Department of Health Policy

Geiger Gibson /
RCHN Community Health Foundation Research Collaborative

Policy Research Brief No. 19

Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform

Leighton Ku, Ph.D., M.P.H.
Patrick Richard, Ph.D.
Avi Dor, Ph.D.
Ellen Tan, M.Sc.
Peter Shin, Ph.D., M.P.H.
Sara Rosenbaum, J.D.

June 30, 2010

THE GEORGE WASHINGTON UNIVERSITY
SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

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 gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Executive Summary

The recent enactment of health reform sets into motion important changes that will expand health insurance coverage, increase funding for community health centers and alter the way that health centers are paid. These reforms will have a major impact on two major challenges of health reform: bolstering the capacity of the nation's primary care system and reducing the long term growth in health care costs.

Our analyses examine the impact of the new health reform law on the number of patients who will receive primary care services at community health centers and the effect of the service expansions on overall health care costs, including federal and state Medicaid expenditures. Research indicates that patients who receive care at community health centers have lower medical costs because providing quality primary care services can reduce the need for other ambulatory and hospital-based medical care, thereby lowering overall medical costs. We examine the effects of health center expansions based on two funding scenarios that are possible under the new law: (1) a minimum level of funding based on mandatory increases of $11 billion in additional health center grants from 2011 to 2015, and (2) higher funding levels that could be appropriated in future years, based on levels authorized under the new law.

- At the minimum mandatory funding levels, the number of patients served by community health centers could rise from 18.8 million in 2009 to 33.8 million by 2015 and could roughly double to 36.3 million by 2019. Under this scenario, total nationwide medical costs could be reduced by $181 billion between 2010 and 2019. Included in these overall savings are $52 billion in federal Medicaid and $33 billion in state Medicaid savings.

- If funding reaches the higher authorized levels, the number of patients could reach 44.1 million by 2015 and 50 million by 2019, almost three times as high as current levels. Overall national medical savings could total $316 billion over the decade. This includes $90 billion in federal Medicaid savings and $58 billion in state Medicaid savings.

- These estimates do not include about $24 billion in medical expenses per year *already* being saved because of the existing levels of patient care at community health centers.

With leadership from the Health Resources and Services Administration, health centers have demonstrated their capacity to grow to meet increasing demand: between 2000 and 2009 the number of patients served doubled. The Administration has been adept at rapidly allocating $2 billion from last year's economic recovery law to help spur further growth by health centers. There is a proven track record for the expansion of services by health centers.

The Congressional Budget Office has estimated that 32 million fewer people will be uninsured by 2019. These analyses indicate that community health centers will be able to provide primary care to a significant share of the newly insured, as well as continuing to serve a large number of those who remain without coverage. As a result, the efficient and effective primary care that will be received by millions more patients at community health centers should help bend the curve of rising health care costs.

Introduction

One of the central issues that arose during the health reform debate was whether the nation can respond to the need for a major expansion of health care capacity – in particular, primary health care – as part of health reform. In an earlier report, the Geiger Gibson Program estimated that 96 million persons, 28 percent of whom are uninsured, reside in communities identified as medically underserved for primary health care.[1] A possible result is that these communities – whose residents stand to benefit the most from reform – will be unable to respond to a surge in health care seeking or will be able to do so only in the costliest health care settings.

In 2008, 1,080 community health centers — independent nonprofit clinics with locations in more than 7,000 medically underserved urban and rural communities — provided comprehensive primary health care to 17 million patients, mostly low-income. At the same time, health centers' current capacity falls substantially short of need. Because of this concern, Congress made a considerable investment in the expansion of community health centers, increasing funding by at least $11 billion over the next five years in order to increase the number of patients and communities served by health centers and widen the range of services offered.

