Testimony of Robert Sayoc Nocon, MHS, PhD
Assistant Professor, Department of Health Systems Science
Kaiser Permanente Bernard J. Tyson School of Medicine

Submitted for the record at a hearing on
Community Health Centers: Saving Lives, Saving Money

Before the
United States Senate Committee on Health, Education, Labor & Pensions
March 2, 2023

Chairman Sanders, Ranking Member Cassidy, and distinguished members of the Committee, thank you for the opportunity to testify on the topic of community health centers.

My name is Robert Sayoc Nocon. I am an Assistant Professor of Health Systems Science at the Kaiser Permanente Bernard J. Tyson School of Medicine in Pasadena, California.[1] My research focuses on the financing and organization of care in the health care safety net. I have extensive experience studying the cost and utilization of care among patients receiving primary care at community health centers supported by the Health Resources and Services Administration (HRSA). Along with collaborators at the University of Chicago, we have conducted a series of studies that compare costs of care for patients who obtain most of their primary care in community health centers against costs for patients who attend other settings. Our studies use national data to analyze this topic among diverse populations and we consistently find that care for patients in community health centers is associated with lower total health care costs. Our studies contribute to a large body of research that dates back over 30 years and repeatedly reaches similar conclusions across different datasets, time periods, and research teams.[2]

The Critical Role of Health Centers

HRSA-supported community health centers (called "health centers" or abbreviated as "HCs" hereafter) have played a critical role caring for the nation's most marginalized patients since their inception in the 1960s. In 2021, health centers served roughly one-in-11 people in the US, including 1-in-5 individuals with Medicaid insurance or no insurance and 1-in-3 people in poverty.[3] To support their role in providing comprehensive primary and preventive care in underserved communities, health centers are eligible to apply for benefits such as enhanced Medicaid reimbursement rates, discounted drug pricing, and assistance in recruitment and retention of primary care providers.[4] The vast majority of health centers receive federal grant funding through Section 330 of the Public Health Service Act from the Bureau of Primary Health Care (BPHC) at HRSA. Through American Recovery and Reinvestment Act (ARRA) and Affordable Care Act (ACA) funding, both the second Bush and the Obama administrations prioritized expansion of this program to meet the needs of uninsured and underinsured Americans as well as those who rely on Medicaid and Children's Health Insurance Program (CHIP) for health insurance. In FY22, the proposed Health Center Program budget was $5.6 billion.[5]

[1] My role in this hearing is to represent my views as a researcher and expert on health center costs of care. My statement does not represent Kaiser Permanente or the Kaiser Permanente Bernard J. Tyson School of Medicine.
[2] https://publichealth.gwu.edu/sites/default/files/The%20Value%20Proposition%20GG%20IB%20%2368_Final_0.pdf
[3] https://www.nachc.org/research-and-data/research-fact-sheets-and-infographics/2021-community-health-center-chartbook/
[4] https://bphc.hrsa.gov/funding/funding-opportunities/health-center-program-look-alikes
[5] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy20220.pdf

Research has Documented Cost Savings Associated with Health Centers

Given the critical role of health centers, a large body of research has assessed the impact of these providers on utilization and cost of care. As Leighton Ku and colleagues have observed, studies comparing total costs of care for health center and non-health center patients have frequently found care in health centers to be associated with lower total costs, with estimates of savings ranging from 8 to 33%.[6] Our team's previous analysis of Medicaid claims from 13 states using 2009 claims data showed that health center patients with fee-for-service Medicaid insurance had lower use and spending than did non–health center patients across all services, with 22% fewer visits and 33% lower spending on specialty care, and 25% fewer admissions and 27% lower spending on inpatient care.[7] Total spending was 24% lower for health center patients. In a study of the Medicare population in 14 states in 2009, total median annual costs for Medicare patients seen in health centers were 10% lower compared to patients in private physician offices and 30% lower compared to patients in outpatient clinics.[8] These findings suggest that investments in comprehensive primary care services offered by health centers reduce the tertiary care burden among publicly insured patients.

