

Federally Qualified Health Centers: The Next Step in Cost-Effective Health Care

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I. INTRODUCTION

During the current economic downturn, health care in the United States is growing increasingly costly, making it less available to those who need it: 2009 marked the greatest increase in healthcare costs since the 1960s.<sup>1</sup> Healthcare spending now accounts for 17.3 percent of the United States' total GDP, reaching \$2.5 trillion.<sup>2</sup> This increase in spending is likely due to loss of jobs and, thus, loss of health insurance.<sup>3</sup> Accordingly, 2009 also marked the first year since 1987 that the number of people with health insurance decreased.<sup>4</sup> Overall, the number of uninsured people in America increased to 50.7 million in 2009, from 46.3 million in 2008.<sup>5</sup>

Despite the ever increasing cost of health care, the United States remains among third-world countries as far as its health care performance.<sup>6</sup> The United States spends the most on health care worldwide, but a 2000 study by the World Health Organization placed the United States thirty seventh, between Costa Rica and Slovenia, in overall health system performance<sup>7</sup> Thus, it is clear that America must reign in its health care spending by making it far more cost-effective than at present.<sup>8</sup> With this in mind, the obvious

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1. Emily P. Walker, *In Bad Economy, Record Growth in Health Spending*, MEDPAGE TODAY (Feb. 4, 2010), <http://www.medpagetoday.com/Washington-Watch/Washington-Watch/18302>.

2. *Id.*

3. Brian C. Martin et al., *Financial Performance and Managed Care Trends of Health Centers*, 35 J. HEALTH CARE FIN. 1, 2 (Spring, 2009).

4. Avery Johnson, *Recession Swells Number of Uninsured to 50.7 Million*, WALL ST. J., (Sept. 17, 2010), <http://online.wsj.com/article/SB10001424052748704394704575496093363948142.html>. 1987 was the first year that comparable health insurance data were collected.

5. *Id.*

6. Juniper Lesnik, *Community Health Centers: Health Care As It Could Be*, 19 J.L. & HEALTH 1, 1-2 (2004-2005).

7. *Id.*

8. See US: *Efficient spending key to strengthening public finances, says OECD survey*, ORG. FOR ECON.

question becomes how to spend less while also achieving better quality care. As several recent studies suggest, the solution to this problem is found in the Federally Qualified Health Center (FQHC) program.

The FQHC program endeavors to impart quality care upon communities and populations that have limited access to health care.<sup>9</sup> For the most part, the centers, which are located in economically depressed urban and rural areas, provide a primary source of care to patients who may or may not have access to health care.<sup>10</sup> While FQHCs rely heavily on federal grants and Medicaid cost-based reimbursement to operate, studies have shown that health centers not only save the government billions of dollars annually, they also serve to stimulate the impoverished communities they reside in.<sup>11</sup>

This article seeks to demonstrate how FQHCs provide a model for the future of health care beyond what is termed “cost-effective,” but, rather, a cost-*saving* model. Part II gives an overview of the Health Center Program, examining the history of FQHCs, as well as the status of such centers today. Part III examines the Patient Protection and Affordable Care Act of 2010 (PPACA) and the impact its increased funding can have on the Health Center Program. Part IV presents FQHCs as a solution to challenges currently facing the United States’ economic and health care systems— providing cost-effective, quality health care and increasing access. Finally, the conclusion explains the current importance of the Health Center Program and future need to expand funding and maximize the Program’s potential.

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& CO-OPERATION DEV., (Sept. 20, 2010), [http://www.oecd.org/document/47/0,3343,en\\_2649\\_34569\\_4604\\_7343\\_1\\_1\\_1\\_37443,00.html](http://www.oecd.org/document/47/0,3343,en_2649_34569_4604_7343_1_1_1_37443,00.html). (“[T]he best way to strengthen public finances would be to make public spending more efficient, in particular health-care programs.”).

9. See NAT’L ASSOC. OF CMTY. HEALTH CTRS., *AMERICA’S HEALTH CENTERS: MAKING EVERY DOLLAR COUNT 1* (2006), <http://www.nachc.org/client/documents/issues-advocacy/policy-library/research-data/fact-sheets/Cost-Effectiveness-Fact-Sheet-12-06.pdf> [hereinafter Fact Sheet].

