

Federally Qualified Health Centers' Importance in the Safety Net Continues as Affordable Care Act Implementation Moves Ahead

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At a Glance

- Over 9 percent of all nonelderly adults ages 18 to 64 reported using an FQHC in September and December 2014 despite the expansion of health coverage under the ACA.
- FQHCs continue to serve a disproportionate share of the most vulnerable adults, including those who have low family incomes and those in worse health.
- Adults who live closer to an FQHC are more likely to rely on one as their usual source of care than those who live further away. Furthermore, location is one of the most commonly reported reasons for going to an FQHC among those who rely on one as a usual source of care.

For 45 years, federally qualified health centers (FQHCs) have provided primary care services to those with limited access to care. FQHCs served about 23 million people in 2014, 28 percent of whom were uninsured.¹ The role of FQHCs in the nation's primary care system is likely to increase in the wake of increased federal investment in FQHCs and expanding Medicaid and Marketplace coverage as provided for in the Affordable Care Act (ACA). FQHCs have long enjoyed considerable financial assistance from the federal government and, more recently, particularly strong support under the ACA. The ACA includes \$11 billion in funding to support the doubling of the nation's FQHC capacity and to help FQHC construction and renovation over a five-year period. Meanwhile, many traditional FQHC patients have gained Medicaid or Marketplace coverage under the ACA and now have more options for where they get their health care. Consequently, some FQHCs may find themselves in the unfamiliar position of competing with private providers for patients who previously had nowhere else to go. This brief explores the demographic, socioeconomic, and health characteristics of nonelderly adults who rely on an FQHC for their usual source of care (USOC)² compared with those who go elsewhere, and it explores how proximity to an FQHC affects the share of nonelderly adults who rely on an FQHC. Our findings provide useful insights for guiding the ongoing FQHC expansion.

What We Did

The Health Reform Monitoring Survey (HRMS), which provides nationally representative data for nonelderly adults (those ages 18 to 64), is designed to provide early feedback on ACA implementation before more robust information from federal surveys with larger sample sizes is available (Long et al. 2014). To gather information about recent FQHC users, we added questions to the September and December 2014 waves of the HRMS asking respondents whether they had used any of the six FQHCs located closest to them in the past year. We also asked respondents whether they relied on one of those FQHCs as their usual source of care and, if so, why they did so. Proximity to FQHCs was determined by the zip code of the respondent's residence and the centers'

zip code.³ In describing the characteristics and circumstances of those who rely on an FQHC for their care, we focus on all nonelderly adults and low-income nonelderly adults (those with family income at or below 138 percent of the federal poverty level, the upper income level for the Medicaid expansion under the ACA).

What We Found

Millions of adults continue to use FQHCs despite the expansion of health insurance coverage under the ACA. In 2014, 9.2 percent of nonelderly adults, or an estimated 18.3 million individuals, reported having received care from a FQHC in the past year (table 1). Among low-income adults, that rate rises to nearly one in five (19.3 percent). Just over 8 percent of all nonelderly adults relied on an FQHC as their USOC. For low-income adults, this figure was nearly double, at 16.3 percent.

Table 1. Share of Nonelderly Adults that use an FQHC, by Proximity to an FQHC and Family Income, September and December 2014

	All	Lives within 1 mile of an FQHC ^a	Lives between 1 and 5 miles from an FQHC	Lives more than 5 miles from an FQHC
All adults				
Received care from FQHC within the past year	9.2%	15.2%	10.2%***	4.7%***
Relied on FQHC as usual source of care	8.1%	13.7%	8.9%***	4.1%***
Sample size	15,284	2,952	6,616	5,716
Low-income adults				
Received care from FQHC within the past year	19.3%	26.1%	21.0%***	10.1%***
Relied on FQHC as usual source of care	16.3%	22.2%	18.0%***	8.0%***
Sample size	3,440	900	1,538	1,002

