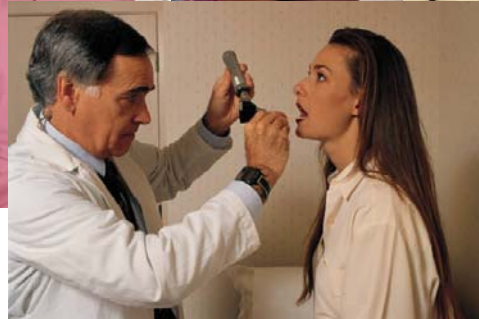
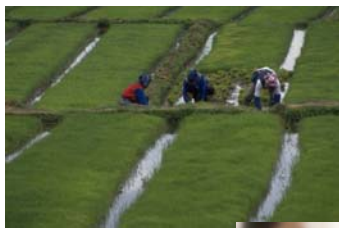


Economic Impact Analysis

THE ECONOMIC IMPACT OF NEW HAMPSHIRE'S HEALTH CENTERS

March 2006



Prepared by:



In collaboration with:



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EXECUTIVE SUMMARY

Eight of New Hampshire's 13 community health centers were surveyed to analyze the economic impact of the state's community health centers on the communities they serve.¹ This report found that the eight New Hampshire health centers had an overall economic impact of more than \$61 million and supported more than 900 jobs in 2004. This analysis clearly demonstrates that as a result of the combined effects of their multiple roles as service providers, employers and local businesses, health centers have a significant impact on community and economic development.

While health centers have long been recognized for the critical role they play in providing access to quality primary health care, the contributions health centers make to the economic viability and growth of the communities in which they are located are often less well known. In addition to providing essential health care services, health centers provide direct employment for people in their communities, including critical entry-level jobs, training and career-building opportunities that are community-based. Health centers also purchase goods and services from local businesses and engage in capital development projects. Every dollar spent and every job created by health centers has a direct impact on their local economies. Health centers also serve as anchors for existing and new businesses and investments in the community. In addition to the direct economic effects, health centers provide indirect and induced economic effects through their purchases of goods and services from other local business, representing the economic growth response by all local industries and individuals.²

Capital Link and Bi-State Primary Care Association have developed this report to illustrate the impact New Hampshire health centers have on their local economies and to promote health centers as viable platforms for economic development both locally and at the state level. This report is intended for the financial and business community, state and federally elected officials, health center executive directors and board members, foundations, and other potential donors, so that they may better understand health centers and their full impact in the state of New Hampshire, in both economic and health outcome terms.

In addition to the economic effects generated by health centers through their regular business operations, many health centers also generate additional economic effects through capital projects and the resulting expansion of services. Every dollar spent on New Hampshire's health centers' capital expansions generates additional dollars and employment opportunities. In 2005, New Hampshire's health centers estimated capital development needs of \$21.9 million over the period 2005-2009.

¹ Four health centers were not included in this report as they have consolidated financial statements within a larger entity and independent statements were not available for this economic impact analysis. Also, one organization has recently been awarded Federally Qualified Health Center designation and the data for this organization is not included.

² For example, Joe Smith, a billing specialist, is paid a salary by the Main Street Health Center (direct effect); he often goes across the street to the local deli to buy lunch (indirect effect); and due to Mr. Smith's support, the deli is able to hire a new employee to handle the lunch crowds (induced effect).

NEW HAMPSHIRE STATEWIDE ECONOMIC IMPACT ANALYSIS RESULTS

New Hampshire's 13 community health centers with 25 facilities statewide served more than 89,000 patients in 2004.³ Nearly 28% or 25,000 of their patients were uninsured, representing 22% of the state's 113,000 uninsured residents.⁴ Approximately 19% or 17,000 of New Hampshire health center patients were enrolled in Medicaid. As such, the health centers play a critical role in the primary care system, particularly for uninsured residents, minority populations and Medicaid recipients who generally lack access to care. Of the 13 community health centers in New Hampshire, eight were surveyed to analyze the economic impact of health centers on the state of New Hampshire.