The health centers expansion brings a special focus on two of the foremost challenges in health reform: how to reduce the rate of growth in health care expenditures in order to "bend the curve" of health care costs while simultaneously improving access to primary health care. With health care spending expected to grow significantly over the coming decade, improving access while containing costs becomes essential to the success of reform. Given health centers' ability to furnish comprehensive primary care efficiently through the use of a team-based approach to care, we sought to measure the impact of a health center expansion on health care costs. Specifically, we sought to determine whether Congress' investment in the planned growth in health care capacity ultimately might reduce the rate of health care cost increases even as access is improved.

This analysis examines the impact of the final legislation. It builds on earlier analyses of House[2, 3] and Senate legislative proposals[4] and focuses on the final legislation and the estimated federal Medicaid savings that can be attributed to health center growth.

---

[1] Rosenbaum, S., Jones, E., Shin, P., Ku, L. "National Health Reform: How Will Medically Underserved Communities Fare?" George Washington Univ., July 9, 2009.
http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_5046C2DE-5056-9D20-3D2A570F2CF3F8B0.pdf

[2] Ku, L, Shin, P., Rosenbaum, S. "Estimating the Effects of Health Reform on Health Centers' Capacity to Expand to New Medically Underserved Communities and Populations." George Washington University, July 23, 2009.
http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_9889E996-5056-9D20-3D1F89027D3F9406.pdf

[3] 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, Sept. 1, 2009.
http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_61D685D5-5056-9D20-3DDB6CDE10382393.pdf

[4] Ku, L., Shin, P., Rosenbaum, S. "Using Primary Care to Bend the Cost Curve: The Potential Impact of Health Center Expansion in Senate Reforms," George Washington University, Oct. 14, 2009.
http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_538E3192-5056-9D20-3D816A92453FBC7E.pdf

How the Final Law Affects Health Centers

The Patient Protection and Affordable Care Act of 2010 (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152), makes a number of changes affecting health centers. Most importantly for this analysis, the final law establishes two potential funding pathways for federal health center grant funding: (1) a minimum "mandatory" level of funding, which adds $11 billion in new federal grants from 2011 to 2015; and (2) a higher "authorized" level of funding that may be appropriated in future years. In effect, the first is the minimum funding level, while the second is the maximum. Total funding in coming years thus may exceed the initial $11 billion investment.

Some of the key changes specific to community health centers include:

- Making $11 billion in mandatory funding available between FY 2011 and FY 2015 to expand health center grantees, sites and operations (ranging from $1 billion more than FY 2008 levels in 2011 to $3.6 billion more in 2015).[5] This amount includes $1.5 billion in funding for construction and renovation of community health centers.[6]
- Permanently authorizing the community health centers program (Section 330 of the Public Health Service Act) and providing authorization for appropriations for health center grants from FY 2010 through FY 2015 and escalating the authorization levels in subsequent years under Section 330 based on changes in medical costs per patient plus 1 percentage point and changes in the number of patients served plus 1 percentage point.[7] Table 1 shows the differences between the mandatory and authorized funding levels.
- Requiring that insurance plans operating under health insurance exchanges contract with essential community providers, including community health centers.[8]
- Requiring that insurance plans operating under the health insurance exchanges pay federally-qualified health centers (FQHCs) (including "look-alike" health centers that

Table 1.
Differences Between the Mandatory and Authorized Funding Levels for Section 330 Grants Under Health Reform

	Fiscal Year				
	2011	**2012**	**2013**	**2014**	**2015**
	(millions of dollars)				
Mandatory*	$3,065	$3,265	$3,565	$4,265	$5,665
Authorized	$3,662	$4,991	$6,449	$7,333	$8,333

* The levels shown are the sum of the FY 2008 funding level and the increases authorized by Sec. 2303 of HCERA. If the FY 2009 appropriation of $2.19 billion is used as the base instead, the levels would be $125 million more in each year.