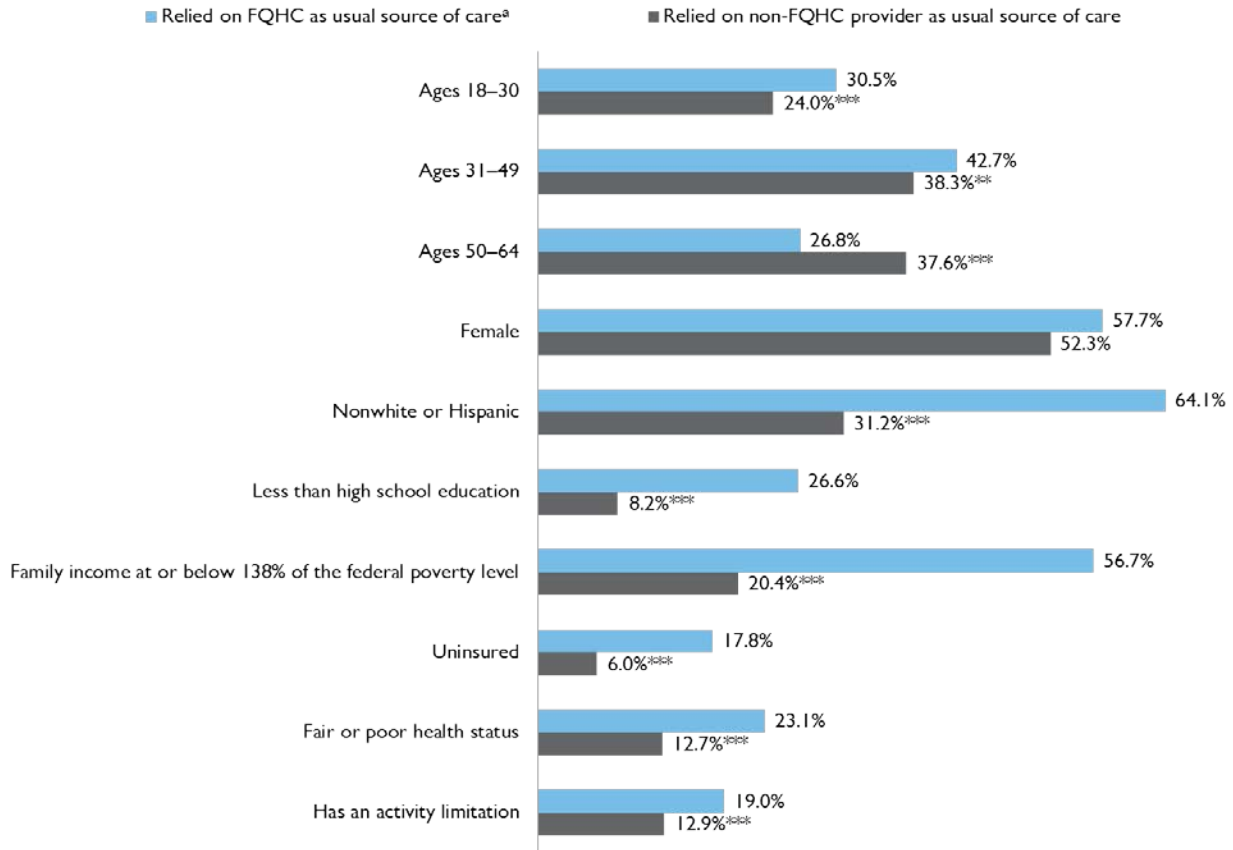
Source: Health Reform Monitoring Survey, quarters 3 and 4 2014.

Notes: FQHC is federally qualified health center. Low-income adults are those with family income at or below 138 percent of the federal poverty level. Data exclude 27 respondents (out of 15,311 total respondents) who did not provide information on health status (26 respondents) or zip code of residence (1 respondent).

*/**/** Estimate differs significantly from the reference category, marked with ^a, at the 0.1/0.05/0.01 levels, using two-tailed tests.