More Recent Studies Have Reinforced these Findings with National Data

In an ongoing series of studies, we sought to expand our previous multi-state studies with national claims data that examined specific patient sub-populations in greater detail, including Adults (age 18-64), Children (<18), and "Duals" (individuals dually eligible for Medicaid and Medicare).[9] We also separately conducted focused analyses of patients with opioid use disorder[10] and diabetes.[11] We used national claims data for all analyses. Most analyses used 2012 data, but we leveraged more recent 2014 and 2016 claims for selected analyses.[12] Our studies classify patients into health center or non-health center groups based on whether they

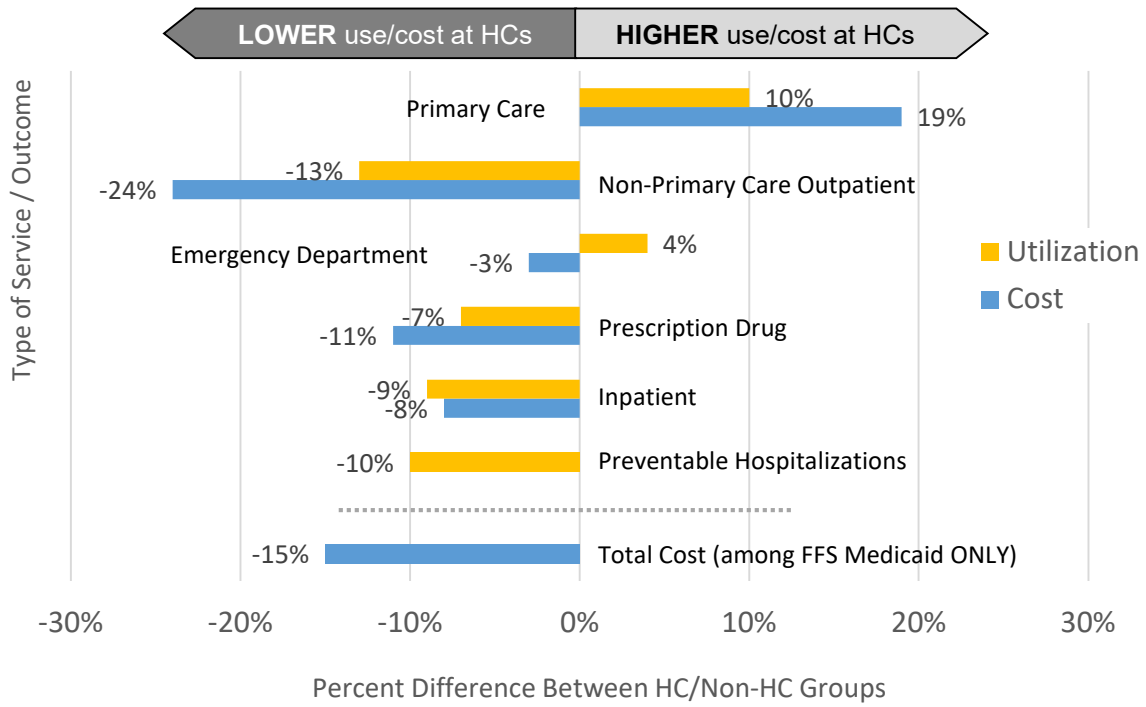
[6] https://publichealth.gwu.edu/sites/default/files/The%20Value%20Proposition%20GG%20IB%20%2368_Final_0.pdf
[7] Nocon RS, Lee SM, Sharma R, et al. Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings. Am. J. Public Health. Nov 2016;106(11):1981-1989.
[8] Mukamel DB, White LM, Nocon RS, et al. Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings. Health Serv. Res. Apr 2016;51(2):625-644.
[9] Adult, Child, and Duals studies have been completed and are in various stages of the peer review process.
[10] Peterson L, Murugesan M, Nocon R, Hoang H, Bolton J, Laiteerapong N, Pollack H, Marsh J. Health care use and spending for Medicaid patients diagnosed with opioid use disorder receiving primary care in Federally Qualified Health Centers and other primary care settings. PLoS One. 2022 Oct 18;17(10):e0276066.
[11] Knitter AC, Murugesan M, Saulsberry L, Wan W, Nocon RS, Huang ES, Bolton J, Chin MH, Laiteerapong N. Quality of Care for US Adults With Medicaid Insurance and Type 2 Diabetes in Federally Qualified Health Centers Compared With Other Primary Care Settings. Med Care. 2022 Nov 1;60(11):813-820. doi: 10.1097/MLR.0000000000001766.
[12] 2012 data was the most recent available for all states at the time we began the work. We were able to incorporate 2016 claims for the analysis of Duals and 2014 claims for a subset of 17 states for some analyses in the Adult study.

receive the majority of their primary care at a health center and we use statistical methods to ensure that we compare similar groups of patients.[13]

In our studies of general populations of adults and children, we consistently find that **health center patients have lower total costs and similar or better levels of quality of care**.