Summary of FY 2004 Total Economic Activity Stimulated by New Hampshire's Health Centers' Current Operations			
	Total Economic Impact (total output incl. value added)	Value Added (increase in household income of communities served)	Employment
Direct	\$35,650,499	\$24,226,395	627.0
Indirect	\$4,726,567	\$2,944,659	48.9
Induced	\$20,630,815	\$12,986,351	226.8
Total	\$61,007,881	\$40,157,405	902.7

Prepared by Capital Link, Inc. using MIG, Inc. IMPLAN Software

By analyzing their 2004 audited financial and 2004 employment information, we found that New Hampshire's health centers supported the state economy in the following ways:

- New Hampshire health centers had an overall economic impact of more than \$61 million and supported over 900 jobs in 2004.
- The eight health centers injected \$36 million of operating expenditures directly into their local economies.
- These expenditures produced additional indirect and induced economic activity of over \$25 million.
- The overall total output of \$61 million includes \$40 million in household purchasing power, e.g., the aggregate gain in household income within the communities the health centers serve.
- New Hampshire's health centers directly generated 627 time jobs and indirectly supported an additional 276 time jobs as a result of their total operating expenditures.

The above economic impact analysis clearly demonstrates that as a result of the combined effects of their multiple roles as service providers, employers and local businesses, health centers have a significant community and economic development role in their communities. An investment in

³ Source: NH Community Health Center 2004 UDS reports and Federal 330 applications.

⁴ Source: "2003 New Hampshire Health Insurance Survey," University of NH, April 2004.

New Hampshire's health centers is an investment in the economic development of the communities they serve and the state as a whole.

Economic Impact of Capital Projects

In addition to the economic effects generated by health centers through their regular business operations, many health centers also generate additional economic effects through capital projects and the resulting expansion of services. When a health center undertakes a capital expansion and/or renovation project, a significant economic revitalization occurs within the local community. This economic impact has been demonstrated by health centers in various cities where additional "units of health care," new jobs and stimulated local businesses served as the immediate outcomes. In most instances, the capital developments and facility expansions of health centers act as catalysts for significant economic revitalizations within their local communities and serve as anchors in the communities. This "anchor concept" is similar to the effect a large department store has in a shopping mall – the health center attracts investment and other businesses to the community. These long-term economic stimulus effects will accrue in addition to the obvious benefit of increased health services to poor and low-income families and the ethnically-diverse populations of the area.

Many health centers operate in inadequate or outgrown facilities — many of which were not originally designed to provide medical services. As a result, health centers are currently engaged in significant capital development activity as they pursue the replacement or expansion of their existing buildings. Every dollar spent on New Hampshire's health centers' capital expansions will generate additional dollars and additional employment opportunities. In 2005, New Hampshire's health centers estimated capital development needs of \$21.9 million over the period 2005-2009.

These capital projects will contribute directly to increased economic activity, household earnings and jobs in the following ways:

- 1) Local businesses will provide predevelopment technical assistance in areas such as feasibility studies, financial planning, capital campaign development, government approvals, architectural design and engineering assessments;
- 2) Local construction companies will be contracted to build the new sites;
- 3) Local companies will be used, when possible, to purchase equipment and supplies for clinical services, programs and administrative support that will be needed in the new expansions;
- 4) An increased number of employment opportunities will be available in health care and other industries; and
- 5) Increased revenues and reserves will result from providing additional "units of health care."

ECONOMIC IMPACT ANALYSIS METHODOLOGY

The key to quantifying economic impact is understanding the concept and application of the "multiplier effect." Within the field of economics, the multiplier effect is used to determine the impact of spending or investing in a defined economy. These are the indirect business effects of the health centers' business operations, which make the economic impact larger than just the direct effects by themselves. It is based on the principles of dollar turnover, and serves to quantify the economic impact and activity that results from each dollar entering, impacting and eventually leaving a defined economy. This results in increased production and expenditures, employment creation and attraction and retention of new residents, businesses and investments.

Description of IMPLAN

The US Department of Agriculture in conjunction with the Minnesota IMPLAN Group (MIG) developed (and MIG continues to refine) a complete integrated analysis tool for economic planning efforts called IMPLAN (IMpact analysis for PLANning). IMPLAN is a microcomputer-based system for constructing regional economic models. It generates input-output multipliers by geographic region and by industry combined with a county / state database (using the Standard Industry Classification [SIC] system developed by the federal Office of Management and Budget) which allows the assessment of change in overall economic activity. IMPLAN can be used to estimate the impact of organizational projects and expenditures by industry on regional output, household earnings and jobs both inside and outside of a given industry. Consequently, IMPLAN (and similar economic databases) has been used nationally by economists, state and city planners, universities and others to gauge the economic impact of both for-profit and not-for-profit organizations' programs and projects on a local economy.