[5] HCERA, §2303
[6] PPACA, §10503
[7] PPACA, §5601
[8] PPACA, §1311(c)(1)(C)

meet all Section 330 requirements but do not receive Sec. 330 grants) the same amount that would be paid under Medicaid, which requires that states pay enhanced reimbursements determined under a prospective payment rate system or alternative methodology.[9]

- Requiring Medicare to develop and adopt a revised payment system for FQHCs based on a prospective payment rate system, which takes into account the type, duration and intensity of services provided. [10]

Health Insurance Expansions

As the expansion of health centers is under way, the two critical insurance expansions will take effect in 2014. The first is the expansion of Medicaid to reach all non-elderly people (except certain immigrants) with incomes below 133 percent of the federal poverty line.[11] The second is the creation of health insurance exchanges coupled with the availability of "affordability" tax credits whose value is adjusted for family income. These credits will help low- to moderate-income families pay for health insurance. The Congressional Budget Office (CBO) has estimated the new law will reduce the number of uninsured people by about 32 million by 2019.[12]

Methods

This report builds on the methodology that we developed in developing estimates for the House and Senate legislative proposals. Because the methods have been fully described in recent reports, we refer readers to those reports for more detail. The methodology has three basic components:

1. We use data about projected funding levels, based on the legislation, and the actual patterns of FQHC revenues, costs and patients served to estimate the number of patients who will be served nationwide in future years. Unlike our prior reports, in this report we estimate two funding scenarios, based on the Sec. 330 grants: one at the minimum mandatory levels and one at the higher authorized funding levels. Since the numeric funding targets under PPACA and HCERA end in 2015, we assume that under the mandatory funding, Sec. 330 grants will rise 5 percent per year from 2016 to 2019 and that under the authorized levels, funding rises 7 percent per year from 2016 to 2019. (Note: To be conservative, we only include the $9.5 billion in mandatory funding provided for health center operations. We do not include the $1.5 billion in funding for construction and renovation of health centers in these estimates. While these funds could further expand health center capacity, they would not directly contribute to the operational costs of patient care.)

[9] PPACA, §10104(a)
[10] PPACA, §10501
[11] In addition, there is a standard 5 percentage point deduction, so the effective income cutoff is 138 percent of the poverty line.
[12] 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.

We base health center financial estimates on actual revenue, cost and patient data from the Uniform Data System reports filed by FQHCs for 2008 (in our prior reports we used 2007 data). We assume 4.2 percentage point annual increases in future costs per patient, which is the average rate experienced over the prior five years. To account for the policy changes under PPACA, we elevate payment rates made by Medicare and private insurers under the health insurance exchanges, beyond those made in 2008.

2. We conducted analyses of the nationally representative 2006 Medical Expenditure Panel Survey (MEPS), comparing annual medical expenditures of people who had received care at community health centers and those who had not. After adjusting for an array of factors, including age, gender, income, insurance coverage and health status, an average person who received care at a community health center had annual medical expenditures of $3,500, while the same person who did not receive care at a health center would have annual expenditures of $4,594. This indicated that there were annual savings of $1,093 per person in 2006, associated with receiving care at a community health center. This included both ambulatory and hospital-related savings. These results were consistent with other studies showing savings and reductions in utilization related to the use of community health centers.[13] We project these annual per person savings forward, using the CMS implicit price deflator estimates for medical expenses.

3. We use CBO estimates of future insurance coverage patterns to adjust the percent of health center patients who are covered by Medicaid, health insurance exchanges, uninsured, etc. Based on the experience in Massachusetts, we assume that post-reform, health centers still continue to attract disproportionate numbers of Medicaid and uninsured patients.[14]

Like any projections, these estimates are based on a variety of assumptions. If future economic trends vary from our assumptions, if our interpolations of CBO estimates are off, if implementation runs quite differently than planned, if medical practices or costs vary considerably from recent experiences, or if future policies change in unexpected ways, then our estimates would be subject to error.

Like all other health expenditures, health centers' expenditure levels are affected by a number of cost drivers, such as changes in the salaries of health center staff, costs for maintenance and improvement of facilities, changes in technology (including both new medical innovations and health information technology), increases in utilization of services and changes in the cost of medications or lab tests.

