Health Centers Overview

National Conference of State Legislatures

Health Care Safety-Net Toolkit for Legislators
Federally Qualified Health Centers (FQHCs), also known as “health centers,” are community-based, nonprofit or public organizations that provide services to people who lack access to health care, including those without insurance, residents of rural and underserved areas, and Medicaid patients. These services are available to all people, regardless of their ability to pay. Health centers include community health centers, migrant health centers, health care for the homeless health centers and public housing primary care centers.

Most health centers receive federal grant funding under Section 330 of the Public Health Service Act, while others—referred to as Look-Alikes—meet all requirements to receive a grant but do not actually receive such funding. To qualify as a health center, an entity must provide comprehensive primary health care services to all, be located in or serve a high-need community and be governed by a patient-majority board. Health centers also offer support services such as health education, translation and transportation. The 2010 Affordable Care Act (ACA) expands the reach of health centers in the nation’s health care system. In this document, the term “health centers” refers to the two main categories of centers—Federally Qualified Health Centers (Section 330-funded grantees) and Look-Alikes.

Location of Health Centers
Health centers are located in areas where there are medically underserved communities and vulnerable populations, including sparsely populated rural locations with few patients or highly populated urban centers with high rates of publicly insured or uninsured patients. Health centers must serve a federally designated medically underserved area or population. In 2012, more than 21 million people accessed health services in the 8,900 health center delivery sites across the nation.1
How Communities Reduce Their Patients’ Barriers to Care

A person’s inability to access health care often involves a complex set of factors, extending beyond insurance or income status. Limited-English speakers, for example, may be uncomfortable with clinical staff who speak only English. Non-drivers may lack transportation to an out-of-neighborhood health care provider. A person may not have the necessary knowledge or skills to manage complex, multi-stage treatments. Supporting services—often referred to as enabling services—offered by health centers reduce obstacles to health care and often attract patients. These services can include translation services, benefit or eligibility counseling, health education and transportation. Nationally, health centers spent $943 million—nearly 7 percent of their total costs—on supporting services to meet a diverse range of patient needs in 2011. Health centers fund these services from a variety of sources. Some states, for example, fund translation services through Medicaid reimbursements. Other services are paid for through federal grants.

Number of Health Center Sites by State, 2012

Special Populations and Community Health Centers

Several groups of people experience unique challenges to accessing health care. While all health centers provide services to meet a range of patient needs, some centers also receive funding to target the distinctive health needs of special populations such as migrant and seasonal farmworkers, homeless individuals and residents of public housing. Such populations tend to face barriers to obtaining care, such as the absence of consistent primary or preventive health care, increased exposure to hazardous work or living conditions and a mobile lifestyle. In 2011, these special population health centers served more than 2 million individuals across the United States. For more information about special population health centers, please see NCSL’s Community Health Centers web page at www.ncsl.org/Default.aspx?TabId=14503.
Managing Chronic Conditions, Focusing on Prevention

Health centers provide preventive care services such as immunizations, mammograms, prenatal care, and screening for prostate and other cancers. These preventive care services are considered to be cost-effective because they are inexpensive to administer and help prevent problems or detect them early. Health centers also may prevent or decrease patients’ use of expensive emergency medical services. Research shows uninsured people who live in communities where there is a health center are less likely to have made an emergency room visit.  

Health centers’ focus on prevention and disease management help patients control their own conditions (such as asthma, diabetes and cardiovascular disease) and avoid emergency department visits as well as hospitalizations. A recent study showed that medical expenses of patients who used health centers as their medical home were 44 percent lower than those of comparable patients seen elsewhere, resulting in savings to the nation’s health care system of between $9.9 billion and $17.6 billion annually.  

Health Center Revenue Sources

Health centers serve a unique patient population, which often presents funding challenges. In 2011, the incomes of approximately 72 percent of health center patients were at or below federal poverty guidelines ($22,350 for a family of four in 2012, and $23,550 in 2013). In addition, 36 percent were uninsured, and 39 percent were enrolled in Medicaid or the Children’s Health Insurance Program (CHIP). Although uninsured patients are the largest group served by health centers, out-of-pocket patient payments account for only about 6 percent of total revenue. Due to this revenue gap, centers rely heavily upon grants to subsidize care to the uninsured. Medicaid payments make up 37 percent of an average health center’s funding, and federal government grants account for approximately 22 percent. Funding from state and local governments is about 10 percent, nationwide. Other support is provided by Medicare, private foundation grants, private insurance and other public programs. Due to this mix of funding sources, health centers are likely to be affected by changes not only to state Medicaid programs, but also in federal and state funding.

For more information about health center revenue sources, including Medicaid, please see the Medicaid section in this toolkit. For more information on payment reform, please see the Payment Reform section of this toolkit.

Health Centers and the Medical Home Delivery Model

As states look for ways to contain long-term costs and improve the quality of life for people with chronic conditions, the patient-centered medical home model of care is receiving more attention. Medical homes rely on a team of providers—such as physicians, nurses, nutritionists, pharmacists and social workers—to meet a patient’s health care needs. Studies have shown that the medical home model’s attention to the whole person and integration of all aspects of health care offer potential to improve physical health, behavioral health, access to community-based social services and manage-
ment of chronic conditions. Health information technology and payment reform are key to the success of patient-centered medical homes. As states move forward on planning and implementing medical home programs, health centers can offer expertise as a major provider for the Medicaid population and one that offers comprehensive, coordinated care.