Standard Economic Multipliers

Within the IMPLAN database, the "Final Demand" effect is examined from the perspective of output (dollars), earnings (purchasing power) and employment (job creation). IMPLAN determines the multiplier effect of these three areas by generating an "Output Multiplier," "Earnings Multiplier" and "Employment Multiplier" for each industry within a defined geographic area.

Output Multiplier: measures the increase in total output generated in a defined regional economy for each dollar spent by a given industry. For example, if the multiplier for health care services is 3.0, then every dollar spent by a health care center would create \$3.00 in economic activity in the local community.

Value-added (Earnings) Multiplier: measures the earnings (purchasing power) that an industry generates, through payroll and the multiplier effect, for households employed by all industries within a defined area. Consequently, the Value-Added impact represents the amount of dollars that aggregate households in a given area will gain in household income based on the dollars put out into that community by a health center through operating expenditures.

Employment Multiplier: measures the number of jobs generated across all industries by the activity within a given industry needed to deliver \$1 million of products or services to a defined geographic area. The multiplier produces an estimate of the total number of new jobs that a local economy can support in all industries due to the dollars being injected into the community by the

health center. In other words, the economic activity of the health center stimulates job growth because of the "snowballing" of the dollars expended.

Summarizing the Results

IMPLAN's output, earnings, and employment figures are aggregated based on direct, indirect and induced economic effects:

Direct effects: represents the response for a given industry (in this case Total Operating Expenditures of New Hampshire's health centers).

Indirect effects: represents the response by all local industries caused by "the iteration of industries purchasing."

Induced effects: represents the response by all local industries to the expenditures of new household income generated by the direct and indirect effects.

ANOTHER ECONOMIC STIMULUS: NEW HAMPSHIRE HEALTH CENTERS AS COST-EFFECTIVE AND HIGH-QUALITY HEALTH CARE PROVIDERS

New Hampshire's health centers and health centers across the country have proven to be not only quality providers, but also cost-effective providers. Health centers save significant amounts of money for their local and state economies by contributing to a healthier and more productive population and by spending every dollar in the most efficient way possible.

By focusing first on prevention, health centers save the health care system overall substantial dollars in avoided emergency room visits, medical treatment and hospitalization costs. National studies show savings to the Medicaid program of more than 30% in annual spending per beneficiary.⁵ Another 2004 federal study published in *Health Services Research* found that uninsured people living in close proximity to a Federally Qualified Health Center (federally funded community health center) were *less likely* to have an unmet medical need, postpone or delay seeking medical care, visit an emergency room, or stay in a hospital compared to other uninsured.⁶ Other studies found the following: 1) that \$1 invested in health center prenatal care provides \$3 to \$4 in savings for care to newborns and their mothers; and 2) \$1 invested in health center diabetes management saves \$3 to \$4 in hospitalization costs for complications.⁷

New Hampshire's community health centers keep people healthy by providing primary and preventive medical and dental care. The health centers provide access to high-quality, comprehensive, low-cost care including immunizations, prenatal care, maternal and child health services, cancer and other preventive health screenings, chronic disease management, and oral health screenings and treatment. In 2004, only 5.2% of all New Hampshire community health center births were low birth weight (<2500 g) compared to 6.3% for New Hampshire overall and 7.8% nationally.⁸ Fewer low birth weight babies means fewer complications, less spent on medical care and a healthier population.

In New Hampshire alone:

- Federally Qualified Health Centers leveraged \$4.85 in federal and community funding for each \$1 received in state general funds in 2004.⁹
- Community Health Centers provided \$5.9 million in charity care to their patients.¹⁰
- Community Health Centers provided \$12.5 million in free prescription drugs to patients through the federal 340B Program, Indigent Drug Program, free samples, etc.¹¹
- Community Health Centers saved their communities an estimated \$1.8 million in medical malpractice premiums through coverage under the Federal Tort Claims Act.¹²

⁵ NACHC Report "Insurance Coverage & a Regular Source of Care: Talking Points on the Need for Both." December 2003.

⁶ *Health Services Research*, Hadley J. and Cunningham P., October 2004.

⁷ Center for Disease Control and Prevention (CDC) 2002.

⁸ Source NH CHCs 2004 UDS, and Source Commercial and Medicaid: The State of Health Care 2003, National Committee for Quality Assurance (NCQA).

⁹ CHC calendar year 2004 UDS and CHC SFY 2004 Governor and Council Approved Primary Care Contracts.

¹⁰ Information as per New Hampshire CHCs, August 2004.

¹¹ Information as per New Hampshire CHCs, May 2005.