In this paper, we refer primarily to FQHCs. We do not include estimates for about one hundred "FQHC-lookalikes" or for self-designated community health centers that meet neither FQHC nor look-alike criteria, although health reform may affect these other centers as well.

---

[13] Streeter, S. et al. "The Effect of Community Health Centers on Healthcare Spending and Utilization." Washington, DC: Avalere Health. Sept. 2010.

[14] Ku, L, Jones, E., Finnegan, B., et al. "How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform." Kaiser Commission on Medicaid and the Uninsured and Geiger Gibson/RCHN Community Health Foundation Research Collaborative. Mar. 2009.

Findings

Since health centers are required to operate as non-profit organizations under strong accountability standards, our approach assumes that health centers will serve as many patients as their revenues permit. As a result, the number of patients served at health centers depends on the revenue available to health centers and the distribution of insurance coverage among health center patients. PPACA and HCERA increase health center revenues in four key ways: (1) by increasing federal health center grants; (2) by increasing Medicaid revenues as a result of expanded Medicaid coverage; (3) by expanding coverage for low- and middle-income people through the insurance exchanges and setting standards for qualified health plans regarding payments to FQHCs; and (4) by raising payment rates from Medicare. In addition, by reducing the percentage of their caseload that is uninsured, health centers will "lose" less money caring for the uninsured, so they can serve more total patients.

It is important to note that federal health center grants and payments under Medicaid and private health insurance represent only a portion of total health center revenue. Other important sources include other federal, state, local and private grants or contracts. As in our prior report, we conservatively assume that these other funding sources will grow by only 5 percent annually. Historically, the other funding sources have grown at a faster pace. While Medicaid, CHIP and Medicare payment rates are ultimately linked to the historical costs of care at health centers, these payment rates have not generally been able to keep pace with total health center costs, so other revenues, such as Sec. 330 grants, help make up the difference.

Table 2 presents our projections of the number of patients that would be served by health centers in 2009, 2015 and 2019 under mandatory and authorized funding levels. At the mandatory funding levels, health center caseloads would rise from about 18.8 million in 2009 to 33.8 million in 2015 and would almost double to 36.3 million by 2019.[15] [16] The share of patients covered by Medicaid or by health insurance exchanges would rise, while the share that is uninsured would fall sharply. The pattern would be similar if funding reached the authorized levels, except that the number of patient served would be much higher, reaching 44.1 million by 2015 and 50 million by 2019.

These projected increases in health center caseloads are fairly consistent with past growth levels. FQHCs served 9.6 million patients in 2000 and the number of patients roughly doubled by 2009. If we assume that Sec. 330 grants rise at the mandatory funding levels, FQHC caseloads would roughly double again by 2019. Health centers have demonstrated the capability to expand in order to serve more needy patients in medically underserved areas, provided that resources are available.

Health center capacity would increase considerably, helping to meet the new demands for primary health care that are expected once more people have health insurance coverage. A major

[15] If we assume that future Sec. 330 funding levels are based on FY 2009 levels and are $125 million more in each year from 2011 to 2015, then caseloads would reach 34.3 million by 2015 and 36.8 million by 2019.

[16] Our projections of caseload growth are somewhat lower than the 20 million estimated by the National Association of Community Health Centers, "Health Centers and Health Care Reform: Health Center Funding Growth," April 2010.

