Health Centers Provide Cost Effective Care

Community, Migrant, Homeless, and Federally-Qualified Health Centers are non-profit, community-directed healthcare providers serving low income and medically underserved communities. For 50 years, health centers have provided affordable, high quality care. Currently, **over 1,300 health centers reach more than 23 million* patients through more than 9,000 service delivery sites in every state and territory.**

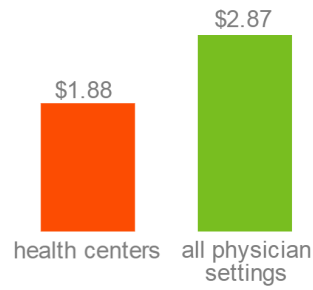
Also known as health centers§, they serve federally-designated underserved areas and populations and provide access to all patients regardless of insurance status or ability to pay. Health centers serve 1 in 7 Medicaid beneficiaries and 1 in 3 patients below poverty.* Despite serving more medically and socially complex patients, health centers produce significant savings to the healthcare system while providing a comprehensive, efficient, and cost effective model of care.

Efficiently Providing High Quality, Affordable Care

Health centers operate as medical homes for their patients, providing a broad array of services including medical, dental, vision, behavioral, pharmacy, and services that facilitate access to care. Health centers offer this comprehensive model of care at a lower cost to patients than other providers; **health centers' average cost runs a dollar less per patient per day compared to all physician settings.**[1]

In addition, while health centers typically serve more complex patients that are more likely to have chronic conditions, they perform just as well or better than other providers on key quality performance benchmarks.[2]

Average Daily Cost of Caring for Patients at Health Centers and All Other Physician Settings, 2012 †



Producing Savings

Health centers save over $24 billion for the healthcare system annually.[3]

Two recent multi-state studies find health centers are associated with lower total costs of care per patient for Medicaid and Medicare compared to other providers serving these patients,[4] saving $414 (23%) per patient for Medicaid and $297-$1,210 (11-34%) for Medicare.[5]

Further evidence of the significant savings health centers produce can be found across the country:

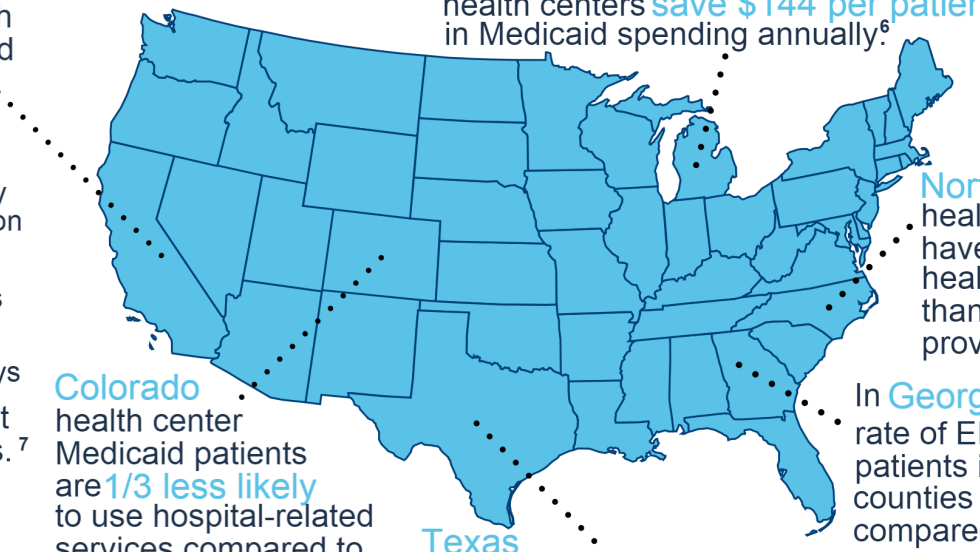
In four California counties, health center Medicaid managed care patients have:

64% lower rates of multi-day hospital admission

18% lower rates of ED visits

25% fewer inpatient bed days

than patients at other providers.[7]