Among adults (Figure 1, below), we find higher cost and utilization for primary care, but lower cost and utilization in other downstream services (e.g., inpatient care). Emergency department care for adults shows a mixed pattern with health center patients having higher emergency department care utilization, but lower costs. We measure total cost across all types of services for Medicaid Fee-for-Service beneficiaries and find that health center patients have 15% lower total cost than comparable non-health center patients. We use a measure of preventable hospitalizations as in indicator of access to quality ambulatory care and find that health center patients have 10% less preventable hospitalizations (i.e. higher quality).

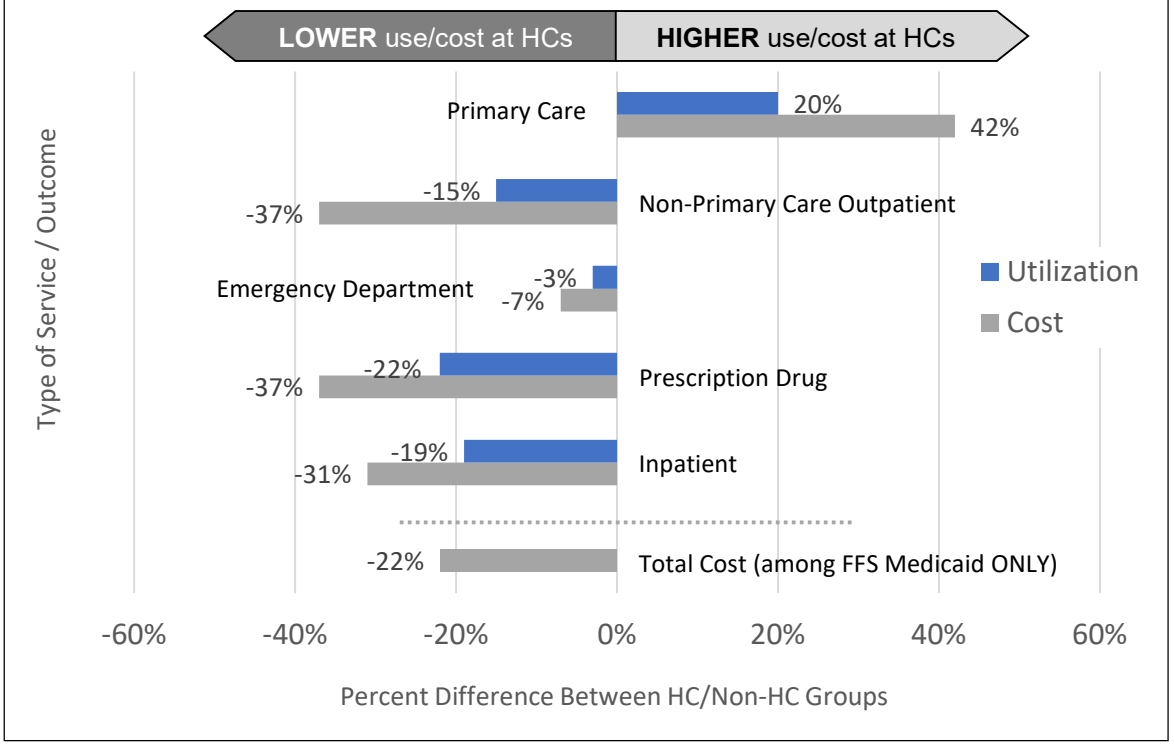
Figure 1: Cost and Utilization for HC Patients Relative to Non-HC Patients (Adults)



[13] We use a statistical method called propensity score overlap weighting to construct similar health center and non-health center groups. Our studies control for characteristics such as patient demographics (age, race/ethnicity, gender), disease burden/illness, insurance characteristics (Medicaid eligibility category, total number of eligible months, Temporary Aid for Needy Families program indicator), patient location, and distance to the nearest health center.