10. *Id.*

11. This 2009 study by George Washington University estimates that the Health Center program will save the United States over \$200 billion dollars from 2010 to 2019. Sara Rosenbaum et al., *Community Health Centers in an Era of Health System Reform and Economic Downtown: Prospects and Challenges*, KAISER FAMILY FOUND., 9 (March 2009), <http://www.kff.org/uninsured/upload/7876.pdf>; see generally Leighton Ku et al., *Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs*, GEIGER GIBSON/ RCHN CMTY. HEALTH FOUND., (Sept. 1, 2009), [http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp\\_publications/pub\\_uploads/dhpPublication\\_61D685D5-5056-9D20-3DDB6CDE10382393.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_61D685D5-5056-9D20-3DDB6CDE10382393.pdf).

## II. FEDERALLY QUALIFIED HEALTH CENTERS

*A. Overview*

As defined by the U.S. Department of Health and Human Services, FQHCs are “community-based and patient-directed organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing.”<sup>12</sup> FQHCs serve areas and populations that are designated “medically underserved” by the Health Resources and Services Administration (HRSA).<sup>13</sup> Whether an area is “medically underserved” is determined by balancing the number of physicians in a given area, the community poverty rate, the community’s infant mortality rate, and its proportion of residents over the age of sixty-five.<sup>14</sup> FQHCs also target medically underserved populations – groups of people who face economic, cultural, or linguistic barriers to medical services.<sup>15</sup> These health centers provide such communities and populations with primary and preventative care regardless of a patient’s ability to pay, including: medical, dental, behavioral, pharmacy and enabling services.<sup>16</sup> In 2009, almost forty percent of the patients served by FQHCs were uninsured, while over sixty percent were minorities – both of which constitute groups that are typically medically-underserved.<sup>17</sup>

*B. Brief History of Health Centers*

Although the idea of community health centers (CHCs) originated in the late nineteenth century with new immigrant outpatient dispensaries, the modern notion of

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12. U.S. DEP’T OF HEALTH AND HUMAN SERVICES (HHS) & HEALTH RESOURCES AND SERVICES ADMIN. (HRSA), HEALTH CENTER PROGRAM: WHAT IS A HEALTH CENTER? (2010), available at <http://bphc.hrsa.gov/about/> [hereinafter WHAT IS A HEALTH CENTER].

13. HHS & HRSA, SHORTAGE DESIGNATION: MEDICALLY UNDERSERVED AREAS & POPULATIONS (2010), available at <http://bhpr.hrsa.gov/shortage/muaguide.htm> [hereinafter MEDICALLY UNDERSERVED AREAS & POPULATIONS].

14. Sara Rosenbaum et al., *National Health Reform: How Will Medically Underserved Communities Fare?*, GEIGER GIBSON/ RCHN CMTY. HEALTH FOUND., 8, (July 9, 2009), [http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp\\_publications/pub\\_uploads/dhpPublication\\_5046C2DE-5056-9D20-3D2A570F2CF3F8B0.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_5046C2DE-5056-9D20-3D2A570F2CF3F8B0.pdf).

15. MEDICALLY UNDERSERVED AREAS & POPULATIONS, *supra* note 13.

16. Eli Y. Adashi et al., *Health Care Reform and Primary Care – The Growing Importance of the Community Health Center*, 362 NEW. ENG. J. MED., 2047, 2047(June 3, 2010), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1003729>.

17. WHAT IS A HEALTH CENTER, *supra* note 12.

such centers came about during the 1960s.<sup>18</sup> The U.S. Office of Economic Opportunity, founded during President Johnson's War on Poverty, created the first federally-funded community health centers – referred to as “neighborhood health centers.”<sup>19</sup> These health centers targeted medically underserved urban and rural communities.<sup>20</sup> They were designed to reduce or eliminate health disparities that affected disadvantaged minorities, the poor, and the uninsured.<sup>21</sup>

CHCs became a federal grant program under Section 330 of the Public Health Service Act (PHSA),<sup>22</sup> and developed into “Federally Qualified Health Centers” in 1989 when Congress passed the Omnibus Budget Reconciliation Act.<sup>23</sup> In an effort to address the growing need for support for underfunded clinics, this piece of legislation required Medicaid and Medicare to reimburse health centers for “reasonable costs” and set forth the criteria to make health centers eligible for such reimbursement.<sup>24</sup> Until Congress consolidated the individual programs under Section 330 of the PHSA in 1996, several separate programs all qualified for federal grants at this time.<sup>25</sup> These programs included the Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs.<sup>26</sup> These four types of centers now constitute the federally- supported health centers known as Federally Qualified Health Centers (FQHCs).<sup>27</sup>

### *C. Current Federally Qualified Health Centers*

Presently, the term “community health center” is the catch-all phrase for those programs funded by the federal government. However, non-profit health centers must meet five requirements to be designated a FQHC in order to receive cost-based reimbursement:

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18. A.H. Strelnick, *Increasing Access to Health Care and Reducing Minority Health Disparities: A Brief History and the Impact of Community Health Centers*, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 63, 64-65 (2004).

