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Community Health Centers and the Economy: Assessing Centers' Role in Immediate Job Creation Efforts

Sara J. Rosenbaum
George Washington University

Peter Shin
George Washington University

Geiger Gibson /
RCHN Community Health Foundation Research Collaborative

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Sara Rosenbaum, JD
Peter Shin, PhD

The George Washington University
School of Public Health and Health Services
Department of Health Policy

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at www.gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Executive Summary

Federal investment in community health centers not only creates health care access but, based on previous studies, generates an estimated 8:1 return for medically underserved communities while creating thousands of jobs. Since our earlier 2008 economic impact study, Congress has made two major program investments: $2 billion under the American Reinvestment and Recovery Act (ARRA) of 2009; and $11 billion under the Affordable Care Act (ACA). This analysis measures the economic and jobs-creation benefits of this cumulative investment in health centers, as well as the impact of legislation enacted in April, 2011, which reduced the first year of new ACA investment by $600 million.

The $2 billion dollars invested in health centers under ARRA was designed to support both expanded operations and new service delivery capacity. ARRA support enabled health centers to reach an additional four million patients, while generating over $3.4 billion in new economic benefits and 32,200 additional jobs. When added to health centers' ongoing operational funding, ARRA helped health centers produce over $23 billion in total community economic benefits while generating jobs for more than 221,000 people.

The $11 billion ACA investment would have translated into an expansion of health care services to at least 16 million additional residents in medically underserved communities and new economic benefits surpassing $33 billion. This funding, when added to health centers' ongoing operations, would have generated $54 billion in overall community economic benefits by 2015 while creating 284,000 new jobs in low-income communities by that year.

However, the $600 million lost to the health center expansion effort as a result of federal funding reductions enacted in April 2011 translates into an annual $1 billion loss in economic stimulus for rural and urban medically-underserved communities, along with 10,000 fewer job opportunities. These economic losses are in addition to reduced health care capacity affecting some 5 million additional children and adults who would have received care.

As a result of this reduction, the federal government has been able to fund only 67 health center expansion projects, leaving unfunded more than 733 "shovel ready" applications from the 50 states, the District of Columbia and Puerto Rico. Nine states alone – California, Ohio, New York, Georgia, Illinois, North Carolina, Florida, Michigan, and Texas – represent over 40 percent of unfunded applications and account for approximately two million patients without a primary care medical home. Restoration of this reduction would allow the health centers program to reach an estimated 300 of these 733 deferred applications while restoring $1 billion in economic investment and 10,000 additional jobs.

Community Health Centers and the Economy:
Assessing Health Centers' Role in Immediate Job Creation Efforts

Introduction

In 2008, early in what has emerged as the most serious economic crisis to confront American workers and their families since the Great Depression, the Geiger Gibson/RCHN Community Health Foundation Research Collaborative launched its *Research Brief* series with an analysis of the economic impact of the federal community health center investment on community economies and job creation. Our inaugural study[1] found that a $250 million investment in health centers not only would create health care for an additional 1.8 million patients but also would generate $2.1 billion (a return of more than 8:1) in community economic benefits including 24,000 additional jobs. Health centers' impact stems from the fact that by law, they are located in medically underserved communities; as a result, investing in health centers reaches those rural and urban families who experience the highest unemployment, the greatest health burdens, the highest rate of being uninsured, and the biggest need for an economic jump start.

Since our inaugural study, Congress has made two considerable direct investments in health centers. The first investment was a $2 billion appropriation under the American Reinvestment and Recovery Act ("ARRA," the stimulus law), $500 million of which was invested in new operational costs and the other $1.5 billion of which allowed health centers to open new service sites and expand their service capacity to meet new community and patient needs.[2]

The second investment was $11 billion in mandatory funding over the FY 2011-2015 time period, enacted as part of the Patient Protection and Affordable Care Act ("PPACA," or the Affordable Care Act). Its immediate purpose was to respond to surging immediate need in the face of rising numbers of uninsured individuals and families; its longer-term purpose was to help ensure that in advance of the full implementation of health reform, historically medically underserved communities would gain new primary health care capacity.

The Act's five-year investment schedule called for the following annual supplemental expenditures that were to be made in addition to regular operating expenditures under annual discretionary appropriations:[3] FY 2011: $1.0 billion FY

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[1] How Does Investment in Community Health Centers Affect the Economy? (George Washington University Medical Center, Geiger Gibson/RCHN Community Health Foundation Research Collaborative Research Brief #1) Feb. 25, 2008.

[2] Ku L., Shin, P., and Bruen B., *Can health care investments stimulate the economy*. Health Affairs blog (March 16, 2010. Available at: http://healthaffairs.org/blog/2010/03/16/can-health-care-investments-stimulate-the-economy/. (Accessed September 7, 2011).

[3] The scheduled $9.5 billion covers operational costs (e.g., base grant adjustments, expanded medical capacity, enabling services, new access points) while the remaining $1.5 billion covers capital costs associated with modernizing existing sites and building new facilities. ARRA provided funding to health centers over two years (2009-2010).