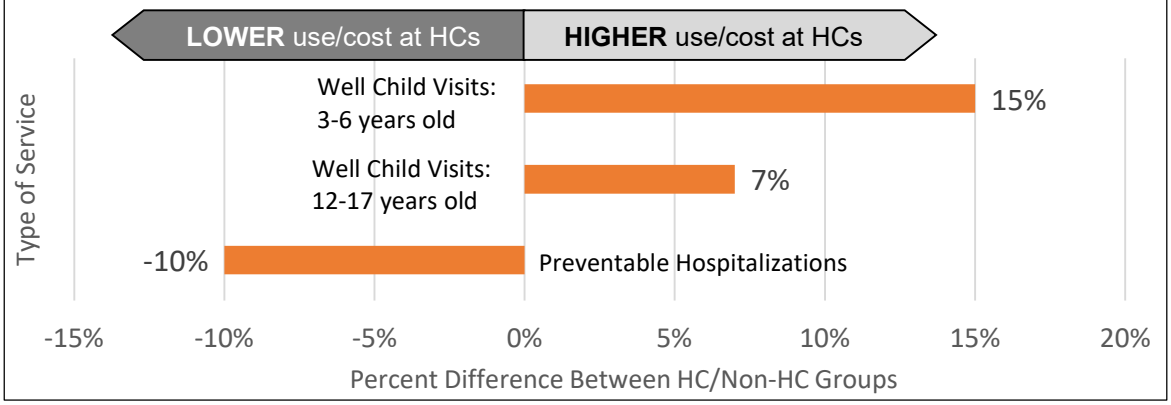
Among children (Figures 2 and 3, below), we find a similar pattern of higher primary care use and cost, lower use and cost of other downstream services, and 22% lower total cost overall for health center patients. In contrast to the adult findings, children in the health center group had lower emergency department utilization than non-health center children.

Figure 2: Cost and Utilization for HC Patients Relative to Non-HC Patients (Children)



Our quality analyses for children included two types of measures – preventable hospitalizations and rate of completion of recommended well-child visits. We find that children receiving most of their primary care from health centers have higher rates of well-child visits and fewer preventable hospitalizations (both indicators of higher quality).

Figure 3: Quality for HC Patients Relative to Non-HC Patients (Children)



In addition to general populations of adults and children, we have conducted in-depth studies of specific subpopulations of interest to HRSA and the health center community: Duals, Medicaid beneficiaries with opioid use disorder, and Medicaid beneficiaries with diabetes.

- *Dually Eligible*. Health center patients had higher primary care costs and lower non-primary care costs, resulting in lower total costs. This pattern was observed in both younger (<65) disabled duals and aged (>=65) duals.
- *Medicaid Beneficiaries with Opioid Use Disorder*.[14] FQHC patients had higher primary care utilization and fee-for-service cost, and similar or lower utilization and cost for other services. No difference in total cost. Quality findings were mixed, with health center patients faring better on measures related to use of behavioral health therapy and potentially inappropriate prescribing of benzodiazepines and opioids, but worse on timely receipt of medication for opioid use disorder and retention in treatment.
- *Medicaid Beneficiaries with Diabetes*.[15] Health center patients had fewer hospitalizations, but more ED visits than comparable non-health center patients. Health center patients had lower rates for several process-based quality measures, with both groups showing low performance overall.

Estimating the Cost Savings to Medicare and Medicaid from Community Health Centers

To provide insight into how these cost differences between health center and non-health center patients may have resulted in cost savings for Medicare and Medicaid, we apply the cost differences observed in our studies to the national population of health center patients in 2021 (Table 1, below). We use the results shown above for the adult, child, and dual-eligible population. Since our most recent national studies do not examine Medicare-only patients, we use the 2016 study of Medicare patients in 14 states by Mukamel et. al. to estimate savings for this population.