19. *Id.*

20. *Id.* at 66.

21. Adashi, *supra* note 16, at 2047.

22. Lesnik, *supra* note 6, at 6; 42 U.S.C. § 254b(c)(1)(A) (2010).

23. Strelnick, *supra* note 18, at 70; Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239.

24. Strelnick, *supra* note 18, at 70-71.

25. *Id.* at 71.

26. WHAT IS A HEALTH CENTER, *supra* note 12.

27. *Id.*

- (1) being located in, or targeted to serve, medically underserved populations and communities;
- (2) having nonprofit, tax exempt, or public status;
- (3) having a Board of Directors, composed of a majority of health center patients<sup>28</sup>;
- (4) providing culturally-competent, comprehensive primary care services to all age groups;
- (5) offering a sliding-fee scale and providing services regardless of ability to pay.<sup>29</sup>

While these criteria apply to those non-profit public and private health centers that receive federal grants, they also affect health centers known as FQHC “look-alikes.”<sup>30</sup> FQHC “look-alikes” are health centers that meet the FQHC criteria, but they do not receive federal funds under Section 330.<sup>31</sup> Although they are funded by state and local grants only, they are eligible for the same cost-based Medicaid and Medicare payments.<sup>32</sup> FQHC “look-alikes” do not receive federal grant funds under Section 330, yet they are eligible for the same cost-based Medicaid and Medicare payments.<sup>33</sup> Both the federally-funded centers and the locally-funded “look-alikes” are considered FQHCs.<sup>34</sup>

### III. EXPANDED FUNDING UNDER THE PPACA OF 2010

Recently, federal funding afforded to community health centers has substantially increased. The 2010 healthcare reform bill, PPACA, significantly expands funding for the Health Centers Program.<sup>35</sup> This reform package authorizes \$11 billion in new funding spread out over five years – \$9.5 billion for expansion of current facilities and construction of new health centers, as well as \$1.5 billion for improvement of existing health centers.<sup>36</sup> By 2015, health centers will double their current capacity to be able to

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28. AMERICA’S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 60 (Marion Ein Lewin & Stuart Altman eds., 2000) [hereinafter AMERICA’S HEALTH CARE SAFETY NET] (“This criterion is not required for homeless grantees”).

29. *Id.* at 60.

30. *Id.* at 62.

31. *Id.*

32. *Id.*

33. *Id.*

34. Rosenbaum, *supra* note 11, at 2.

35. Patient Protection and Affordable Care Act of 2010 (PPACA), Pub. L. No. 111-148, § 5601 (codified as amended at 42 U.S.C. § 254b(r)).

36. NAT’L ASSOC. OF CMTY. HEALTH CTRS. (NACHC), EXPANDING HEALTH CENTERS UNDER HEALTH

serve forty million patients.<sup>37</sup> Although there are more than 8,000 community-based health centers currently operating across the country, many medically underserved areas remain without care centers.<sup>38</sup> The new funding from the PPACA will allow for substantial growth in the number of health center patients nationwide by bringing CHCs to those medically underserved areas still lacking primary care sources.<sup>39</sup>

#### IV. BEYOND COST-EFFECTIVE: COST-SAVING

The expanded funding provided by PPACA carries with it not only the ability to provide more Americans with quality health care, but also the opportunity to save the United States billions of dollars in the process. Through savings in Medicaid, lower rates of hospitalizations, and community economic stimulation, it is estimated that the total medical savings due to the health centers expansion would be over \$212 billion over ten years.<sup>40</sup>

Studies have consistently shown that patients who do not live in an area with a health center are more likely to utilize expensive and inappropriate avenues of health care, including hospitals and emergency rooms.<sup>41</sup> Under the Emergency Medical Treatment and Active Labor Act, all hospitals receiving Medicare payments are required to provide treatment to emergency room patients regardless of their ability to pay, Medicare or citizenship status.<sup>42</sup>

Since hospitals cannot legally refuse service to patients, the uninsured largely depend upon hospitals as their primary sources of care: a practice that proves to be extremely expensive to the health care system.<sup>43</sup> However, recent studies suggest that Medicaid patients, not the uninsured, cost the system the most in preventable hospitalizations. One such report suggested that five to twenty-five percent of emergency room visits by Medicaid patients could have been properly addressed at an outpatient facility such as a

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CARE REFORM: DOUBLING PATIENT CAPACITY AND BRINGING DOWN COSTS 1 (2010), [http://www.nachc.com/client/HCR\\_New\\_Patients\\_Final.pdf](http://www.nachc.com/client/HCR_New_Patients_Final.pdf).

