

# Characteristics of Public vs. Private Federally Qualified Health Centers



J Gen Intern Med 37(4):987–9  
DOI: 10.1007/s11606-021-06761-1  
© Society of General Internal Medicine 2021

## INTRODUCTION

Federally qualified health centers (FQHCs) address critical shortages in primary care and care for the uninsured. While non-profits operate most FQHCs, many public agencies such as municipal governments also operate clinics. Section 330 of the US Public Health Service Act limits federal health center grants to public agencies to 5%; however, it is unclear what justification exists for such a cap.<sup>1</sup> Here, we examine differences between demographic, financial, and quality outcomes between public and private FQHCs, which to our knowledge have not been described previously.

## METHODS

We examined publicly available databases (Nationally Aggregated Health Center Data and Health Center Service Delivery Sites) from the Health Resources and Services Administration (HRSA) from 2019.<sup>2</sup> We defined “Public FQHCs” as health center grantees listed as a “U.S. Government Entity” or as health departments, city/county governments, public hospital districts, and public universities. All other grantees, including tribal organizations, were classified as “Private FQHCs” per guidance from HRSA.<sup>3</sup> County-level demographic data were obtained via the Agency for Health Care Research and Quality Social Determinants of Health database.<sup>4</sup>

We examined demographic and financial characteristics using two sample *t* tests. Using primary care metrics reported annually by FQHCs, we analyzed these markers using both univariate and multivariate linear multiple regressions to adjust for proportion of patients uninsured, age over 65, income below poverty level, and whether FQHCs were located in a

rural county. Outcome measures missing data from more than 5% of FQHCs were not included. Significance was defined as  $\alpha = 0.05$ . Statistical analysis was completed in R (R Core Team 2018).

## RESULTS

There are 97 (7%) FQHCs that are operated by government entities, serving 1.8 million patients and accounting for 5% of federal health center grants. These include 43 local health departments, 29 city/county governments, 14 public hospital systems, and 11 universities.

We do not find a significant difference in the number of patients served at either public or private FQHCs (18,930 vs 21,891,  $p = 0.33$ , Table 1), the proportion of patients who identify as racial/ethnic minorities (0.52 vs. 0.56,  $p = 0.15$ ), or those with incomes below the federal poverty level (0.67 vs. 0.64,  $p = 0.09$ ). Public FQHCs had significantly higher proportions of uninsured patients (0.31 vs. 0.24,  $p < 0.001$ ) and fewer Medicare patients (0.09 vs. 0.11,  $p = 0.002$ ). Patients at public FQHCs had slightly lower rates of diabetes (0.14 vs. 0.15,  $p = 0.002$ ) and hypertension (0.27 vs 0.30,  $p = 0.01$ ).

A similar proportion of public and private FQHCs are in rural counties (0.27 vs. 0.26). Private FQHCs are located in counties with lower median incomes (\$58,156 vs. \$62,234,  $p = 0.03$ ), and have higher proportion of residents in poverty (0.16 vs. 0.14,  $p = 0.02$ ).

Public FQHCs were not associated with significant differences in the proportion of patients who suffer from uncontrolled diabetes, appropriately received statin therapy, had an asthma treatment plan, received childhood immunizations, received depression screening, or appropriately received tobacco cessation in unadjusted or adjusted analyses (Table 2). In adjusted analysis, public FQHCs were associated with a 3% reduction proportion of patients with blood pressure control ( $p = 0.03$ ) and 3% lower rate of cervical cancer screening ( $p = 0.05$ ).

Public FQHCs were associated with lower rates of colorectal cancer screening and prenatal screening in

Received December 6, 2020

Accepted March 25, 2021

Published online April 26, 2021

**Table 1 Summary of Demographic (at Patient and County Level), Chronic Disease Prevalence, and Financial Performance by Public and Private FQHC**