We estimate that in 2021, the health center program saved over $25 billion to Medicaid and Medicare over a 1-year period, which reflects higher use and spending on primary care for health center patients, but much lower spending on non-primary care services. Notably, these cost savings estimates are on par with work from Ku and colleagues that used different methods and datasets to reach an estimate of $24 billion in savings across all payers in 2009 dollars[16] and in an updated 2023 memo on costs and savings associated with community health centers.[17]

[14] Peterson (2022)
[15] Knitter (2022)
[16] https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1024&context=sphhs_policy_ggrchn
[17] Leighton Ku. "Preliminary Thoughts on Cost and Savings Associated with Community Health Centers." February 2023. (Provided by the author and attached as an Appendix)

Table 1. Estimated Cost Savings to Medicare and Medicaid

Patient Population	Average Annual Cost Savings Per Patient	Number of Health Center Patients	Total Estimated 2021 Savings
Adults with Medicaid (18-64)	$1,786	8.4 million	$14,954 million
Children with Medicaid (0-17)	$937	6.6 million	$6,183 million
Dual Medicare-Medicaid Eligible	$1,559	1.3 million	$1, 965 million
Adults with Medicare only	$670	3.3 million	$2,234 million
		Estimated Total	$25.3 billion[18]

Conclusion: Our Research – and the Broader Health Center Literature – Shows Strong Evidence for Health Center Value

Across general adult, pediatric, and dual eligible populations, care for health center patients shows consistent patterns of greater primary care use and cost, lower use and cost of most services downstream of primary care, all resulting in lower total cost for health center patients. While quality of care findings show more mixed results depending on the specific patient sub-population, we generally find that patients receiving most of their primary care in a health center tend to receive comparable or better quality of care than patients in other settings. This combination of lower cost and comparable quality provides strong evidence for health center value.

One explanation for this pattern of utilization is that health centers may provide a more comprehensive model of primary care that reduces the use of more acute medical care services. This interpretation is consistent with the design and intent of the Health Center Program, which is constructed by statute to align with medically and socially complex needs. For example, health centers must be governed by a board of directors with a majority of representatives from their patient populations and maintain "enabling" services (e.g., translation, transportation) designed to increase access to care for safety-net populations.

[18] We use adjusted differences between health center and non-health patient total costs among fee-for-service Medicaid and Medicare beneficiaries (as described above in this statement) and adjust for medical care inflation to estimate 2021 savings. We note that in sensitivity analyses that we conduct in our adult and child Medicaid studies, utilization results are generally similar between fee-for-service and managed care populations, which provides evidence for the generalizability of cost findings from fee-for-service to managed care. Adult and child populations reflect non-dually eligible. Counts of health center patients were obtained from HRSA Uniform Data System and include both Awardee and Look-a-Like health centers.

A key strength of our analyses is that we are able to examine these patterns of care and lower total cost across national populations in Medicaid and Medicare, using detailed administrative claims databases from every state and the District of Columbia for most analyses. We acknowledge that the 2012-2016 data used in our studies does not reflect major shifts in the national health care landscape such as later stage effects of the Affordable Care Act or the dramatic national impact of the COVID-19 pandemic. However, the consistency of similar findings across different studies over several decades (which cover previous major shifts in the national and healthcare landscape) lead us to believe that we will continue to see similar patterns of care for health center patients with more recent data. Our team is currently analyzing 2018 claims to provide updates to these analyses.

Strong and stable funding of health centers is essential for these organizations to continue to serve as the backbone of the US primary care safety net. Prior research by our team has shown that community health center grant funding is associated with better overall financial performance among health centers, which is particularly important given that one-quarter of health centers operated at a negative or near-zero margin from 2012 to 2017.[19] Our work has also shown the critical importance of health center grant funding in maintaining community health center staffing and services, with a recent policy forecasting model created by our team showing the outsized impact that Section 330 funds have on health centers staffing and services.[20] Health centers serve communities with some of the greatest medical needs and complex social risks, such as unstable housing and limited financial resources. These communities are also among those that have been hit hardest by the pandemic, creating a challenging operating environment for any healthcare organization.[21] As we attempt to move forward from the pandemic and support our most vulnerable communities in their recovery, ensuring adequate financing for health centers is a strong investment in the US healthcare system and one that research shows provides high value.

[19] Jung D, Huang ES, Mayeda E, Tobey R, Turer E, Maxwell J, Coleman A, Saber J, Petrie S, Bolton J, Duplantier D, Hoang H, Sripipatana A, Nocon RS. Factors associated with federally qualified health center financial performance. Health Services Research. 2022 March 9. Online ahead of print.