37. *Id.*

38. Adashi, *supra* note 16, at 2047. (“As recently as 2009, the Government Accountability Office reported that 43% of medically underserved areas continue to lack a [community health center] site.”).

39. *See id.*

40. Ku, *supra* note 11, at 8.

41. *See* Lesnik, *supra* note 6.

42. 42 U.S.C. § 1395dd (a)-(b)(1) (2006).

43. Lesnik, *supra* note 6, at 8.

community health center.<sup>44</sup> Accordingly, patients living in an underserved area with a FQHC have significantly fewer preventable hospitalizations than patients who live in areas without such health centers.<sup>45</sup> In 2006 alone, redirecting these avoidable emergency room visits to health centers could have saved the nation over \$18 billion in annual health care costs.<sup>46</sup> Therefore, providing underserved communities with a regular source of health care such as an FQHC can significantly reduce preventable hospitalizations and save the nation billions in unnecessary spending.

Additionally, the dollar amount that health centers save in Medicaid spending is more than the federal government allocates to the FQHC program annually.<sup>47</sup> A study by George Washington University estimated that, given an increase of twenty million patients over the next ten years, the expansion of health centers will result in a federal Medicaid savings of almost \$60 billion.<sup>48</sup> These savings result from the health centers' ability to prevent unnecessary emergency room visits and hospitalization, as well as lower specialty care referrals and prescription drug costs.<sup>49</sup> The estimated return in Medicaid savings alone is more than double the amount allocated for the entire health centers program under the PPACA.<sup>50</sup> The statistics from the George Washington University study demonstrate how health centers are not just "cost-effective," but are also cost-saving. Rather than simply using government funds in an efficient manner, health centers are able to stop unnecessary expenditures, thereby saving the federal government more in capital than the Program requires to operate.

The Health Center Program not only saves federal funds, it acts as an economic stimulus in poverty-stricken communities throughout the United States.<sup>51</sup> The expansion of the Program provides health care to a greater number of people and creates jobs for healthcare professionals and community members alike.<sup>52</sup> In 2009, federally-funded

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44. Devon Herrick, *Report: Uninsured Emergency Room Use Greatly Exaggerated*, HEARTLAND INST., (Aug. 2010), [http://www.heartland.org/healthpolicy-news.org/article/27902/Report\\_Uninsured\\_Emergency\\_Room\\_Use\\_Greatly\\_Exaggerated.html](http://www.heartland.org/healthpolicy-news.org/article/27902/Report_Uninsured_Emergency_Room_Use_Greatly_Exaggerated.html).

45. Fact Sheet, *supra* note 9, at 2.

46. *Id.*

47. Ku, *supra* note 11, at 8.

48. *Id.*

49. Fact Sheet, *supra* note 9, at 1-2.

50. Ku, *supra* note 11, at 8.

51. Fact Sheet, *supra* note 9, at 2.

52. Rosenbaum, *supra* note 11, at 9.

health centers staffed more than 123,000 employees in these underserved communities.<sup>53</sup> New health centers also generate industry for businesses such as community vendors and local pharmacies.<sup>54</sup> One 2008 study on community health centers' impact on local economies concluded that every \$1 million invested in health centers produced a \$6 million rate of return<sup>55</sup> As opposed to for-profit hospitals and care centers that generate profit, FQHCs take in no revenue and, instead, stimulate the economies of the areas they reside in.

#### V. CONCLUSION

Although the Health Center Program is largely overlooked as a primary source of health care in the country, the care they provide and their cost-saving capabilities make evident the overwhelming need to foster such programs in our current economic climate. FQHCs provide care to many people who would not otherwise have access to treatment, while allowing the federal government to curtail unnecessary health care spending in economically difficult times. Greater federal funding will permit the building of additional health centers in those areas that remain medically-underserved. An increase in grant money will also make it possible for existing FQHCs to serve a greater number of community members in their area. The PPACA's expanded funding is a step in the right direction towards spending health care dollars in the United States more cost effectively, yet much more future support is needed for the Health Center Program to realize its full potential.

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53. HRSA, HEALTH CENTER DATA (2009), available at <http://www.hrsa.gov/data-statistics/health-center-data/index.html>.

54. Fact Sheet, *supra* note 9, at 2.

55. Rosenbaum, *supra* note 11, at 9.