The Health Resources and Services Administration’s (HRSA) Patient-Centered Medical/Health Home (PCMH) Initiative, which supports and encourages health centers to gain recognition as medical homes, is offered in partnership with the National Committee for Quality Assurance (NCQA). For more information see HRSA’s Program Assistance Letter 2011-01 (HRSA PCMH PAL 2011-01).

For more information about patient-centered medical homes, see NCSL’s Medical Home Model of Care Web page at www.ncsl.org/Default.aspx?TabID=17723.

**Affordable Care Act Provisions for Health Centers**

While states continue to address implementation issues of health insurance exchanges, the expansion of Medicaid and other provisions in the Affordable Care Act, health centers are also working to implement and integrate new ACA requirements.

Expanding insurance coverage and Medicaid will allow more people access to the primary and preventive care services health centers provide. With this new demand from newly insured patients, in each state. Some states provide funding support to specific programs or services, such as tobacco cessation or HIV education programs. Other states offer more general support to increase access to care for the uninsured, or to support general safety-net providers in the state.

### State Funding for Community Health Centers

According to the National Association of Community Health Centers, 35 states provided funding to health centers in 2012. At least 19 states decreased health center funding levels, and six states increased funding for health centers. The scope and purpose of state funding for health centers differs in each state. Some states provide funding support to specific programs or services, such as tobacco cessation or HIV education programs. Other states offer more general support to increase access to care for the uninsured, or to support general safety-net providers in the state.

### State Funding for Health Centers, 2012

Health centers face a number of operational challenges. These include: inadequate capital capacity, increased workforce shortages, changing outreach and enrollment dynamics, and changing reimbursement systems. Increased funding for health centers authorized in the ACA will allow health centers to expand and enhance medical, oral and behavioral health services, and to expand health center capital capacity. The new health law authorized and appropriated $11 billion over five years to expand and sustain federal funding for health centers. The majority of this funding, $9.5 billion, will support ongoing health center operations, new health centers sites, the establishment of new centers, and expanded preventive and primary care services at existing sites. The remaining $1.5 billion will support construction and renovations at existing health centers.

**Health Information Technology and Meaningful Use**

The Electronic Health Record (EHR) Incentive Program, created under the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, offers financial incentives to providers to upgrade their existing health information technology systems. To qualify for this incentive program, eligible providers must demonstrate “meaningful use” of EHR technology. “Meaningful use” refers to the adoption of certified EHR technology and the ability to use that technology to meet specific objectives. Those include capturing health information in a standardized electronic format, using that information to engage patients and their families in their care, and securely transmitting the information across multiple settings. Eligible providers at health centers have a patient population of at least 30 percent who are receiving Medicaid or CHIP, are uninsured, or otherwise qualify as a “needy individual.” Physician’s assistants (PAs) at health centers also are considered as eligible providers for the meaningful use and EHR program. The program, managed by the Centers for Medicare and Medicaid Services in partnership with the Office of the National Coordinator for Health Information Technology, will provide the incentive payments. Although states are responsible for administering the Medicaid program, the federal government provides 100 percent federal financial participation (FFP) reimbursement for the incentive payments. In addition, because program administration requires resources and funding, states are eligible to receive an enhanced 90 percent FFP for administrative costs.
Conclusion
Health centers may be a valuable partner in containing health costs and, at the same time, expanding quality medical coverage to underserved patients. With a mission to serve and care for the high-need communities in which they are located, these centers can leverage state and federal resources to address some of the most complex health system problems, including barriers to care for the nation’s uninsured and underserved people, the shortage of primary care providers, disparities in care for people living in rural communities and for racial and ethnic minorities, and the shortage of medical homes for the underserved. Legislators play an important role in helping health centers meet their community’s needs and operate more efficiently. Legislators can be leaders for the network of centers that serve their district and bring useful expertise to their future operations and growth.

Notes
2. Ibid.

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### Getting to Know the Health Center(s) in Your District

- Set up an appointment with any health center in your district and your state primary care association or the primary care office, usually located in the state health department.
- To find health center(s) in your district, use HRSA’s Find a Health Center tool at http://findahealthcenter.hrsa.gov/Search_HCC.aspx.
  - Ask the health center director questions you may have, such as:
    - Who does the health center serve?
    - How many patients does it serve?
    - What is the average patient income?
    - How many patients are uninsured?
    - How many patients are children?
    - How is the center financed?
    - What is the per-patient cost for health care?
    - How long is the waiting list?
    - Where do patients receive specialty services?
    - Are behavioral health services provided?
    - Are dental services provided?
    - What hospitals do patients use?
    - What health needs remain in your legislative district?
    - What challenges does the health center face?
- Contact your state primary care office and ask them about provider shortages in your state.
This brief was written by Hollie Hendrikson.

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