2012: $1.2 billion; FY 2013: $1.5 billion; FY 2014: $2.2 billion; FY 2015 $3.6 billion. However, in April of 2011, Congress reduced funding for health centers by $600 million for the current fiscal year (2011), as part of a spending agreement that cut $38 billion in overall federal spending in order to avert a government-wide shutdown.

Study Purpose and Methods

The purpose of this updated analysis is to gauge the economic and jobs-creation benefits of this cumulative investment in health centers and the consequence of subsequent Congressional reductions. Based on available health center economic impact reports and methods developed in our prior economic studies,[4] we estimate the impact of ARRA and Affordable Care Act investments on economic benefit to and jobs in underserved communities served by health centers.

Findings

We estimate that the $500 million in ARRA funding for operational costs, coupled with funding to support the cost of service expansions,[5] resulted in health center services to **an additional four million patients**, **while generating over $3.4 billion in new economic benefits annually**.[6] We also estimate ARRA funding also produced **some 32,000** jobs both at health centers and in the communities they serve. When added to health centers' ongoing operational funding, ARRA helped health centers produce over $23 billion in total economic benefits in medically underserved communities and generate jobs for more than 221,000 people.[7]

The Affordable Care Act's $11 billion health center investment is projected to have a similarly strong impact. In total, the investment is expected to translate into an expansion of health care services to at least 16 million additional people[8] and new

[4] The Economic Stimulus: Gauging the Early Effects of ARRA Funding on Health Centers and Medically Underserved Populations and Communities. Feb. 16, 2010, (George Washington University Medical Center, Geiger Gibson/RCHN Community Health Foundation Research Collaborative Research Brief #17) and How Does Investment in Community Health Centers Affect the Economy? Feb. 25, 2008. (George Washington University Medical Center, Geiger Gibson/RCHN Community Health Foundation Research Collaborative Research Brief #1)

[5] $500 million of this funding went towards service expansions and the remaining $1.5 billion covered capital costs and acquisition of health information technology.

[6] We assumed a conservative 1.73 return on investment (see Brief #17) and same level of economic activity associated with job creation in 2009 (see National Association of Community Health Centers and Capital Link. *Community Health Centers as Leaders in the Primary Care Revolution,* August 2010). Also see, HRSA, *Health Centers: Where to go for care you can afford*. Available at http://www.hrsa.gov/ourstories/healthcenter/healthcenterweek.html (September 9, 2011)

[7] Assumes additive value of ARRA funding on economic activity and jobs to 2009 estimates which excluded much of the $2 billion allocated to health centers between 2009 and 2010; see The National Association of Community Health Centers and Capital Link. *Community Health Centers as Leaders in the Primary Care Revolution.* August 2010. Available at: http://www.nachc.com/client/documents/Primary_Care_Revolution_Final_8_16.pdf. (September 7, 2011)

[8] Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform, Jun 30, 2010. (George Washington University Medical Center, Geiger Gibson/RCHN Community Health Foundation Research Collaborative Research Brief #19)

economic benefits of over $33 billion in medically underserved communities. This will bring the total contribution of health centers to $54 billion in overall community economic benefit by 2015, while creating 284,000 new jobs in low-income communities by that year.[9]

The $600 million lost to the health center expansion effort earlier in 2011 will, of course, alter this picture. We estimate that this reduction translates into a $1 billion loss in economic stimulus for medically underserved communities, along with 10,000 fewer job opportunities than initially projected annually.[10] These losses come on top of reduced health care capacity affecting 5 million additional children and adults who would have received care.[11]

The $600 million in funding losses as a result of the earlier 2011 legislation was the consequence of eliminating the additional funds that health centers were to receive over and above their current operations. Had the $600 million cut come from *current* operational funding, we estimate that it would have translated to an immediate loss of over $4 billion in community economic benefits along with 41,000 jobs in urban and rural medically underserved communities.[12]

The $600 million in losses experienced earlier this year in turn forced HRSA to divert $850 million of the initial $1 billion in planned expansion funds simply to keep health centers from having to reduce current patient capacity, services, service locations, and staff. HRSA was able to continue the support for both health centers' base operations and the additional operational capacity health centers had developed with their 2009 ARRA supplement; had HRSA been unable to backfill on both current operations and ARRA supplemental operations, care would have ceased for millions of patients and thousands of jobs would have disappeared.

Because of this essential backfilling effort, HRSA was forced to deny nearly all of the new start and "new access point" applications it received. In addition, 1,100 health centers that had submitted applications for "expanded services" funding to both improve services and expand care were also denied funding.

The National Association of Community Health Centers (NACHC), which tracks applications for new starts and new access points, reports that as of May 2011, HRSA had received more than 800 new start/new access point applications. Of this number,

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[9] Based on estimates prepared by Capital Link with MIG, Inc. IMPLAN Software Version 3.0, 2008 structural matrices, 2008 state-specific multipliers, and 2009 UDS data to the National Association of Community Health Centers. A more detailed explanation of the economic model can be reviewed in a prior report by The Robert Graham Center, NACHC, and Capital Link, *The Primary Care Payoff*, August 2007.