¹² Analysis conducted by Bi-State Primary Care Association, 2004.

What Types of Services do Federally Qualified Health Centers Provide?

Services provided by Federally Qualified Health Centers (FQHCs) are available to people of all ages, regardless of financial, linguistic, cultural or geographic barriers to access. FQHCs often have multilingual staff and/or interpreters available on request to ensure high-quality and culturally-competent service to minority populations. They serve Medicaid and Medicare recipients, low-income uninsured and underinsured, high-risk populations and the elderly, as well as insured persons.

In general, FQHCs offer, or make available through contract with other providers, the following types of services:

General Primary Medical Care Services

Adolescent Health
Adult Medicine
Eye Care
Family Practice
Geriatric
Gynecology
Obstetrics
Pediatrics
Podiatry

Other Primary Medical Care Services

Diagnostic Laboratory
Diagnostic X-Ray Procedures
Emergency Medical Services
Urgent Medical Care
24-Hour Coverage
Family Planning
HIV Testing
Immunizations

Dental Care Services

Other Professional Services

Hearing Screening
Nutrition Services other than WIC
Occupational or Vocational Therapy
Physical Therapy
Pharmacy
Vision Screening
WIC Services
Smoking Prevention and Cessation Programs
Chronic Disease Management

Mental Health / Substance Abuse Services

Enabling Services

Case Management
Child Care (during visit to health center)
Discharge Planning
Eligibility Assistance
Employment/Educational Counseling
Environmental Health Risk Reduction
(via Detection and/or Alleviation)
Food Bank/Delivered Meals
Health Education
Housing Assistance
Interpretation/Translation Services
Nursing Home and Assisted Living Placement
Outreach
Transportation Assistance

¹³ For more historical background and definitions/categories of the different kinds of health centers, please refer to Appendices C, D & E.

What Challenges and Opportunities Do Health Centers Face?

Health centers, by virtue of their history and mission, are usually located in financially-disadvantaged communities. Most health center patients have their care paid for by Medicaid, Medicare or federal grants for the uninsured. Health centers are struggling to absorb the swelling ranks of uninsured and underinsured clients who continue to increase at an alarming rate, far outpacing growth in federal grant funding.

An additional problem faced by a growing number of health centers is that over the years they have outgrown their facilities. Many started operations out of small and often donated old buildings not originally designed for the provision of primary health care services. Laboring under perennially tight budgets with slim net margins, health centers have had few, if any, resources available for facility development. Being relatively small in size, most health centers are not staffed to have substantial development expertise in house. Most cannot afford to have individual staff members solely dedicated to capital projects. The lack of development expertise and staffing resources in house is one reason for stalled capital projects. The main obstacle, however, is that many health centers do not have the financial resources to undertake a sizeable project on their own. In addition, limited debt capacity results in fewer willing lenders, which creates an obstacle to obtaining financing for building projects. As a result, centers must solicit resources from other groups, which can be a very time-consuming process.

Despite the challenging financial reality faced by many health centers, they are extremely resourceful and continue to survive in both good and bad economic times. As the sole providers of medical and social services in many instances, health centers are vital components of healthy communities and thus have strong community support. In addition to providing essential services, health centers also serve as economic engines. They are often the largest employers in their respective communities, and are anchors for attracting new businesses and investments into the communities, particularly during and after significant facility renovation or expansion projects.

Health Centers as Cost-Effective and High-Quality Health Care Providers

A 2001 article in a peer-reviewed journal examined various health policy studies and reports documenting the success of health centers in reducing and eliminating health disparities.¹⁴ Highlights from the article include the following:

- Medicaid beneficiaries who seek care at health centers were 22% less likely to be hospitalized for potentially avoidable conditions (Ambulatory Care Sensitive Conditions, or ACSCs) than beneficiaries who obtain care elsewhere.
- Health center patients were 16% more likely to have outpatient visits for ACSC-associated conditions. As a result, health centers have demonstrated reductions in Medicaid costs of 30 to 34% compared with patients receiving care elsewhere.
- The presence of a health center in a community has been associated with a reduction in unnecessary emergency room use, ranging from 13% to 38% in the case of pediatric emergency room use, together with improved health outcomes and lower incidence of chronic disease and disability.

¹⁴ Politzer, R.M., Yoon, J., Shi, L., Hughes, R.G., Regan, J., & Gaston, M. (2001). Inequality in America: The contribution of health centers in reducing and eliminating disparities in access to care. *Medical Care Research and Review*, 58(2), 234-248.