Table 2.
Estimated Number and Percent of Health Center Patients Under Health Reform at Mandatory and Authorized Funding Levels: 2009, 2015 and 2019

	At Mandatory Funding Levels					
	Millions of Patients			Percent Distribution		
	2009	2015	2019	2009	2015	2019
Medicaid	6.7	14.5	15.9	35.8%	43.0%	43.9%
Medicare	1.4	2.7	3.0	7.5%	8.0%	8.2%
Other Public	0.5	1.0	1.1	2.8%	3.0%	3.0%
Private Insurance	2.9	5.1	5.0	15.6%	15.0%	13.7%
Exchange Plans	0.0	2.2	3.3	0.0%	6.5%	9.2%
Self-pay/Uninsured	7.2	8.3	8.0	38.3%	24.5%	22.0%
TOTAL	**18.8**	**33.8**	**36.3**	**100.0%**	**100.0%**	**100.0%**

	At Authorized Funding Levels					
	Millions of Patients			Percent Distribution		
	2009	2015	2019	2009	2015	2019
Medicaid	6.7	19.0	22.0	35.8%	43.0%	43.9%
Medicare	1.4	3.5	4.1	7.5%	8.0%	8.2%
Other Public	0.5	1.3	1.5	2.8%	3.0%	3.0%
Private Insurance	2.9	6.6	6.9	15.6%	15.0%	13.7%
Exchange Plans	0.0	2.9	4.6	0.0%	6.5%	9.2%
Self-pay/Uninsured	7.2	10.8	11.0	38.3%	24.5%	22.0%
TOTAL	**18.8**	**44.1**	**50.0**	**100.0%**	**100.0%**	**100.0%**

Source: GW estimates

concern that has been expressed about health insurance expansion is whether there would be enough primary care providers to meet the new demands. These results suggest that health centers can go a long way toward meeting that demand. CBO has estimated there will be 32 million fewer uninsured people by 2019; this analysis shows that health center capacity can grow by about 18 million by then and ought to be able to handle a substantial portion of those newly insured, while continuing to serve many who remain uninsured.

In order to expand to serve so many more patients, we assume that the number of health center grantees and the number of health center delivery sites (i.e., clinics) would grow substantially, permitting a major expansion of health centers and clinics into more medically underserved rural, suburban and urban communities. As we noted in our earlier report,[17] the analyses have limits. While we controlled for a number of factors, such as age, health status and insurance coverage in our analyses of MEPS data, there may be other unmeasured factors that lead to differences in medical expenditures of health center users and non-users; this was not a randomized study. Some health centers users receive care intermittently and might not attain the level of health center use assumed by the models above. In addition, the new patients who enroll in health centers may differ in risks or characteristics from the average population, so the average savings estimated under the models may not correspond perfectly to those for the newly enrolled.

To estimate the total medical savings associated with the expansion of services at health centers over the next ten years, we used the projections of growth in the number of health center

[17] Ku, et al. Sept. 2009, o*p cit.*

Table 3.
Estimated Total Medical Savings and Federal Medicaid Savings Related to the Increase in the Number of Patients Served at Community Health Centers

	2009	2015	2019	Multi-year Totals 2010-2015	Multi-year Totals 2010-2019
With Funding at Mandatory Levels					
Total Number of Patients (mil.)	18.8	33.8	36.3		
Increase Over 2009 Patients (mil.)		15.1	17.6		
Est. Per Person Total Med Savings	$1,262	$1,520	$1,756		
Est. Total Medical Savings ($ bil.)	--	$22.9	$30.9	$70.1	$181.0
Est. Federal Medicaid Savings ($ bil.)	--	$6.5	$9.6	$18.7	$51.8
Est. State Medicaid Savings ($ bil.)	--	$4.2	$5.9	$12.9	$33.2
With Funding at Authorized Levels					
Total Number of Patients (mil.)	18.8	44.1	50.0		
Increase Over 2009 Patients (mil.)		25.3	31.3		
Est. Per Person Total Med Savings	$1,262	$1,520	$1,756		
Est. Total Medical Savings ($ bil.)	--	$38.5	$54.9	$121.7	$315.6
Est. Federal Medicaid Savings ($ bil.)	--	$11.0	$17.0	$32.4	$90.3
Est. State Medicaid Savings ($ bil.)	--	$7.1	$10.5	$22.3	$57.8

Source: GW estimates
Note: Numbers may not sum due to rounding.

patients above 2009 levels and applied inflation-adjusted per person savings associated with the use of community health centers. The results are summarized in Table 3.