[20] Shiyin Jiao S, Konetzka RT, Pollack HA. Huang ES. Estimating the Impact of Medicaid Expansion and Federal Funding Cuts on FQHC Staffing and Patient Capacity. Milbank Q. April 12, 2022.

[21] https://www.kff.org/medicaid/issue-brief/how-community-health-centers-are-serving-low-income-communities-during-the-covid-19-pandemic-amid-new-and-continuing-challenges/

Appendix: Memo shared by Leighton Ku: “Preliminary Thoughts on Costs and Savings Associated with Community Health Centers” (5 pages)

TO: David Reynolds, Senate HELP Committee
Sophie Kasimow, Senate HELP Committee
Michaela Brown, Senate HELP Committee

FROM: Leighton Ku, PhD, MPH
Professor of Health Policy and Management
Director, Center for Health Policy Research
George Washington University

DATE: Feb. 24, 2023 - revised

SUBJECT: Preliminary Thoughts on Costs and Savings Associated with Community Health Centers

You requested my input about evidence concerning the costs and savings associated with the use of community health centers, as authorized under Section 330.

My colleagues and I at the Milken Institute School of Public Health at George Washington University recently released two reports that are relevant to this topic. An August 2022 report summarizes research and evidence about the contributions of community health centers, particularly cost savings that may occur when patients receive care at community health centers, compared to similar patients getting care at other places (mostly private physician offices).[1] It highlights nine studies from a number of researchers (including me and my GW colleagues and researchers from the University of Chicago, Johns Hopkins University, Michigan State University and others) using different data and research designs:

Study	CHC Patient Population	Cost-Savings
Duggar et al, 1993	California Medicaid Patients	33%
Duggar et al, 1994	New York Medicaid Patients	26%
McRae & Stampfly, 2006	Michigan Medicaid Patients	10%
Richard et al, 2012	National Population	24%
Mundt & Yuan, 2014	Michigan Medicaid Patients	8%
Mukamel et al, 2016	14 States Medicare Patients	10%
Nocon et al, 2016	13 States Medicaid Population	24%
Bruen & Ku, 2019	National Population Children	35%
Huang, Nocon, et al, 20222	Adult Medicaid Patients	15%

[1] Ku L, Sharac J, Morris R, Jacobs F, Shin P, Brantley R, Rosenbaum S. The Value Proposition: Evidence of the Health and Economic Contributions of Community Health Centers. Geiger Gibson/RCHN Community Health Foundation Research Collaborative Policy Brief #68. August 2022. https://publichealth.gwu.edu/sites/default/files/The%20Value%20Proposition%20GG%20IB%20%2368_Final.pdf

[2] In the August report this study is cited as Nocon (not yet published). It is still not published in a peer reviewed journal, but the Univ. of Chicago team shared a more complete unpublished summary of a series of papers: Huang E, Nocon R, Jankins R, Asfour N, Chin M. Health Centers and the Changing Policy

These studies, done over a span of roughly 30 years, consistently show that, health centers increase use for primary and preventive care for disadvantaged populations, which has the result of lowering the use of and costs for other, more expensive forms of care like inpatient or emergency care. These results are backed up by numerous other studies (cited in the August report) that show how community health centers provide high quality primary care for patients, compared to care that may be received in other settings. For the sake of simplicity, I can summarize the findings as estimating that CHC patients have significantly lower total medical expenditures, compared to similar patients who did not receive care at CHCs (or less care from CHCs):

- For Medicaid patients, savings equivalent to 8% to 33% of total Medicaid costs across six studies, **with a conservative midpoint savings of about 20%.**
- For Medicare patients, Mukamel, et al. found that care for CHC patients cost 10% less than care for patients at regular physician offices and 30% less than care at hospital outpatient departments**. A conservative estimate is 10% savings.**
- We conducted national studies, not using Medicaid or Medicare claims data and one study estimated 24% average savings and another estimated 35% savings for children.
- While the studies vary somewhat in the methods and findings, they are surprisingly harmonious in their conclusions: investments in quality primary and preventive care in community health centers helps spare the use of more expensive forms of care and lowers overall medical expenditures.