- Preventable hospitalizations in communities served by health centers were lower than in other medically-underserved communities not serviced by health centers. Specifically, patients in underserved areas served by these centers had 5.8 fewer preventable hospitalizations per 1,000 people over three years than those in underserved areas not served by a health center.
- Medicaid patients seen in health centers report the lowest total health care costs, the lowest cost per ambulatory visit, the lowest rate of hospital inpatient days, and the lowest inpatient care costs compared to Medicaid patients seen by area private physicians and hospital outpatient departments.
- Health centers participate in the Health Disparities Collaboratives, a national effort to improve health outcomes for all medically-underserved people with chronic diseases, such as Diabetes, Cardiovascular Disease and Asthma.
- Health centers are eligible for the federal 340B Drug Pricing Program, which provides significant savings on pharmaceuticals for patients of the health centers.
- Behavioral health services at health centers increase the cost-effectiveness of care by managing psychosocial aspects of medical conditions, by providing alternative interventions to psychotropic medications and by preventing reliance on the costly specialty mental health system.
- Health center Medicaid patients are 19% less likely to use the emergency room and 11% less likely to be hospitalized for potentially avoidable conditions than those with a usual source of care who received care elsewhere.
- The Institute of Medicine and the General Accounting Office cite health centers as models for screening, diagnosing and managing chronic illness and recognize the success of health centers in removing barriers to care. The federal Office of Management and Budget recently cited the health center program as one of the 10 most successful federal programs.
- Numerous studies show that the use of health centers leads to:¹⁵
 - Improved health outcomes,
 - Reduced inpatient admission rates for their patients,
 - Lower incidence of chronic disease and disability,
 - Lower utilization of more costly emergency rooms, and
 - Reduced length of stay among those who are admitted.
- Health centers score above average on Health Plan Employer Data and Information Set (HEDIS) quality measures. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing.
- All health centers funded under Section 330 of the Public Health Service Act undergo a federal performance review or comparable private sector survey every three to five years. The federal performance review is a comprehensive quality review tool created for health centers by the federal government. These surveys, which include on-site chart audits, are a thorough test of quality of care and other clinic functions. All Section 330-funded health

¹⁵ See Politzer et. al.

centers must successfully complete such a survey in order to continue receiving federal funds.

- All health centers funded under Section 330 of the Public Health Service Act undergo an independent financial audit, and if their budgets exceed \$500,000 in federal revenue, they must undergo a more detailed and rigorous A133 federal standard review.