Michigan health centers save $144 per patient in Medicaid spending annually.[6]

North Carolina health center patients have 62% lower healthcare spending than patients of other providers.[10]

In **Georgia** the mean annual rate of ED visits for uninsured patients is 25% less in counties with a health center compared to those without.[11]

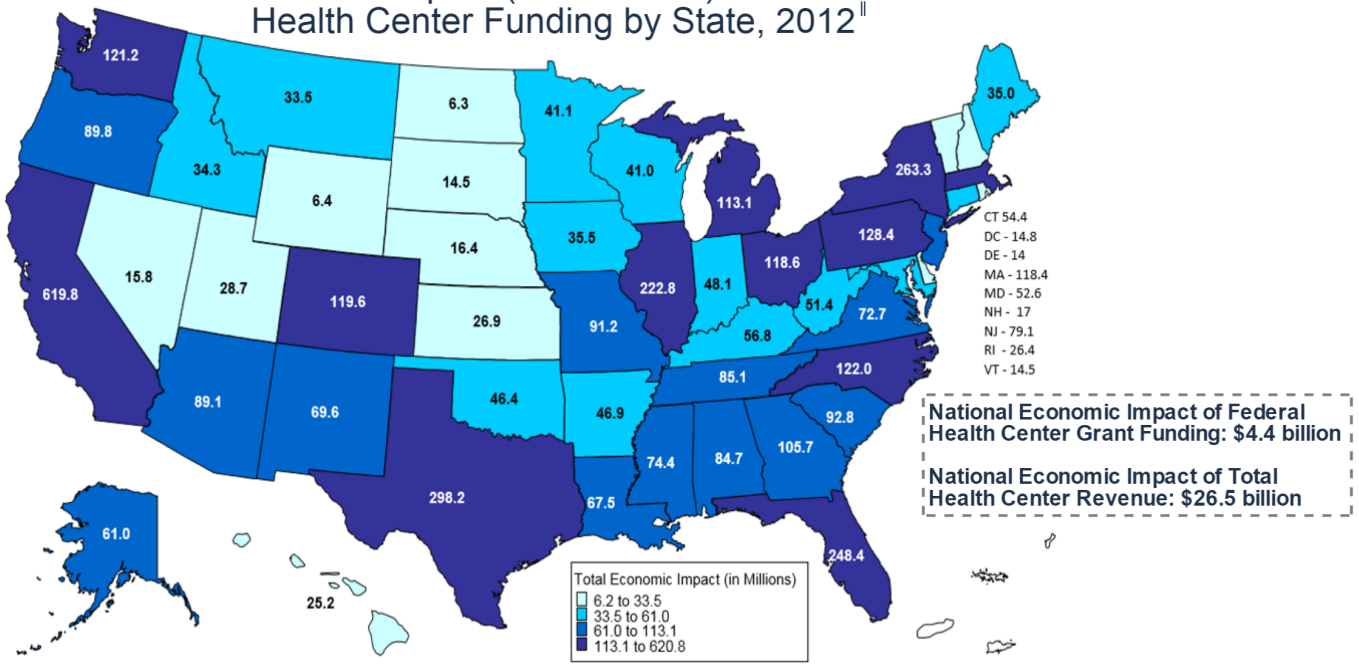
Colorado health center Medicaid patients are 1/3 less likely to use hospital-related services compared to Medicaid patients seen by office-based providers.[8]

Texas health center patients with Medicaid have $384 less in total costs compared to those served by office-based physicians.[9]

Generating Jobs and Economic Benefits

The communities health centers target tend to experience high rates of poverty and economic distress. Yet health centers produce an economic "ripple effect" by creating jobs and stimulating economic activity through the purchase of goods and services from local businesses.

