COLORADO
Safety Net Collaborative

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From Dollars to Care: The Evidence for Investing in Safety Net Clinics

How free, charitable and community safety net clinics convert public and philanthropic dollars into needed care and lower costs across the health system

Executive Summary

Independent safety net clinics, including free and charitable clinics, community clinics, pediatric clinics, and dental and women's health clinics, care for people who have nowhere else to turn, largely through donated time and private support. A growing body of evidence links them to lower emergency and hospital use. Uninsured patients discharged from an academic medical center who were not referred to its partner free clinic had 1.8 times the odds of returning to the emergency department or hospital within 90 days, and 2.3 times the cost when they did.[1] Studies that separate avoided emergency and hospital costs from the value of health gained have estimated savings of $1.30 to $5.50 for every dollar spent on clinic care, though results vary by clinic and year.[2,3,4] Donated care multiplies public dollars: Florida spent $579,539 to administer a program through which volunteers at participating clinics donated care the clinics valued at approximately $163 million.[5] Clinics also deliver services with documented returns, from well-child care, immunization and preventive dental care to integrated behavioral health and family planning.

The need for this care is growing. Colorado hospitals' charity care and bad debt rose 31.5% in a single year, to $716.7 million in 2024,[6] and 378,500 Medicaid members will be subject to new federal work requirements beginning in January 2027.[7] People who lose coverage will still need care. Sustaining and expanding state support for safety net clinics, including the Primary Care Fund and the Provider Stabilization Fund, is a high-value, evidence-based way for Colorado to protect access to primary care and reduce avoidable emergency and hospital use.

Pressure on the Safety Net Is Growing

According to the Colorado Health Institute's Colorado Health Access Survey (CHAS), the state's uninsured rate was 5.9% in 2025, and 27.5% of Coloradans put off care because of cost.[8] Consistent with Colorado safety net clinic experience, gaps are far wider for some groups: 31.9% of Spanish-speaking immigrants in Colorado were uninsured, compared with 4.5% of U.S.-born Coloradans.[9] Hospital charity care and bad debt in Colorado rose from $545 million in 2023 to $716.7 million in 2024, an increase the state says is likely due in large part to the end of pandemic-era continuous Medicaid enrollment.[6] The Congressional Budget Office estimates the 2025 reconciliation law will add 10 million people to the nation's uninsured by 2034, 7.5 million of them because of Medicaid changes.[10] In Colorado, HCPF estimates about 378,500 members will be subject to work requirements beginning in January 2027, before exemptions are applied.[7]

Uninsured people who cannot get primary care tend to seek it later and in more expensive settings. Potentially preventable hospital stays among U.S. adults cost $33.7 billion in 2017, an average of about $9,500 per stay, and residents of the lowest-income communities were hospitalized for these conditions at more than twice the rate of residents of the highest-income communities.[11]

Who Independent Safety Net Clinics Serve

More than 1,400 free and charitable clinics and charitable pharmacies operate nationwide. They are overwhelmingly independent: 72% are free clinics, 10% charitable clinics and 10.5% hybrid clinics. Volunteers make up 91% of their workforce, including 72,000 licensed or certified clinicians, and nearly half operate on annual budgets of $250,000 or less.[12] In 2025 they recorded more than 8.2 million patient visits, up from 6 million in 2024, and 84% reported rising demand.[13] Most patients are uninsured and working, and hypertension, diabetes,

and depression or anxiety are their most common conditions.[12] In Colorado, CSNC member clinics that reported data served at least 56,832 patients across 165,779 visits in 2024.[14]

Savings From Avoided Emergency and Hospital Care

Observed hospital use. In a study of 6,014 uninsured adults discharged from an academic medical center's emergency department or inpatient units, those not referred to the center's partner free clinic had 1.8 times the odds of another emergency visit or admission within 90 days. Among patients who did return, mean hospital costs were 2.3 times higher for those not referred.[1] The study is observational, but it measures actual utilization and hospital costs.