Our estimates indicate that if funding is set at mandatory levels and caseloads rise to 36.3 million by 2019, then total medical savings will reach $181 billion over the ten-year 2010-2019 period.[18] On the other hand, if funding reaches the higher authorized levels and health center caseloads grow to 50 million by 2019, then overall medical savings will reach $316 billion over ten years.

These estimates are for the *incremental* savings associated with growth in the number of health center patients beyond the 2009 levels. (This estimate of additional savings is akin the approach used by the CBO when they estimate the cost or savings associated with legislation; they estimate only the marginal or additional costs or savings, not the current costs or savings.) These do not include the estimated $23.7 billion in medical expenditures per year that are *already* saved by the 18.8 million patients served in 2009. After adjusting for inflation, the estimated medical savings associated with the 18.8 million patients already served is about $282 billion over the 2010-19 period.

[18] If future Sec. 330 funding levels are based on FY 2009 appropriations and are $125 million higher in each year from 2011 to 2015, then the savings would be about 2 percent higher: $185 billion total savings from 2010-19, $53 billion in federal Medicaid savings and $34 billion in state Medicaid savings.

The total medical savings shown in Table 3 includes savings that could be realized by governments, insurers, and consumers. To help illustrate the impact on governments, we also estimate the federal and state Medicaid expenditure savings. We estimate these savings based on the estimated proportion of health center revenues deriving from Medicaid and from adjusted estimates of the federal and state fractions of total Medicaid cost. Since health reform increases the federal matching rate for adults whose eligibility is expanded (and for childless adults in states that had already expanded coverage), the overall federal portion of total Medicaid costs will rise, while the states' share will fall. We computed the adjusted federal and state shares of Medicaid costs based on the CBO estimates.[19]

As seen in Table 2, if Sec. 330 funding is at the mandatory levels, then federal Medicaid expenditures are estimated to fall by $52 billion over the 2010 to 2019 period, while states' Medicaid expenditures will decline by $33 billion. If Sec. 330 funding reaches the authorized levels, then Medicaid savings would be larger: $90 billion in federal savings over the decade and $58 billion in state Medicaid savings. To the best of our knowledge, CBO did not consider these savings when deriving its projected budget effects of health reform. Thus, these savings would be in addition to CBO's assumptions of federal and state Medicaid expenditures.

The discussion above has primarily focused on savings over the next 10 years. In the nearer term, we can examine savings over the six year period 2010 to 2015. At the *current* levels of service –18.8 million patients per year – we estimate $158 billion in overall medical savings from 2010 to 2015, including $42 billion in federal Medicaid savings and $29 billion in state Medicaid savings. With the *additional* funding at mandatory levels provided under PPACA, there would be additional medical savings of $70 billion, including $19 billion in federal Medicaid savings and $13 billion in state savings; these are the incremental savings associated with increased numbers of patients served. All told, combining the savings due to current number of patients and the additional patients possible due to increased funding, the medical savings from health centers will total more than $200 billion from 2010 to 2015, including more than $60 billion federal Medicaid savings and more than $40 billion in state Medicaid savings.

Discussion

Two challenges loom large after the passage of health reform: (1) Will the nation be able to hold down health care costs in the long run? (2) Will there be enough primary care providers to serve those who are newly insured? Our findings indicate that the expansion of community health centers will play an essential role in addressing two of the long-term challenges of health reform: curbing the growth of overall health care expenditures and bolstering the capacity of the primary care system to meet the needs of the millions of newly insured Americans.