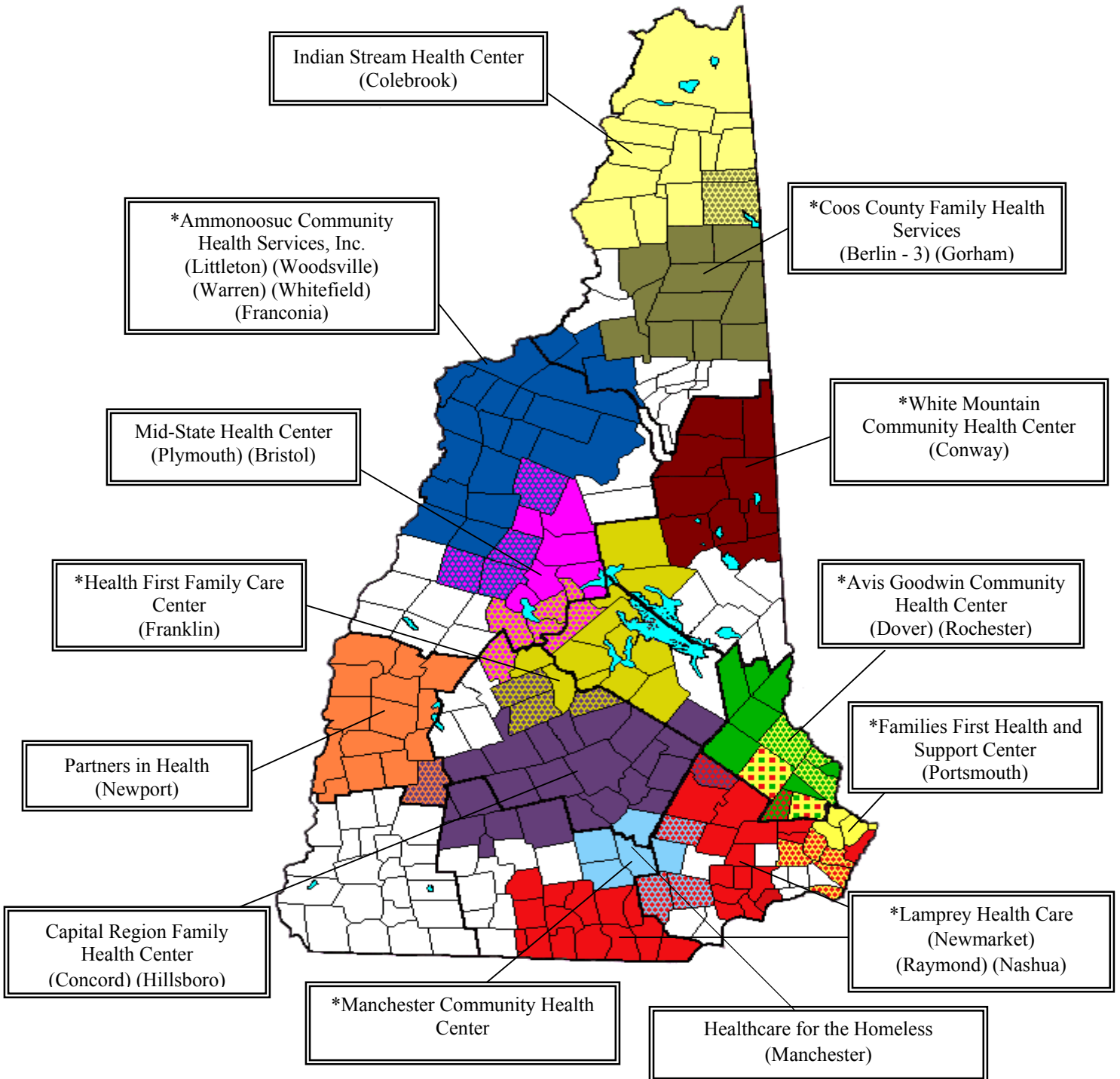
APPENDIX A: NEW HAMPSHIRE HEALTH CENTER MAP

BI-STATE PRIMARY CARE ASSOCIATION



SERVING VERMONT & NEW HAMPSHIRE

**NEW HAMPSHIRE
COMMUNITY HEALTH CENTER SERVICE AREAS**
*Indicates Health Centers Included in the Report



* Based on service areas October 2005 and textured areas denote towns in two or more CHC service areas.

APPENDIX B: REPORT AUTHORS

Bi-State Primary Care Association

Bi-State Primary Care Association's mission is to foster the delivery of primary health care services to medically-underserved and geographically, culturally and linguistically isolated persons in the states of Vermont and New Hampshire.

Bi-State is a private, 501(c)3 not-for-profit organization with a broad membership of 32 organizations in Vermont and New Hampshire that provide and/or support community-based primary care. A "voice" for the medically-underserved, Bi-State members include community health centers, rural health clinics, private/hospital-based primary care practices, Community Action Program, health care for the homeless programs, area health education centers, clinics for the uninsured, family planning and social service agencies, and hospitals.

Bi-State works with federal, state and regional health policy organizations and policymakers, foundations, and payers to develop strategies, policies and programs that promote and sustain community-based, primary health care services. With offices in Montpelier, Vermont and Concord, New Hampshire, the organization provides advocacy, technical assistance, education and training, networking opportunities, and resource and information services.

Bi-State also operates a non-profit recruitment center (the NH/VT Recruitment Center), which provides primary care recruitment services to federally qualified health centers and rural health clinics, as well as private and hospital-sponsored physician practices. Key to these recruitment efforts are incentive programs such as educational loan repayment and National Health Service Corps programs. Recruitment Center staff members promote these opportunities and assist candidates through the application process.

Services Provided

- Advocacy for 100% Access, No Disparities in Medical and Oral Health
- Work Force Recruitment Activity
- Policy Monitoring and Analysis
- Advocacy for Appropriate Reimbursement from Public and Private Payors
- Resources to Assure Access to Care for the Under- and Uninsured
- Networking, Support, Information and Resource Sharing
- Continued Education, Training/Technical Assistance and Consultation
- Integrated Service Network Development
- Clearinghouse Activities
- Project Collaboration and Development of Public-Private Partnerships
- Community Development and Planning

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Capital Link

Capital Link, a nonprofit organization headquartered in Boston, Massachusetts, assists health centers nationally in planning and obtaining financing for capital projects. Capital Link provides a wide range of services and products, which include but are not limited to the following:

- Preliminary Feasibility Analysis
- Project Planning & Team Development
- Assistance with Debt Financing
- Assistance with Fundraising
- Business Plans & Financing Applications
- Capital Needs Survey & Financial Trends Analysis
- Statewide Economic Impact Analysis
- Educational Presentations to PCA Members

Capital Link is currently staffed in six states (Massachusetts, Maryland, Missouri, North Carolina, Washington and California) and is governed by a Board appointed by the National Association of Community Health Centers, the Community Health Center Capital Fund, the Massachusetts League of Community Health Centers, the Illinois Primary Health Care Association, the New Carolina Primary Health Care Association and the Texas Association of Community Health Centers. Capital Link receives support from the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.

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APPENDIX C: THE BEGINNINGS OF THE HEALTH CENTERS

The concept of community-based health care came to prominence during the mid 1960s, driven by concerns over an increasing number of people without adequate access to basic health care, particularly in the inner cities and rural areas of the country. Many types of organizations identify themselves as “community health centers,” “neighborhood health centers,” “health centers” or “health clinics.”

There are however, two main federally-designated categories for health:

- Rural Health Centers (RHCs) and
- Federally Qualified Health Centers (FQHCs)

The FQHC category is further divided into two subgroups:

- “Section 330” community health centers (CHCs)- those that receive an annual federal operating grant from BPHC to subsidize the cost of providing care to the uninsured and/or medically underserved
- FQHC “Look-Alikes” - those that do not receive federal operating support but otherwise meet the definition of an FQHC

A fundamental quality of FQHCs is the involvement of the community in the governance of the center. Most FQHCs operate independently and all are governed by a community board of directors of which at least 51% are users of the health center’s services.

All FQHCs are public or private non-profit entities, which provide comprehensive primary and preventive health care, including dental care and related social services to medically-underserved individuals and families regardless of their abilities to pay. FQHCs serve children, families, the elderly, Medicaid and Medicare recipients, low-income uninsured and underinsured individuals, high-risk populations, farm workers and the homeless. They provide a wide range of cost-effective primary and preventive medical services as well as other services including health and nutrition counseling, translation and community outreach. According to the most recent Uniform Data System (UDS) data available from the federal Bureau of Primary Health Care (BPHC), over 1,000 Section 330 and FQHC Look-Alike community health centers served over 15 million patients in 2004.¹⁶

The Community Health Center Program was originally authorized under Section 330 of the U.S. Public Health Service Act, 42 USC, 254b. Section 330 was subsequently revised in 1996 by the Consolidated Health Centers Act, which combined the prior community health center program (Section 330e), the migrant health center program (Section 330g), health care for the homeless program (Section 330h), and the public housing primary care program (Section 330i). Though they each serve slightly different subgroups of medically-underserved individuals, all of these health center types are currently known as “Section 330 health centers.” Public Law 107-251, passed by Congress in October 2002 and titled “The Health Care Safety Net Amendments of 2002,” amended the Public Health Service Act to reauthorize and strengthen the health center program and the National Health Service Corps through 2006.

¹⁶ 2004 UDS. NACHC Fact Sheet, August 2005, <http://www.nachc.com/research/Files/IntrotoHealthCenters8.05.pdf>.

Other Community-Based Primary Care Programs

There are certain other community-based primary care providers that do not entirely meet the federal definitions for FQHC, but are considered by the National Association of Community Health Centers (NACHC) and state Primary Care Associations (PCAs) to be safety-net providers. These providers are typically hospital-based clinics, state or county-owned clinics or stand-alone health centers that share many of the characteristics of FQHCs but are not formally designated as such.

Beyond the FQHC, FQHC “Look-Alike,” and RHC organizations, there are also many other organizations that are community-based health providers. Examples of these types of organizations would be free clinics for the uninsured, family planning clinics, home health care agencies, etc., which do not provide a full range of comprehensive primary care services, but provide health care services to certain categories of “underserved” populations.

