capacity to serve 33.8 million to 44.1 million patients by 2015 and save approximately \$1,551 per person in health care costs.¹⁸

Building on the success of the ARRA's investment in health centers and the further need to expand access to primary health care services for 32 million uninsured Americans who are likely to be insured by 2019,¹⁹ the Affordable Care Act invested \$11 billion in additional funding to health centers over the next five years.²⁰ However, direct reduction of health center funding now threatens to weaken primary care capacity and increase overall health care costs.

On February 20, 2011, the U.S. House of Representatives approved decreasing discretionary funding to community health centers by \$1.3 billion, which would essentially reduce their overall funding level to slightly less than that in FY 2009; the proposed reduction of \$1.3 billion from the President's proposed budget of \$2.48 billion and the addition of \$1 billion in mandatory ACA funding for health centers leaves health centers with \$2.18 billion dollars in total proposed funding for FY 2011. Although the

http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_A186E838-5056-9D20-3D9EA92EB75DAC24.pdf

¹⁵ See Ku L., Shin P., Bruen B. et al., "Can Health Care Investments Stimulate the Economy?," Health Affairs blog, Mar 16, 2010. <http://healthaffairs.org/blog/2010/03/16/can-health-care-investments-stimulate-the-economy/>

¹⁶ Shin P., Bruen B., Jones E. et al., Feb 16, 2010, *op cit*.

¹⁷ National Association of Community Health Centers. Entering the Era of Reform: The Future of State Funding for Health Centers, October 2010. <http://www.nachc.com/client/State%20Funding%20Report-%20Final.pdf>

¹⁸ Ku L., Richard P., Dor A. et al., Jun 30, 2010, *op cit*.

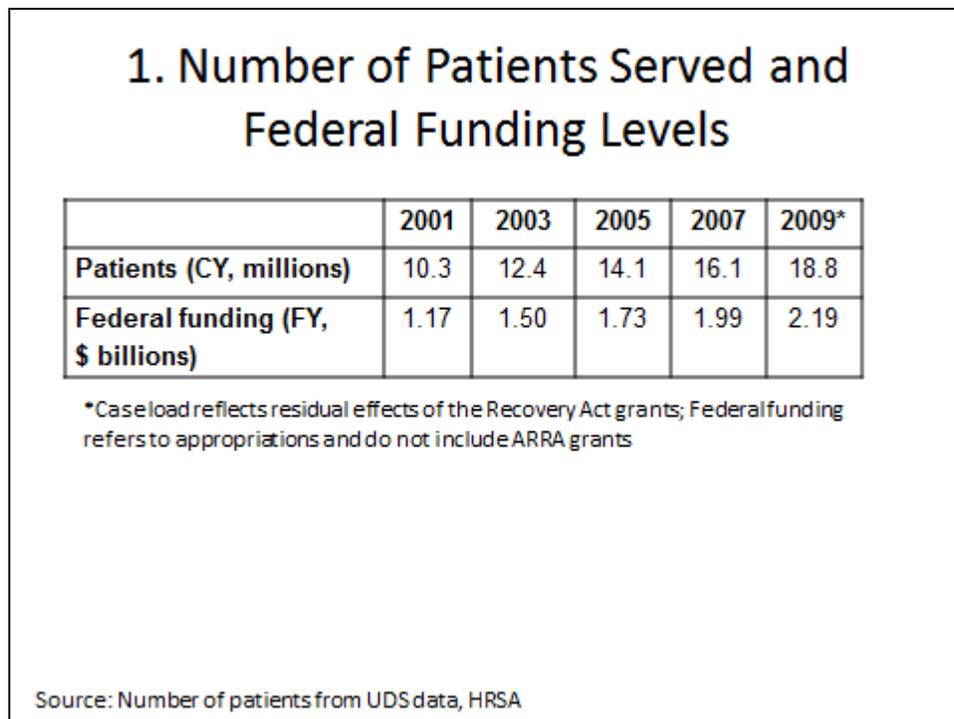
¹⁹ Elmendorf, D. Congressional Budget Office estimate sent to House Speaker Nancy Pelosi on the combined effects of the Patient Protection and Affordable Care Act and the reconciliation act, Mar. 20, 2010.

²⁰ Of the \$11 billion allocated for health centers under the Community Health Centers Fund, \$1.5 billion covers capital costs over the next five years. The remaining \$9.5 billion go towards operational cost and is allocated as follows: \$ 1 billion in FY2011, 1.2 billion in FY 2012, \$1.5 billion in FY 2013, \$2.2 billion in FY 2014, and \$3.6 billion in FY 2015. HCERA, §2303 and PPACA, §10503

spending bill was rejected by the U.S. Senate on March 10, 2011, final spending measures for health centers are yet to be determined.