Although individuals who rely on FQHCs as their USOC cut across all demographic and socioeconomic groups, the health centers continue to serve a disproportionate share of the most vulnerable adults under the ACA. Nonelderly adults who rely on FQHCs as their USOC are diverse in age; gender; racial and ethnic background; health status; and income (figure 1). Nonetheless, consistent with FQHCs' longstanding mission,⁴ FQHCs continue to serve a disproportionate share of the most vulnerable adults, including those with limited financial resources, the uninsured, and those with greater health care needs. Adults that rely on an FQHC as their USOC are more likely than adults who rely on other providers to be low-income (56.7 versus 20.4 percent) and to be uninsured (17.8 versus 6.0 percent). They are also more likely to be in fair or poor health (23.1 versus 12.7 percent) and have an activity limitation (19.0 versus 12.9 percent).

Figure 1. Selected Characteristics of Nonelderly Adults by Usual Source of Care, September and December 2014



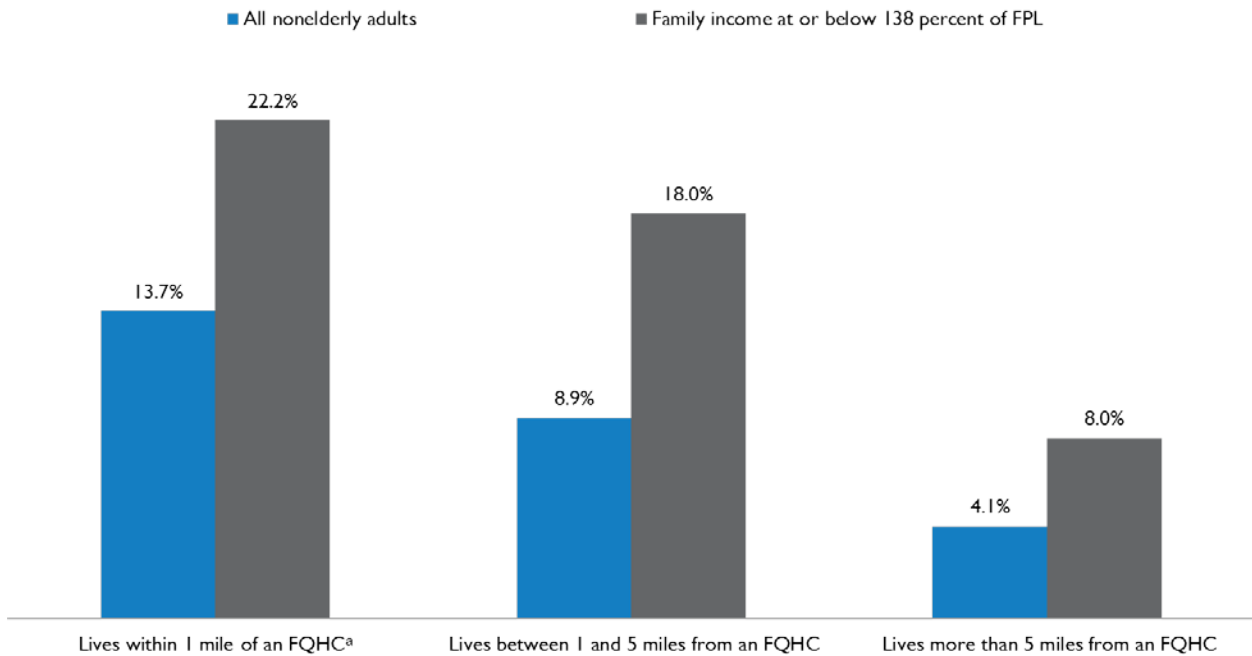
Source: Health Reform Monitoring Survey, quarters 3 and 4 2014.

Notes: FQHC is federally qualified health center.

*** Estimate differs significantly from the reference category, marked with ^a, at the 0.05/0.01 levels, using two-tailed tests.