APPENDIX D: HEALTH CENTER CATEGORIES

Criteria	Federally Qualified Health Center (FQHC)		Rural Health Center (RHC)
	<i>Section 330 Health Center</i>	<i>FQHC Look-Alike</i>	
<i>Location</i>	Urban or Rural.	Urban or Rural.	Rural.
<i>Designation by</i>	BPHC, through annual grant application.	Centers for Medicare & Medicaid Services (CMS), through annual recertification.	CMS, through annual renewal.
<i>Designation Requirement</i>	Must serve a defined geographical area or population, which is federally-designated as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP).	Must serve a defined geographical area or population, which is federally-designated as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP).	MUA, MUP, federally designated Health Professional Shortage Area (HPSA) or designation by the state's governor as underserved.
<i>Corporate Structure</i>	Non-profit entity.	Non-profit entity.	Non-profit or For-profit entity.
<i>Board of Directors</i>	Governing board with full authority over operations. Majority of board members must be users of center services.	Governing board with full authority over operations. Majority of board members must be users of center services.	No board required.
<i>Management Staff</i>	Must have at least an Executive Director, Clinical Director and a Finance Director.	Must have at least an Executive Director, Clinical Director and a Finance Director.	Not required.
<i>Services</i>	Must provide defined scope of comprehensive primary and preventive health services to include all lifecycle ages. Must also provide supplemental services necessary to assure the effectiveness of the required primary health care services.	Must provide defined scope of comprehensive primary and preventive health services to include all lifecycle ages. Must also provide supplemental services necessary to assure the effectiveness of the required primary health care services.	Must be capable of delivering outpatient primary care services. Scope not defined, could be one or a combination of primary care services.
<i>340-B Pharmacy Program</i>	Eligible for the federal 340B Drug Pricing Program, which provides significant savings on pharmaceuticals for patients of the health centers.	Eligible for the federal 340B Drug Pricing Program, which provides significant savings on pharmaceuticals for patients of the health centers.	Not eligible.
<i>Financial Access</i>	Services must be available to all regardless of ability to pay. Sliding-fee scale based on income must be in place.	Services must be available to all regardless of ability to pay. Sliding-fee scale based on income must be in place.	Not required.

Criteria	Federally Qualified Health Center (FQHC)		Rural Health Center (RHC)
	<i>Section 330 Health Center</i>	<i>FQHC Look-Alike</i>	
<i>After-Hours Coverage</i>	Must be open at least 32 hours per week and provide professional coverage when practice is closed.	Must be open at least 32 hours per week and provide professional coverage when practice is closed.	Not required.
<i>Audit and Reporting Requirements</i>	Must conduct an annual audit that meets federal 330 compliance requirements. Must submit an annual Uniform Data System (UDS) report to the BPHC.	Must conduct an annual audit that meets federal compliance requirements.	Not required.
<i>Financial Support</i>	Section 330 operating grant to provide care to medically-underserved.	No Federal Grant.	No Federal Grant.
<i>Medical Malpractice Coverage</i>	Eligibility for other federal programs/initiatives, e.g., Federal Tort Claims Act (FTCA) malpractice coverage of clinicians.	Not eligible.	Not eligible.

APPENDIX E: GLOSSARY

*For more information
please go to ▼*

- CMS** **Centers for Medicare & Medicaid Services:** (formerly Health Care Financing Administration [HCFA]) oversees the federal Medicare and Medicaid programs.
www.cms.hhs.gov/
- HPSA** **Health Professional Shortage Areas:** HPSA designations are based on the evaluation of shortage/underservice criteria established to qualify either geographic areas, population groups or facilities as having a shortage of primary health care providers, dentists or mental health professionals.
- Criteria to designate areas as HPSAs include: the geographic area is rational for the delivery of health services, a specified population-to-clinician ratio representing shortage is exceeded within the area, and resources in contiguous areas are over-utilized, excessively distant, or otherwise inaccessible. If a geographic area does not meet these criteria, but a population group within the area has access barriers, a population group designation may be appropriate. In some cases, individual facilities may be designated as HPSAs.
bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm
- Medicaid** Jointly funded, federal-state health insurance program for certain low-income and needy people.
www.cms.hhs.gov/medicaid/
- Medicare** Provides health insurance to people age 65 and over, those who have permanent kidney failure and certain people with disabilities.
www.cms.hhs.gov/medicare/
- MUA/P** **Medically Underserved Areas/Populations:** MUA/P designation is a prerequisite to obtaining grant awards to plan, develop and operate a community health center under Section 330 of the U.S. Public Health Service Act. This requirement means that before a health center can obtain Section 330 status, it needs to prove that the center will serve a medically-underserved area or a medically-underserved population.
- The designation is based on a scoring system (Index of Medical Underservice [IMU] score). Designation as an MUA or MUP does not mean that a health center will automatically receive federal funding. The scoring is based on primary care providers per 1,000 population, percentage of the population below poverty, infant mortality rate, and percentage of the population over 65.