These savings are all the more remarkable given that community health centers receive enhanced payments in Medicaid and Medicare under the prospective payment system (or alternative payment models), so they generate savings despite the higher primary care payment rates. The enhanced payments coupled with federal health center funding help health centers provide additional health services, including mental health, dental and substance use services, and non-reimbursable social and other support services, such as transportation, needed by low-income patients in underserved areas, which are not available in most doctors' offices. In fact, even though health centers serve a patient population at higher risk for complex health issues than those served in "regular" private physician offices, data show that health centers run very lean operations and use efficient primary care teams, including greater use of nurse practitioners, physician assistants, nurses and medical aides and others to deliver high quality care to provide primary care in medically underserved areas. This is why community health centers are an effective and efficient way to expand primary care services.

Unfortunately, none of these studies reflect more recent changes brought on by the COVID-19 pandemic. Regrettably, it will take several years before it is possible to conduct such an assessment because COVID – and now the Medicaid unwinding – are still affecting care and because it takes years to accumulate and analyze the data.

---

and Payment Environment, Sept. 12, 2022. The Medicaid savings estimates are based on fee-for-service Medicaid claims data from 2012. There also appear to be results related to child and dual eligible Medicaid populations, but the details are not available.

But we know that health centers were surprisingly resilient through their ability to pivot to telehealth in 2020 and then to reopen their doors more recently. During this public health crisis, health centers provided critical COVID testing to approximately 19 million low-income patients, the majority of whom are racial/ethnic minorities, extensive vaccination support and substantial mental health care in underserved communities.[3]

I used the CBO Medicaid and Medicare baselines (from May 2022) to estimate the effect of 20% Medicaid and 10% Medicare savings per Medicaid or Medicare patient enrolled at CHCs:

MEDICAID (20% savings)	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**
Federal Savings per person per year"							
Child	$354	$376	$334	$360	$372	$394	$436
Traditional Adult	$964	$1,030	$1,030	$1,100	$1,168	$1,230	$1,280
Expansion Adult	$1,334	$1,418	$1,542	$1,654	$1,756	$1,860	$1,982
*Blended Avg**	*$792*	*$843*	*$857*	*$914*	*$971*	*$1,026*	*$1,082*
Total (Fed & State) Savings per person per year:							
Child	$545	$578	$514	$538	$572	$606	$640
Traditional Adult	$1,482	$1,576	$1,713	$1,838	$1,951	$2,067	$2,191
Expansion Adult	$1,482	$1,576	$1,713	$1,838	$1,951	$2,067	$2,191
*Blended Avg**	*$1.070*	*$1,137*	*$1,186*	*$1,266*	*$1,344*	*$1,424*	*$1,504*

* The blended average assumes the average composition of non-elderly Medicaid patients in health centers is 44% children, 30% traditional adults and 26% expansion adults. The actual proportions vary across sites; remember that 12 states have not yet expanded Medicaid.

MEDICARE (10% savings)	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**
Federal Savings per person per year*	$1,302	$1,413	$1,376	$1,535	$1,636	$1,708	$1,924

* Based on the net Medicare federal benefit outlays per Part B beneficiary

The estimate is that, in years FY 2024 to 2028, for every additional Medicaid patient served at a community health center, the federal savings will roughly average $857 to $1,082 per year, while combined federal and state savings will average about $1,186 to $1,504 per Medicaid enrollee per year. (This is conservative because the 20% savings estimate is conservative and because I am only basing this on adult and child expenditures, not more costly aged or disabled Medicaid patients at health centers.)

[3] Sharac J, Jacobs F, Shin P, Rosenbaum S. Community Health Centers' Response to the COVID-19 Pandemic: Two-Year Findings from HRSA's Health Center COVID-19 Survey (April 2020—April 2022). May 2022. https://www.rchnfoundation.org/wp-content/uploads/2022/05/Two-Year-Findings-from-HRSA%E2%80%99s-Health-Center-COVID-19-Survey.pdf

The estimate of Medicare savings in FY 2024-28 is that, for every additional Medicare patient served at a health center, federal Medicare outlays will be reduced by about $1,376 to $1,924 per person per year (The 10% savings estimate is conservative and I am excluding non-federal Medicare costs, e.g., the amounts paid by patient premiums and cost-sharing). Although the estimated percent savings per person are smaller for Medicare (10%) than for Medicaid (20%), the dollar savings per person are larger because total federal expenditures per beneficiary are so much larger for Medicare's aged and disabled populations.