Low-income adults and adults who live closer to an FQHC are more likely to rely on an FQHC for their care. For adults overall and for low-income adults, reliance on FQHCs is highest for those living closest to an FQHC (table 1). For example, 13.7 percent of all nonelderly adults living within one mile of an FQHC relied on one as their USOC compared with less than 5 percent of adults living more than five miles from an FQHC. Among low-income nonelderly adults, nearly one-quarter (22.2 percent) living within one mile of an FQHC relied on one as their USOC compared with just 8.0 percent of low-income adults living more than five miles from an FQHC (figure 2). We found no significant difference in FQHC use across the nine geographic regions of the country examined. We also found no significant difference in FQHC use by whether a person lived in a state that had implemented the ACA Medicaid expansion.

Figure 2. Share of Nonelderly Adults that Received Care from an FQHC Within the Past Year, by Proximity to an FQHC and Family Income, September and December 2014



Source: Health Reform Monitoring Survey, quarter 3 2014 and quarter 4 2014.

Notes: FQHC is federally qualified health center; FPL is the federal poverty level. Excludes 27 respondents (out of 15,311 total respondents) who did not provide information on health status (26 respondents) or zip code of residence (1 respondent).

**** Estimate differs significantly from the reference group, denoted by ^a, at the 0.05/0.01 levels, using two-tailed tests.

Staff and environment; location; and quality of care are the three most important reasons that nonelderly adults rely on an FQHC for their care. We found that location is an important reason for choosing to go to an FQHC, which is consistent with the finding that individuals who live near an FQHC are more likely to rely on one than those who live far away. Nearly half (47.4 percent) of individuals who relied on an FQHC in September 2014 reported that its location was a reason that they went there. Staff/environment (52.8%) and quality of care (40.4%) were two other commonly cited reasons.

What It Means

Our findings demonstrate that even with the significant coverage expansion and greater access to care the ACA affords to nonelderly adults and especially low-income nonelderly adults (Long et al. 2015; Shartzter, Long, and Anderson 2015), FQHCs continue to serve individuals with high health care needs and low economic resources. Our results also reveal that physical proximity to an FQHC is important to those who use them. With the continued significant federal investment in health centers the ACA provides, FQHC stakeholders should pay attention to where new health centers are located relative to populations they aim to serve.

References

- Long, Sharon K., Michael Karpman, Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Adele Shartzter, Nathaniel Anderson, and Katherine Hempstead. 2015. [Taking Stock: Gains in Health Insurance Coverage under the ACA as of March 2015](#). Washington, DC: Urban Institute.
- Shartzter, Adele, Sharon K. Long, and Nathaniel Anderson. 2015. [“Access to Care and Affordability Have Improved Following Affordable Care Act Implementation; Problems Remain.”](#) *Health Affairs* 35(1): 1–8.

About the Series

This brief is part of a series drawing on the HRMS, a survey of the nonelderly population that explores the value of cutting-edge Internet-based survey methods to monitor the ACA before data from federal government surveys are available. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation and the Urban Institute.

For more information on the HRMS and for other briefs in this series, visit www.urban.org/hrms.

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Notes

¹ [“Health Centers and the Affordable Care Act,”](#) Health Resources and Services Administration, Health Center Program, accessed July 14, 2016.

² A usual source of care is defined as the place an individual usually goes when they are sick or need advice about their health.

³ To identify FQHCs, we downloaded the Health Care Service Delivery dataset from the Health Resources and Services Administration Data Warehouse (datawarehouse.hrsa.gov). We limited the analysis to permanent sites that delivered direct health care services to adults in traditional health care settings, based on center names and other descriptors in the HRSA data. We included only sites that were open year-round or seasonally; we excluded mobile vans and sites located in schools, correctional facilities, nursing homes, domestic violence shelters, and homeless shelters. We also excluded sites dedicated exclusively to HIV prevention and treatment, migrant worker care, pediatric care, and drug rehabilitation.

⁴ [“2014 Health Center Data: National Program Grantee Data,”](#) Health Resources and Services Administration, Health Center Program, accessed July 14, 2016.