Our research indicates that the expansion of health centers can reduce both federal and state Medicaid expenditures. To the best of our knowledge, CBO did not consider these potential effects of health center expansion when estimating that the federal government would spend about $434 billion more on Medicaid and CHIP over the next decade and that states would spend about $20 billion more.[4] Our analyses suggest that the effective federal cost of the combination of health center and Medicaid expansions ought to be much lower than projected by

[19] Elmendorf, *op cit.*

CBO and that states could reduce their overall Medicaid expenditures, not increase them. For example, the $20 billion in additional state expenditures estimated by CBO minus $33 billion in FQHC-related state Medicaid savings estimated here assuming mandatory funding levels suggests that states might actually save about $13 billion over the next decade, compared to the amounts they would otherwise spend. This also suggests that if states provide further funding for health centers, the additional funds will fuel additional health center growth and generate even greater medical savings.

The expansion of community health centers should also help lessen concerns about a potential provider shortage. By law, health centers are located in medical underserved areas or serve medically underserved populations. Thus, they are designed to serve the areas and populations most likely to be affected by provider shortages. After Massachusetts implemented its health reform, health centers were able to increase their caseloads to help serve the newly insured populations, as well as continue to serve those who remained uninsured.[6] Of course, the growth of health centers also depends on the availability of primary care clinicians and sometimes health centers have difficulty recruiting physicians. The increase in funding for the National Health Service Corps provided by the health reform law should help bolster the supply of clinicians able to serve at FQHCs and other areas with a shortage of health professionals. Moreover, more than most private physician practices, FQHCs usually rely on a team-based approach to care and make fuller use of nurse practitioners, physician's assistants, regular nurses and other allied health staff to provide patient care.[20, 21] For example, almost 90 percent of health centers employ nurse practitioners or physician's assistants, compared to less than half of regular private physicians' offices, and almost a third of health center patients receive care from such clinicians.[22] By diversifying staffing, health centers are better able to cope with shortages of any specific type of clinician. In the long run, however, the supply of primary care clinicians, whether they are to serve patients in community health centers or in private practices, will need to be expanded and the nation and states will need to consider how to address this problem. The health reform law creates new federal and state organizations to help monitor the health care workforce and to recommend future solutions.

Two key considerations arise in assuring that these savings are realized. The first is the extent to which the health center growth funds are invested quickly — as a readiness matter — in advance of the expansion of health insurance coverage in 2014. The second is the ability to sustain this initial health center investment over time through continuing support for the initial growth in health centers and through public and private health insurance payments.

With respect to the rapid investment of health center funds, the federal government, particularly the Health Resources and Services Administration, has an admirable record in promoting the growth of health centers, with strong bipartisan support. Between 2000 and 2009, the number of patients receiving care at health centers roughly doubled. More recently, the

[20] National Association of Community Health Centers, Robert Graham Center, George Washington University. *Access Transformed: Building a Primary Care Workforce for the 21st Century*. Washington, DC: Authors. Aug. 2008.

[21] Adashi, E., Geiger, H.J., Fine, M. "Health Care Reform and Primary Care — The Growing Importance of the Community Health Center," *NEJM,* published online on April 28, 2010.

[22] Hing, E., Hooker, R. and Ashman, J. "Primary Care Delivery in Community Health Centers," presentation at American Association of Medical Colleges Physician Workforce Conference, May 2010.

Administration proved adept at rapidly allocating $2 billion in new funding, provided under the American Recovery and Reinvestment Act, into grants to help health centers expand operations and improve capital facilities. It has been projected that these funds will help health centers serve about 2 million more patients by 2011.[23]

With respect to the second issue, the implementation of the health insurance expansions, along with the modifications of health center reimbursement provisions in health reform, will be central to achieving growth in the number of people receiving care at community health centers and realizing savings through improved primary care. The Department of Health and Human Services will need to carefully plan and work with states and health insurers to ensure that the coverage expansions and reimbursement reforms are implemented on a timely basis. Taken together, the health insurance expansions and investments in primary care capacity can create an economic engine to spur a high quality and sustainable system of primary health care for the nation.

[23] Shin, P., et al. "The Economic Stimulus: Gauging the Early Effects of ARRA Funding on Health Centers and Medically Underserved Populations and Communities." George Washington Univ., Feb. 16, 2010.