Savings per dollar. Counting only the avoided costs of heart attacks and strokes from improved blood pressure control, plus patient-reported avoided emergency visits, Boston's Family Van mobile clinic returned at least $1.30 per dollar spent, a lower bound that excludes all of its other services.[2] An earlier analysis of the same clinic estimated $3.1 million in avoided emergency department costs in one year on an operating budget of $567,700, about $5.51 per dollar.[3] A California free clinic serving low-income, mostly Hispanic adults avoided an estimated $4.6 million in emergency department costs in 2022 on operating costs of $869,920, about $5.24 per dollar; including the value of health gained, its estimated return was $13.18 per dollar.[4] The two higher estimates assume a share of clinic visits would otherwise have gone to the emergency department. Clínica Esperanza, a free walk-in clinic in Providence, reduced Rhode Island emergency department spending by about $449,000 a year.[15]

Other findings. Results vary. At one free primary care clinic, non-urgent emergency and inpatient costs fell by $170 per patient per year after enrollment, against first-year primary care costs of $505 per patient; the author estimated the savings would offset those costs if sustained for at least three years.[16] Evidence on short-term impacts on utilization is mixed: one program found no difference in first-year hospital or emergency use between patients enrolled in a free primary care program immediately and those placed on a waiting list.[17]

Donated Care Multiplies Public Dollars

Florida's Volunteer Health Care Provider Program extends state sovereign immunity to licensed clinicians who treat low-income patients for free. In fiscal 2024–25, the program cost $579,539 to administer. Its 10,506 volunteer clinicians delivered 476,861 medical and dental services, and participating clinics reported 1,075,210 donated hours valued at about $163 million; including supplies, equipment and monetary donations, the clinic-reported value exceeded $300 million.[5] The Virginia Health Care Foundation, which receives state funding to expand care for the uninsured, reports leveraging $11 in cash, health services and in-kind contributions for every dollar it spends.[18] Research on community health centers points the same direction: their Medicaid patients had 24% lower total spending than Medicaid patients served in other primary care settings.[20]

Evidence Across Core Safety Net Services

Children's health. Young children who had the fewest recommended well-child visits had twice the risk of a hospitalization for a condition that timely primary care can usually prevent; among children with chronic disease, the risk was more than three times higher.[21] Fluoride varnish applied in pediatric primary care saved Virginia Medicaid $75.32 per child,[22] and school-based sealant programs become cost-saving within two years.[23] School-based health centers produce $1.38 to $3.05 in societal benefits per dollar and net Medicaid savings of $46 to $1,166 per user.[24] Routine childhood immunization for children born from 1994 to 2023 is projected to yield net payer savings of $540 billion, about $3.30 for every dollar spent.[25]

Chronic disease care. Team-based blood pressure care, in which nurses, pharmacists and community health workers share management with clinicians, cost a median of $12,897 per quality-adjusted life year gained in U.S. studies, well below a conservative $50,000 benchmark.[26]

Oral health. Emergency departments handled 1.6 million visits for non-traumatic dental conditions in 2022 at a cost of $3.9 billion, an average of $2,437 per visit; two-thirds were by patients with Medicaid or no insurance.[27] When California eliminated adult Medicaid dental benefits in 2009, dental emergency visits rose by more than 1,800 a year and their cost by 68%.[28] Among Medicaid enrollees with diabetes, periodontal treatment was associated with 14% lower total health care costs.[29]

Behavioral health. In a study of 21 million commercially insured people, the 27.3% with behavioral health conditions accounted for 56.5% of total health spending, while behavioral health treatment itself was only 4.4%.[30] In the IMPACT trial, depression care integrated into primary care cost $522 per patient and lowered per patient health care costs by an estimated $3,363 per patient over four years, a result with wide confidence intervals.[31]

Women's health and family planning. Publicly funded family planning produced an estimated $13.6 billion in net government savings in 2010, $7.09 per public dollar spent. Of those savings, $9.9 billion came from services at publicly funded health centers, including $7 billion at Title X–funded centers.[32] In Colorado, teen birth and abortion rates fell by nearly half during the Colorado Family Planning Initiative, which expanded long-acting contraception through Title X clinics; the state estimates $66.1 million to $69.6 million in public assistance costs were avoided.[33] An independent analysis attributed a 6.4% reduction in the teen birth rate over five years directly to the initiative in the counties where it operated.[34]

Implications for Colorado

- **Protect and grow the Provider Stabilization Fund.** SB25-290 created the Provider Stabilization Fund for safety net providers that serve low-income uninsured people at no cost or on a sliding fee, at $25 million in fiscal 2025–26, $20 million in 2026–27 and $15 million in each of the following three years, and directs HCPF to draw federal matching funds.[36] Sustaining and expanding this program is a direct, economical way to absorb rising need.
- **Plan for coverage losses.** As work requirements take effect in 2027, Coloradans who lose Medicaid will need a primary care home. Independent safety net clinics already serve uninsured patients and can absorb more with added capacity.
- **Fund the full scope of primary care.** Pediatric, oral health, behavioral health, women's health and preventive services delivered in clinics carry documented returns and belong in public funding streams for primary care.
- **Invest in measurement.** Consistent clinic-level data on patients, services, donated care and outcomes would let Colorado document the return on its safety net investment.

