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Federally Qualified Health Centers: Are They Effective?

In 1964, the Office of Economic Opportunity established federally qualified health centers (FQHCs), which were initially called neighborhood health centers, as part of President Lyndon B. Johnson's "War on Poverty." The legislative goals for neighborhood health centers were to:

- Provide comprehensive, high-quality health services.
- Be accessible to low-income residents.
- Be responsive to patient needs.
- Offer employment, education and social assistance.

These goals, with the exception of providing employment assistance, continue today and have expanded to include additional services such as oral health, mental health and pharmaceutical services. The number of FQHCs has grown over the past 40 years. In 1965, there were two FQHCs in the country; today there are more than 1,200 FQHCs with more than 8,500 service sites.[1] The growth has largely resulted from a view that FQHCs can achieve the original goals as well as help curb health care costs by reducing emergency department visits and hospitalizations. Indeed, the Patient Protection and Affordable Care Act (ACA) provides an $11 billion Health Center Trust Fund because of their perceived importance in serving the Medicaid population. In fiscal year (FY) 2011 and FY 2012, however, the federal government cut annual health center appropriations by 27 percent (from $2.2 billion to $1.6 billion).[2] To offset the funding cuts, the Obama administration diverted $600 million from the Health Center Trust Fund each year, preventing those funds from creating new access points and expanding services as intended. In FY 2013, the federal government again held health center appropriations to $1.6 billion, which necessitated another diversion of trust fund dollars.[3] The core question is: What does the evidence say about the impact FQHCs have had on the noted goals? A companion piece to this summary provides a comprehensive overview of FQHCs.

The bottom line answer to this question is that FQHCs are generally meeting their original goals by serving low-income populations with quality, cost-effective health care. Specifically:

1. Health centers, which include FQHCs and FQHC look-alikes,* are providing care to more than 20 million people in the country and more than 600,000 people in Michigan. In 2010, health centers served about 15 percent of the uninsured, 16 percent of the Medicaid population, and 1.6 percent of the privately uninsured, nationally.[4] Similarly, Michigan health centers served about 15 percent of the uninsured, 16 percent of the Medicaid population, and fewer than 2 percent of the privately uninsured in 2010.[5] There remains a significant unmet need.[6]

* FQHC look-alikes are health centers that do not receive Section 330 grant funding but meet the same requirements as FQHCs and receive enhanced payments from Medicare and Medicaid.

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With the ACA Medicaid expansion, FQHCs will become increasingly important. A study of Massachusetts health centers found that the newly insured population did not significantly shift to private health care sources after the state implemented its health reform.[7] In fact, health centers experienced a 31 percent increase in patient volume between 2005 and 2009.[8] Health centers played a major role in caring for the newly insured, particularly during a period when many had difficulty finding primary care, while continuing to serve uninsured residents. Health centers also provided insurance enrollment assistance for the newly eligible. The National Association of Community Health Centers expects health centers to double their capacity to 40 million patients by 2019.[9] The Michigan Primary Care Association anticipates the patient capacity of Michigan's health centers will increase to between 800,000 and 1 million patients by 2015.[10]

2. Quality of care at health centers is comparable to that of private practice physicians, despite serving patients who are generally sicker and poorer.[11, 12, 13, 14]Research indicates that, while there is variability across health centers[15], they perform equal or better than private practice physicians on established ambulatory care quality measure categories (pharmacologic management of chronic disease, preventive counseling, appropriate use of screenings and appropriate prescribing for elderly patients).[16] Health center patients are more likely to be Medicaid-insured, obese or depressed and have a lower household income than the patients of private practice physicians.[17, 18]

3. Health centers appear to be cost effective. Health centers have demonstrated lower rates of preventable hospitalizations and lower emergency department visits than comparable populations that did not use health centers, likely because health centers offer a regular source of care and focus on primary care.[19, 20, 21, 22, 23]
   One Michigan study, commissioned by the Michigan Primary Care Association, found that Michigan FQHCs saved the Michigan Medicaid program $44.87 per member per month overall, relative to the cost of Medicaid fee-for-service beneficiaries who do not use FQHCs.[24]

Overall, FQHCs appear to be achieving their original legislative goals. They face significant challenges, however, including long-term sustainability, clinical staff shortages, lack of access to specialty care and insufficient collaboration with hospitals and other safety net providers.

Having experienced significant appropriations cuts, adequate funding for health centers remains a challenge for their long-term sustainability. As millions of people obtain coverage, health centers expect substantial clinical staff shortages, including primary care physicians, nurses, dentists and mental health professionals.[25] They continue to have difficulty securing specialty referrals for health center patients, often due to specialists' refusal to accept Medicaid or uninsured patients. Finally, health centers often find it challenging to coordinate with other health care and social service providers. These issues need to be addressed for health centers to fully achieve their goals.

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