	Private FQHC	Public FQHC	Difference (95% CI)	p value
Number of clinics	1255 (93%)	97 (7%)	n/a	n/a
Number of patients	29,309,889 (94%)	1,836,279 (6%)	n/a	n/a
Patient demographics				
Average patients served	21,891	18,930	2,961 (-3,101 to 9,022)	0.33
Children < 18	0.27	0.25	0.02 (- 0.02 to 0.04)	0.46
Adults 18-64	0.62	0.66	-0.04 (-0.06 to -0.01)	0.02
Adults > 65	0.11	0.08	0.03 (0.02 to 0.04)	<0.001
Below 100% FPL	0.64	0.67	-0.03 (-0.08 to 0.1)	0.09
Below 200% FPL	0.89	0.89	0 (-0.03 to 0.03))	0.99
Uninsured	0.24	0.31	-0.07 (-0.11 to -0.02)	<0.001
Medicare	0.11	0.09	0.02 (0.01 to 0.03)	0.002
Medicaid/CHIP	0.43	0.43	0 (-0.04 to 0.05)	0.99
Racial/ethnic minority	0.56	0.52	0.04 (-0.02 to 0.10)	0.15
Black/African American	0.23	0.21	0.02 (-0.03 to 0.06)	0.48
Hispanic/Latino	0.28	0.26	0.02 (-0.04 to 0.06)	0.61
Native American/Alaskan Native	0.03	0.02	0.01 (0.01 to 0.02)	<0.001
Asian	0.05	0.05	0 (-0.01 to 0.01)	0.85
Best Served in Other language	0.18	0.20	0.02 (-0.06 to 0.03)	0.51
Prevalence of conditions				
Diabetes	0.15	0.14	0.01 (0.006 to 0.02)	0.002
HTN	0.30	0.27	0.03 (0.001 to 0.05)	0.01
HIV	0.01	0.01	0 (-<0.001 to <0.001)	0.12
Substance use	0.02	0.02	0 (-0.01 to 0.004)	0.33
County-level demographics				
Proportion FQHCs in rural county	0.26	0.27	n/a	n/a
Median Household Income	\$58,156	\$62,234	-\$4,078 (-\$7,650 to -\$505)	0.03
County below 100% FPL	0.16	0.14	0.02 (.002 to .026)	0.02
Residents <65 uninsured	0.11	0.11	0 (-.004 to .02)	0.27
White	0.72	0.76	-0.04 (-0.06 to 0.03)	0.07
Black	0.12	0.11	0.1 (-.01 to .04)	0.3
Hispanic	0.17	0.14	0.03 (-.005 to 0.06)	0.054
Native American/Alaskan Native	0.02	0.01	0.1 (-.001 to .01)	0.11
Asian	0.05	0.05	0 (-.02 to .01)	0.85
Financial performance				
Cumulative federal grant	\$4,806,583,650 (95%)	\$241,679,225 (5%)	n/a	n/a
Average federal grant per patient	\$283	300	-17 (-71 to 38)	0.55
Average cost per patient	\$1,159	\$1,090	69 (-82 to 220)	0.37

univariate analysis; however, this difference was no longer significant after controlling for demographics and location. There was no difference in federal grants received per patient (\$300 vs. \$283,  $p = 0.55$ ) or average cost per patient between public and non-governmental FQHCs (\$1,090 vs. \$1,159,  $p = 0.37$ ).

**DISCUSSION**

Public FQHCs serve a higher proportion of uninsured patients while achieving comparable quality on most metrics without differences in grants received or cost compared to private FQHCs. Policymakers should consider eliminating the 5%

**Table 2 Comparison of Unadjusted and Adjusted Beta Coefficients for Public FQHC Compared to Private FQHC on Eleven Quality Outcomes**

Outcome measure	Mean (private FQHC)	Unadjusted B (SE) public FQHC*	p value	Adjusted B (SE) public FQHC**	p value
BP control (<140/90)	0.64	-.03(.01)	.004	-.03(.01)	.030
Cervical cancer screening	0.52	-.03(.02)	.10	-.03(.02)	.050
Colorectal cancer screening	0.43	-.05(.02)	.003	-.03(.02)	.053
Statin therapy	0.7	-.02(.01)	.057	-.03(.01)	.058
Asthma treatment	0.95	-.02(.01)	.14	.02(.01)	.13
Access to prenatal screening	0.78	-.04(.02)	.03	-.02(.01)	.20
Uncontrolled DM (A1c > 9)	0.32	.01(.01)	.40	-.01(.01)	.62
Depression screening	0.71	.00(.02)	.99	-.01(.02)	.67
Adults receiving tobacco cessation	0.85	-.002(.01)	.88	-.01(.01)	.69
Childhood immunization	0.35	.01(.02)	.57	.003(.02)	.91

\*Univariate linear regression

\*\*Multivariate linear regression with controls for proportion of patients uninsured, age over 65, income below poverty level, and rural location as defined by USDA Rural-Urban Continuum Code > 3

cap on grants allocated to public centers, as they may be easier to establish in areas without non-profits available to sponsor new health centers. Our study is limited by its cross-sectional nature impairing inferences on causality, and its relatively small sample sizes may restrict our ability to detect population-level differences. Additionally, we did not subgroup centers focused on serving Native populations, but this may be the focus of future study.

---

---

*Sanjay Kishore, MD<sup>1</sup>*  
*Micah Johnson, MD<sup>1</sup>*  
*Rahul Nayak, MD<sup>2</sup>*

<sup>1</sup>Department of Medicine, Brigham and Women's Hospital,  
Boston, MA, USA

<sup>2</sup>Department of Medicine, Massachusetts General Hospital,  
Boston, MA, USA

**Corresponding Author:** Sanjay Kishore, MD; Department of Medicine, Brigham and Women's Hospital, Boston, MA, USA (e-mail: SKISHORE1@PARTNERS.ORG).

## REFERENCES

1. 42 U.S.C. § 254b(r)(2)(A).
2. Health Resources & Service Administration. National Aggregated Health Center Data. 2019. Available online at <https://data.hrsa.gov/tools/data-reporting/program-data/national>
3. Health Resources & Service Administration. Health Center Compliance Manual - Chapter 1: Health Center Program Eligibility. 2018. Available online at <https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-1.html#titletop>
4. Social Determinants of Health. Agency for Healthcare Research and Quality. 2020. Available online at <https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html>

**Publisher's Note:** Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.