Sources

1. Wallace S, et al. The Financial Impact of a Partnership Between an Academic Medical Center and a Free Clinic. American Journal of Medicine. 2021;134(11):1389–1395. https://doi.org/10.1016/j.amjmed.2021.06.011
2. Song Z, et al. Mobile Clinic in Massachusetts Associated With Cost Savings From Lowering Blood Pressure and Emergency Department Use. Health Affairs. 2013;32(1):36–44. https://doi.org/10.1377/hlthaff.2011.1392
3. Oriol NE, et al. Calculating the Return on Investment of Mobile Healthcare. BMC Medicine. 2009;7:27. https://doi.org/10.1186/1741-7015-7-27
4. Dion AE, et al. Prevalence of Chronic Disease and Cost Effectiveness of a Free Clinic. Journal of Community Health. 2025;50(2):259–269. https://doi.org/10.1007/s10900-024-01417-7
5. Florida Department of Health. Volunteer Health Care Provider Program, Fiscal Year 2024–25 Annual Report. December 2025. https://www.floridahealth.gov/wp-content/uploads/2026/03/2024-25-Volunteer-Health-Care-Provider-Program-Annual-Report.pdf
6. Colorado Department of Health Care Policy and Financing (HCPF). Colorado Healthcare Affordability and Sustainability Enterprise Annual Report. January 15, 2026. https://spl.cde.state.co.us/artemis/hcpserials/hcp1231internet/hcp12312026internet.pdf
7. HCPF. Work Requirements Frequently Asked Questions. Updated June 2, 2026. https://hcpf.colorado.gov/work-requirements-faqs
8. Colorado Health Institute. 2025 Colorado Health Access Survey. November 2025. https://coloradohealthinstitute.org/research/colorado-health-access-survey-2025
9. Colorado Health Institute. 2025 CHAS: Immigrant Health. September 22, 2026. https://www.coloradohealthinstitute.org/research/2025-chas-immigrant-health
10. KFF. How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State? Updated August 20, 2025 (citing Congressional Budget Office estimates). https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/
11. McDermott KW, Jiang HJ. Characteristics and Costs of Potentially Preventable Inpatient Stays, 2017. HCUP Statistical Brief #259. Agency for Healthcare Research and Quality, 2020. https://hcup-us.ahrq.gov/reports/statbriefs/sb259-Potentially-Preventable-Hospitalizations-2017.jsp
12. National Association of Free & Charitable Clinics. NAFC Data Report 2026 (2025 member data). July 2026. https://nafcclinics.org/wp-content/uploads/2026/07/NAFC-Data-Report-2026.pdf
13. National Association of Free & Charitable Clinics. 2026 NAFC Data Report: Rising Demand for Free Care. 2026. https://nafcclinics.org/2026-nafc-data-report-rising-demand-for-free-care/
14. Colorado Safety Net Collaborative. 2025 Member Survey (calendar 2024 data; 20 of 41 members responding, 15 reporting patient and visit counts).