Economic Impact (in $ millions) of Federal Health Center Funding by State, 2012‖



In 2012, health centers nationally produced an influx of $26.5 billion in economic benefits in resource-poor rural and urban communities.[12]

The economic impact resulting from federal health center funding alone contributes one-sixth ($4.4 billion) of this total impact. As this federal funding leverages other sources of revenue for health centers, $11 is generated in total economic activity for every $1 of federal funding invested in health centers.[12]

In addition, health centers employed nearly 157,000 full time positions[13] while also creating an additional 112,000 other local jobs.[12]

*NACHC, 2014. Includes all patients of federally-funded health centers, non-federally funded health centers, and expected patient growth for 2014.
§ Health centers include those that receive federal Health Center Program grants under the Public Health Service Act and those that meet the same program requirements but do not receive these grants, known as Federally-Qualified Health Center Looks Alikes.
† Agency for Healthcare Research and Quality. Medical Expenditure Survey. Table 8.1.a: Office-based Medical Provider Services-Median and Mean Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2012. Available at http://meps.ahrq.gov. And Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2012 Uniform Data System.
‖ Economic impact of federal health center funding only, by state. Economic impact includes direct impact, such as money generated in the community, and indirect impact, such as goods and services purchased and additional economic stimulus generated. Source: Economic impact analysis conducted by Capital Link, Inc. using IMPLAN Version 3, Trade Flows Model, an integrated economic modeling and planning tool and 2012 Uniform Data System, Bureau of Primary Health Care, HRSA, HHS.

1. Agency for Healthcare Research and Quality. Medical Expenditure Survey Summary Tables, 2012. http://meps.ahrq.gov. And Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2012 Uniform Data System.
2. Goldman L, et al. Federally qualified health centers and private practice performance on ambulatory care measures. Am J Prev Med. 2012;43(2):142-149. Shi L, , et al. Characteristics of ambulatory care patients and services: A comparison of community health centers and physicians' offices. J Health Care Poor Underserved. 2010;21(4):1169 – 83.
3. Ku L, et al. Using primary care to bend the cost curve: Estimating the impact of a health center expansion of health care costs. Policy Research Brief No. 14. September 2009. Geiger Gibson/RCHN Community Health Foundation Collaborative at the George Washington University.
4. Health Resources and Services Administration, forthcoming research.
5. Mukamel DB, White LM, Nocon RS, et al. Comparing the cost of caring for Medicare beneficiaries in federally funded health centers to other care settings. Health Serv Res. 2015 July. Sharma R, Lebrun-Harris LA, Ngo-Metzger Q. Costs and clinical quality among Medicare beneficiaries: Associations with health center penetration of low-income residents. Medicare Medicaid Res Rev. 2014 Sep 8;4(3).
6. Mundt C, Yuan S. An evaluation of the cost efficiency of Federally Qualified Health Centers (FQHCs) and FQHC look alikes operating in Michigan. October 2014. The Institute for Health Policy at Michigan State University.
7. California Primary Care Association. Value of community health centers study: Partnership HealthPlan of California case study. January 2013. Available at http://www.cpca.org.
8. Rothkopf J, et al. Medicaid patients seen at federally qualified health centers use hospital services less than those seen by private providers. Health Aff. 2011 July;30(7): 1335 – 42.
9. Texas Association of Community Health Centers. Comparative costs of community health centers and other usual sources of primary care: The Texas story. 2011. Available at www.tachc.org
10. Richard P, et al. Bending the cost curve in North Carolina: The experience of community health centers. Policy Research Brief #24. August 2011. Geiger Gibson/RCHN Community Health Foundation Collaborative at the George Washington University.
11. Rust G, et al. Presence of a community health center and uninsured emergency department visit rates in rural counties. J Rural Health. 2009 Winter;25(1):8-16.
12. NACHC, Capital Link. National economic and community impact of the health center program. Infographic #0814. August 2014. Available at http://www.nachc.com/research. Based in IMPLAN Version 3 which estimates sector-specific economic impact using 2008 structural matrices, 2008 state-specific multipliers, and healthcare service sector-specific IMPLAN data.
13. Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2013 Uniform Data System.

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