[10] See footnote #6.

[11] Estimates based on The Health Care Access and Cost Consequences of Reducing Health Center Funding. March 15, 2011, (George Washington University Medical Center, Geiger Gibson/RCHN Community Health Foundation Research Collaborative Research Brief #21)

[12] Assuming level funding at $2.19 billion, $600 million would account for 27 percent of federal appropriations.

the agency was able to fund only 67 awards (which will serve an additional 286,000 patients),[13] leaving unfunded more than 733 "shovel ready" applications (representing care to an estimated additional 4 million patients) from the 50 states, the District of Columbia and Puerto Rico. According to a NACHC-conducted survey of state PCAs, nine states alone – California, Ohio, New York, Georgia, Illinois, North Carolina, Florida, Michigan, and Texas – represent over 40 percent of unfunded applications and account for approximately two million patients without a primary care medical home. [14]

We further estimate that were Congress, as part of a new short-term economic stimulus bill to restore the $600 million in health center expansion funding that was diverted into backfilling efforts, the federal government could provide expansion funds to an estimated 300 of the 733 communities meriting new start/new access point grants, while also providing expanded services grants to 1,100 communities.[15] The economic impact gained by reversing this earlier reduction would restore at least $1 billion in new economic activity along with 10,000 new jobs.

Conclusion

Our estimates underscore the major impact of health centers on direct and indirect economic conditions of the communities they serve, which by definition, are the communities in greatest need of economic investment during a serious economic downturn. In August 2011, the reported overall unemployment rate stood at 9.1 percent while real unemployment (a figure that includes people who have stopped looking for work as well as marginally employed and part-time workers looking for full-time work) exceeded 16 percent. In medically-underserved communities, the unemployment figures are far worse, with figures as startling as those reported in New York City, where recent estimates show that only one in four young African American men has a job.[16]

One of the notable aspects of health center investments is their high value in medically-underserved communities and the speed with which appropriated funds can be committed to those communities. It is important, as well, to understand the nature of the health center jobs created. It is true that many jobs at health centers require clinically trained health professionals, but thousands more do not. Among health center staff, data from the Uniform Data System (UDS) (a national reporting system to which

[13] HRSA. (2011). HHS awards Affordable Care Act funds to expand access to health care. [Press release] Available at: http://www.hhs.gov/news/press/2011pres/08/20110809a.html. (September 7, 2011)

[14] Based on survey of state Primary Care Associations provided by the National Association of Community Health Centers; PCAs identified 729 of 800 applications.

[15] Approximately 350 applications were expected to be funded per the Funding Opportunity Announcement (HRSA-11-017) prior to the $600 reduction; $250 million of the ACA funding was originally budgeted for the new access points and $350 million was to fund the expanded services grants, which was subsequently terminated.

[16] Community Service Society, Only One in Four Young Black Men in New York City Has a Job (December, 2010) . Available at: http://www.cssny.org/userimages/downloads/OnlyOneInFourYoungBlackMenInNYCHaveaJobDec2010.pdf (September 6, 2011)

all federally-funded health centers must provide data on patients, revenues, staffing, and services) indicate that 48 percent of all health center staffing positions fall within a category other than one for which a professional degree is required in medicine, nursing, psychology, social work, or dentistry.[17] These staff, essential to successful health center performance, span all dimensions of health center operations, from clinical support to financial operations, information systems, patient support and outreach services, and patient counseling and case management services.

To be sure, senior health center administration positions require significant advanced training. But these positions and thousands of other health center staff positions involve competencies and activities that can be learned on the job and through health center-based and community-based training programs as well as through academic partnerships with high schools, community colleges, and universities. Indeed, many health centers have entered into partnerships with community educational and training programs in order to create a jobs pipeline into health center practice. However, cuts to health center funding are likely to limit, if not entirely eliminate, a number of health center job opportunities as well as reduce the overall economic benefit of health center investment. Health center investment has an important community impact, as these estimates show. It is also clear from an earlier study that health center appropriations reach their communities rapidly;[18] indeed, our research into ARRA spending for health centers found that within one month of enactment, the Health Resources and Services Administration (HRSA) not only allocated newly available funds but also effectively targeted communities hardest hit by the economic downturn. [19] Health center funding represents a sound investment for improving access to preventive and primary care in addition to supporting underserved communities suffering from relatively higher unemployment levels and weaker economies.

[17] 2010 UDS, HRSA.
[18] The Economic Stimulus: Gauging the Early Effects of ARRA Funding on Health Centers and Medically Underserved Populations and Communities. Feb. 16, 2010, (George Washington University Medical Center, Geiger Gibson/RCHN Community Health Foundation Research Collaborative Research Brief #17)
[19] Ku L., Shin, P., and Bruen B., *Can health care investments stimulate the economy*. Health Affairs blog (March 16, 2010. Available at: http://healthaffairs.org/blog/2010/03/16/can-health-care-investments-stimulate-the-economy/. (Accessed September 7, 2011).