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15. Barry K, et al. Four Years of CHEER: Cost and QALY Savings of a Free Nurse-run Walk-in Clinic Serving an Uninsured, Predominantly Spanish-speaking Immigrant Population in Providence. Journal of Health Care for the Poor and Underserved. 2019;30(2):806–819. https://doi.org/10.1353/hpu.2019.0057
16. Fertig AR. Benefits and Costs of a Free Community-Based Primary Care Clinic. Journal of Health and Human Services Administration. 2012. https://experts.umn.edu/en/publications/benefits-and-costs-of-a-free-community-based-primary-care-clinic/
17. Mackinney T, et al. Does Providing Care for Uninsured Patients Decrease Emergency Room Visits and Hospitalizations? Journal of Primary Care & Community Health. 2013;4(2):135–142. https://doi.org/10.1177/2150131913478981
18. Virginia Health Care Foundation. 2025 Impact Report (report to the Virginia General Assembly, RD548). 2025. https://rga.lis.virginia.gov/Published/2025/RD548/PDF
19. HCPF. Primary Care Fund Annual Report, FY 2024–25. February 1, 2026. https://hcpf.colorado.gov/sites/hcpf/files/FY%202024-25%20Primary%20Care%20Fund%20Annual%20Report.pdf
20. Nocon RS, et al. Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings. American Journal of Public Health. 2016;106(11):1981–1989. https://doi.org/10.2105/AJPH.2016.303341
21. Tom JO, et al. Well-Child Care Visits and Risk of Ambulatory Care–Sensitive Hospitalizations. American Journal of Managed Care. 2013;19(5):354–360. https://www.ajmc.com/view/well-child-care-visits-and-risk-of-ambulatory-caresensitive-hospitalizations
22. Scherrer CR, Naavaal S. Cost-Savings of Fluoride Varnish Application in Primary Care for Medicaid-Enrolled Children in Virginia. Journal of Pediatrics. 2019;212:201–207. https://doi.org/10.1016/j.jpeds.2019.05.026
23. Community Preventive Services Task Force. Dental Caries (Cavities): School-Based Dental Sealant Delivery Programs. The Community Guide. https://www.thecommunityguide.org/findings/dental-caries-cavities-school-based-dental-sealant-delivery-programs.html
24. Community Preventive Services Task Force. Social Determinants of Health: School-Based Health Centers (economic evidence). The Community Guide. https://www.thecommunityguide.org/findings/social-determinants-health-school-based-health-centers
25. Zhou F, et al. Health and Economic Benefits of Routine Childhood Immunizations in the Era of the Vaccines for Children Program — United States, 1994–2023. MMWR. 2024;73(31):682–685. https://www.cdc.gov/mmwr/volumes/73/wr/mm7331a2.htm
26. Jacob V, et al. Economics of Team-based Care for Blood Pressure Control: Updated Community Guide Systematic Review. American Journal of Preventive Medicine. 2023;65(4):735–754. https://doi.org/10.1016/j.amepre.2023.04.013
27. CareQuest Institute for Oral Health. Dental Care in Crisis: Tracking the Cost and Prevalence of Emergency Department Visits for Non-Traumatic Dental Conditions. November 3, 2025. https://carequest.org/dental-care-in-crisis-tracking-the-cost-and-prevalence-of-emergency-department-visits-for-non-traumatic-dental-conditions/
28. Singhal A, et al. Eliminating Medicaid Adult Dental Coverage in California Led to Increased Dental Emergency Visits and Associated Costs. Health Affairs. 2015;34(5):749–756. https://doi.org/10.1377/hlthaff.2014.1358
29. Thakkar-Samtani M, et al. Periodontal Treatment Associated With Decreased Diabetes Mellitus–Related Treatment Costs. Journal of the American Dental Association. 2023;154(4):283–292. https://doi.org/10.1016/j.adaj.2022.12.011
30. Davenport S, Gray TJ, Melek S. How Do Individuals With Behavioral Health Conditions Contribute to Physical and Total Healthcare Spending? Milliman, August 2020. https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx
31. Unützer J, et al. Long-term Cost Effects of Collaborative Care for Late-life Depression. American Journal of Managed Care. 2008;14(2):95–100. https://www.ajmc.com/view/feb08-2835p095-100
32. Frost JJ, et al. Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program. Milbank Quarterly. 2014;92(4):696–749. https://doi.org/10.1111/1468-0009.12080
33. Colorado Department of Public Health and Environment. Colorado's Success with Long-Acting Reversible Contraception (Colorado Family Planning Initiative). https://cdphe.colorado.gov/fpp/about-us/colorados-success-long-acting-reversible-contraception-larc
34. Lindo JM, Packham A. How Much Can Expanding Access to Long-Acting Reversible Contraceptives Reduce Teen Birth Rates? American Economic Journal: Economic Policy. 2017;9(3):348–376. https://www.aeaweb.org/articles?id=10.1257/pol.20160039
35. Sanders J, Lacey M, Guse CE. Accrued Cost Savings of a Free Clinic Using Quality-Adjusted Life Years Saved and Return on Investment. Journal of the American Board of Family Medicine. 2017;30(4):505–512. https://www.jabfm.org/content/30/4/505
36. Colorado General Assembly. SB25-290, Stabilization Payments for Safety Net Providers. 2025. https://leg.colorado.gov/bills/SB25-290