Of course, it is important to remember that about half (47%, 14.3 million persons in 2021) of health center patients are on Medicaid and 10.6% are on Medicare. The proportion of Medicaid patients almost certainly rose in 2022 and 2023 and the proportion of Medicare patients is rising and will continue to rise as baby boomers age. Thus, for every additional 1 million total patients that health centers can serve, we could roughly estimate there will be about 500,000 more Medicaid patients and 11,000 Medicare patients, which could yield savings per person comparable to those stated above. (About one-fifth of health center patients are uninsured and one-fifth have private insurance (including Health Insurance Marketplaces.)

These numbers are changing, however. Because of the Medicaid continuous enrollment requirement, the number on Medicaid has certainly grown, but after March 2023 enrollment will fall as the "Medicaid unwinding" takes its toll. In a January 2023 report, we estimated that by the time unwinding is done, health centers could lose about 2.5 million Medicaid patients.[4] We have also seen draft data from a survey that the National Association of Community Health Centers has fielded; a majority of health center respondents anticipate serious financial and staffing problems will arise from unwinding and the loss of Medicaid revenue. Unless Congress responds by bolstering health center grant funding, this will lead to substantial revenue losses for health centers and could result in them losing the capacity to serve between 1.2 and 2.1 million patients (compared to 30 million total patients in 2021).

We know from prior analyses that the number of patients who can be served by health centers has been primarily influenced by the level of HRSA grants as well as by Medicaid expansions.[5] [6] Section 330 funding forms the core of financial support and "primes the pump" so that centers can earn more revenue by serving Medicaid, Medicare and other insured patients, as well as supporting costs to care for the uninsured. In addition to their core Section 330 grants and insurance revenue, health centers rely on other federal, state and local grants as well as patient cost-sharing.

---

[4] Ku L, Sharac J, Shin P, Rosenbaum S, Jacobs F. The Potential Effect of Medicaid Unwinding on Community Health Centers. Jan 2023. Geiger Gibson Program in Community Health. Data Note. https://geigergibson.publichealth.gwu.edu/potential-effect-medicaid-unwinding-community-health-centers

[5] Han X, Luo Q, Ku L. Medicaid Expansions and Increases in Grant Funding Increased the Capacity of Community Health Centers, Health Affairs, 2017 Jan.; 36 (1):49-56.

[6] Jiao S. et al. Estimating the Impact of Medicaid Expansion and Federal Funding Cuts on FQHC Staffing and Patient Capacity. Milbank Quarterly, 2022; 100(2):1-21.

If federal community health center grants are level-funded in 2024 (i.e., total funding around $5.8 billion), then health centers will be forced to shrink, due to both underlying medical inflation and the loss of Medicaid revenue due to the unwinding. This will lower the level of primary care services in communities across the county and would stifle the ability of health centers to serve their current patients, much less serve new areas or expand the range of services offered.

Increases in community health center grant funding could, depending on the level of increase, permit health centers to cover some of Medicaid revenue losses to stem the loss of patient capacity due to Medicaid unwinding and keep pace with rising medical costs. Larger grant increases could enable health centers to expand into other underserved communities across the nation, to increase the number of Medicaid and Medicare patients receiving quality primary care at health centers, which would lead to further reductions in federal Medicaid or Medicare expenditures. It could also help health centers expand the range of services available, such as mental health, substance use and dental care services available in underserved communities.

As you know, a challenge is whether CBO's interpretation of scorekeeping rules would permit it to offset increases in health center funding with Medicaid or Medicare savings. Usually, funds spent through discretionary appropriations are not scored as providing budgetary savings in mandatory programs.[7] It may be possible to score offsetting Medicaid or Medicare savings if increases for health center funding are provided as mandatory funds rather than as discretionary appropriations, but that may be subject to the interpretation of scorekeeping rules.

[7] Congressional Budget Office. CBO Explains Budgetary Scorekeeping Guidelines. Jan. 2021. https://www.cbo.gov/system/files/2021-01/56507-Scorekeeping.pdf