Impacts of the Budget Cuts

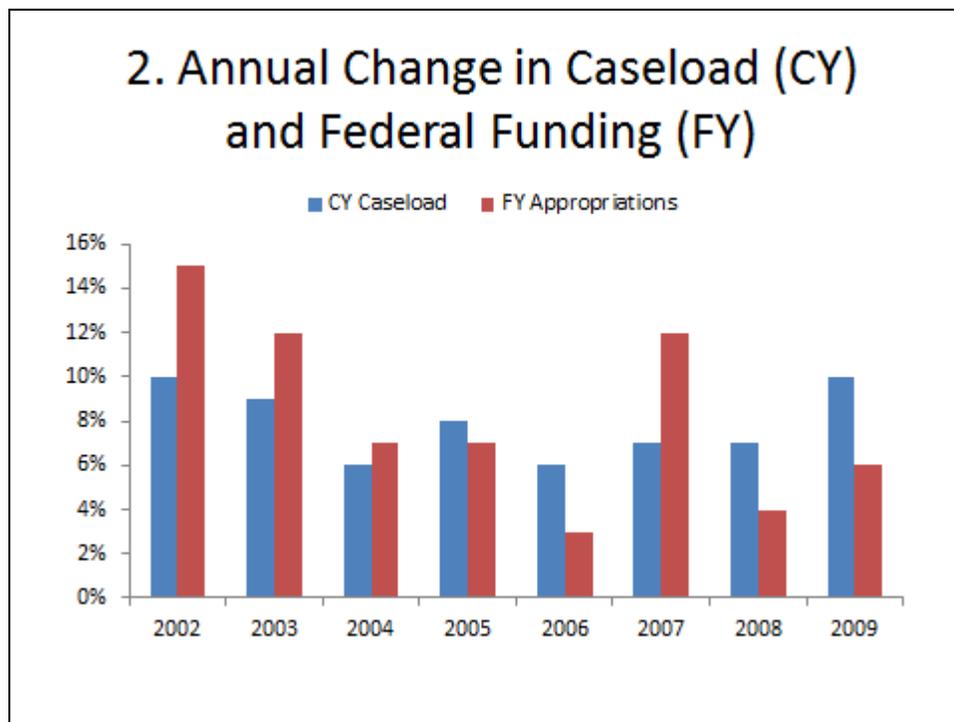
Figure 1 shows federal funding levels over the past decade and the number of patients served by health centers. For example, in FY 2001 and 2003, federal investments of \$1.17 billion and \$1.50 billion, respectively, helped support 10 million to 12 million patients in CY 2001 and 2003. The \$1.3 billion proposed spending reduction for FY 2011 virtually equates to earlier federal funding levels in nominal dollars. In nominal dollars, a \$1.3 billion reduction would eliminate health center capacity to serve 10-12 million patients: the National Association of Community Health Centers (NACHC) estimate that 11 million patients would lose access to care falls within this range.



Although it is too early to project the impact on health center capacity over the next decade, it is highly unlikely that the goal of doubling capacity to serve 40 million over the next five to ten years can be attained with reduced funding. While health centers rely on reimbursement from Medicaid and other payors to provide, manage and sustain services, they depend principally upon federal funding to create new access points (i.e., new sites) and growth capacity.²¹ As Figure 2 shows, growth in health center patient loads tends to track to changes in appropriations. As with all businesses, health centers anticipate changes in revenue sources, use of cash, and demand for services and

²¹ LoSasso A.T. and Byck, G.R. Funding growth drives community health center services. Health Affairs, 2010; 29(2): 289-296.

undertake measures to expand or protect core services based on expected income. Because the bill includes early termination of ARRA funding, NACHC anticipates health centers will be forced to reduce services or close new sites almost immediately, resulting in reduced access to primary care services for at least three million patients over the next few months.²²



Without access to health center services, millions of patients with ongoing health needs are likely to forgo or delay care, and ultimately seek care in more costly settings.²³ Based on our earlier estimates of per patient cost-savings,²⁴ NACHC's estimated reduction of three million health center patients before the end of the fiscal year alone would represent a loss of approximately \$4.1 billion in cost savings; the aggregate loss of capacity to serve 11 million patients would equate to a loss of approximately \$15

²² According to ARRA data reported by health centers as of September 30, 2010, health centers served 3.1 million patients with the expansion funds. See the National Association of Community Health Center's Immediate Impact of Federal Funding Cuts to Health Centers.

<http://www.nachc.org/client/StatebyStateImpact.pdf>

²³ See profile of patients at risk of losing care, Rosenbaum S., Shin P., Ku L. et al., "Who Are the Health Center Patients Who Risk Losing Care Under the House of Representatives Proposed FY 2011 Spending Reductions?," George Washington University, Feb 24, 2011. http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_4_EEA7517-5056-9D20-3D95F2D309535145.pdf

²⁴ Ku L., Richard P., Dor A. et al., "Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs," George Washington University, Sep 1, 2009. http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_61_D685D5-5056-9D20-3DDB6CDE10382393.pdf

billion in cost-savings annually. We arrive at this figure by taking the following factors into account: age, gender, income, insurance coverage and health status.²⁵

Discussion

Federal funding is critical to health centers' ability to serve as medical homes for 1 in 5 low-income Americans, including a disproportionate share of patients at high risk of poor health. Although federal investments in health centers under ARRA and ACA were intended to strengthen and expand primary care capacity, the U.S. House of Representatives' bill would undermine health center capacity to provide care in the midst of stagnant state and local funding. Cuts to other federal programs, including the National Health Service Corps, further undermine health center efforts to expand access to quality care for vulnerable populations, reduce health disparities, improve outcomes, protect local economies, and save (federal and state) health care costs. We estimate that every federal dollar withdrawn from health center funding equates to a loss of approximately \$11.50 in cost-savings. Thus, while reducing the health center investment may appear to nominally lower federal spending, the almost-immediate downstream consequences for health and health care costs send a strong cautionary message about the consequences of spending reductions.

²⁵ Using the 2006 Medical Expenditure Panel we compared annual expenditures of patients who used health centers with those who did not and found health centers saved approximately \$1,093 per person in 2006. After adjusting for inflation, the difference between health center and non-health center patients is \$1,351.