Milken Institute School of Public Health
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Geiger Gibson Program in Community Health Policy

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RCHN Community Health Foundation Research Collaborative

Policy Research Brief # 49

What are the Possible Effects of Failing to Extend the Community Health Center Fund?

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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 Milken Institute School of Public Health 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 is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing 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 https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy or at rchnfoundation.org.

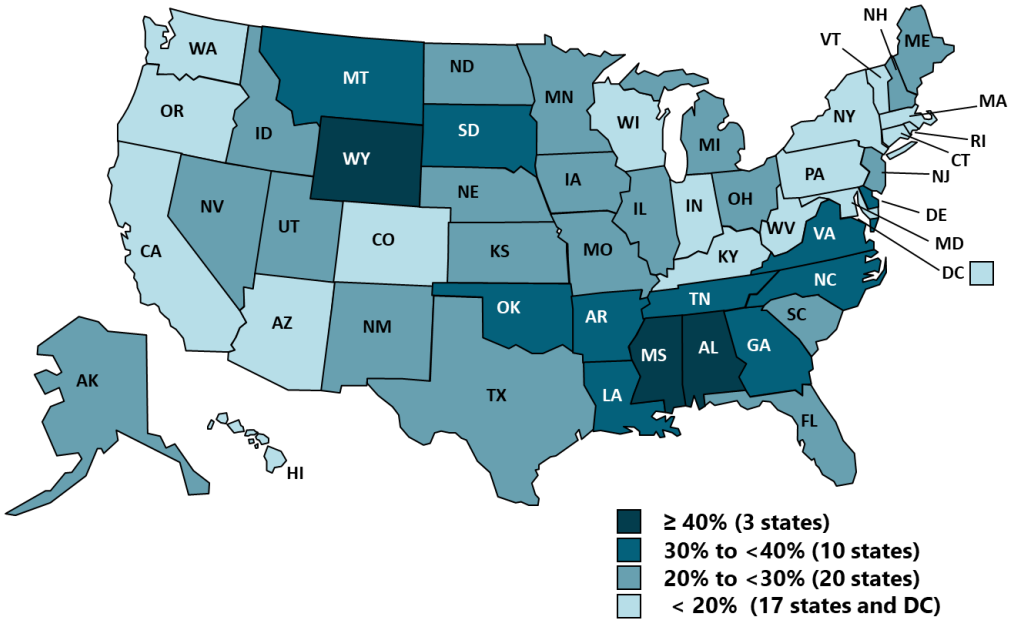
Executive Summary

In order to expand access to primary health care in medically underserved urban and rural communities, the Affordable Care Act established the Community Health Center Fund (CHC Fund). Between 2010 and 2016, the CHC Fund in turn helped propel a 22 percent increase in the number of health centers, a 50 percent increase in the number of health center sites, and a 33 percent increase in the number of patients served, from 19.5 million in 2010 to 25.9 million in 2016. In 2015, Congress extended the CHC Fund through Fiscal Year 2017, and like federal CHIP funding, the CHC Fund is set to expire if Congress does not act. Without an extension, health centers will experience a 70 percent loss in grant funding.

Such a drop in grant funding carries far-reaching implications, affecting health centers' ability to reach new communities, staff existing sites, and increase care to medically vulnerable populations. Ending the CHC Fund will result in a $3.6 billion drop in health center funding in Fiscal Year 2018. This figure translates into a loss of 51,000 clinicians and other health center staff and a loss of access to care for 9 million people – over one-third of all patients served by health centers currently.

Health centers most at risk under this scenario are those that rely most heavily on grants to operate. These health centers share certain key characteristics: location in non-Medicaid-expansion states; rural location; and smaller health centers serving fewer than 5,000 patients annually.

Health Center Reliance on Federal Section 330 Funding, 2016

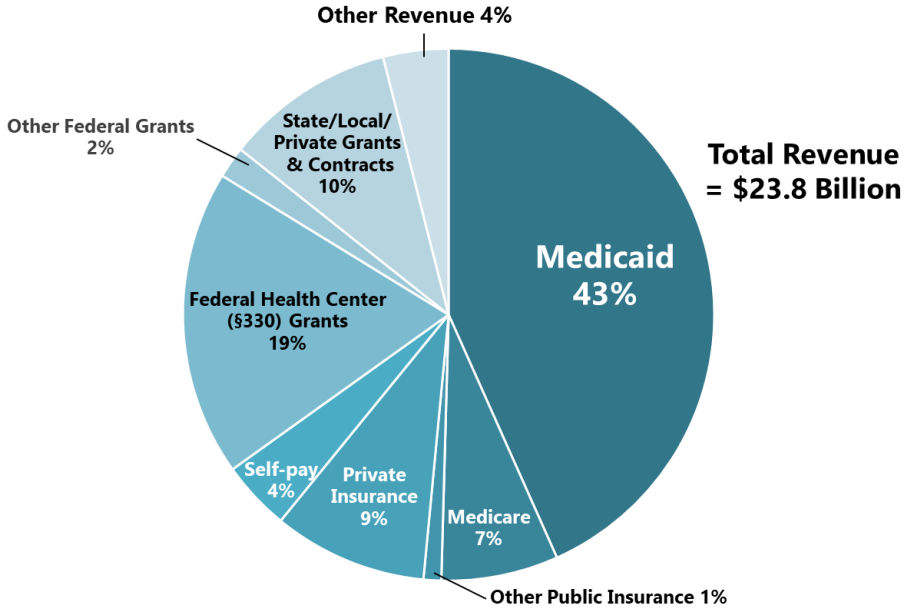


Source: GWU analysis of 2016 UDS data

Background

Like other health care providers, community health centers rely on a variety of funding sources: payments from public and private health insurers; out-of-pocket payments from their patients; and various sources of federal, state, and local grant funds. Because 70 percent of all health center patients have incomes below poverty,[1] out-of-pocket payments represent only 4 percent of total health center revenue. Public and private insurance together represent 61 percent of revenue, while grants account for 31 percent of the revenue on which health centers and the communities they serve depend.

Figure 1. Health Center Revenue, by Source, 2016



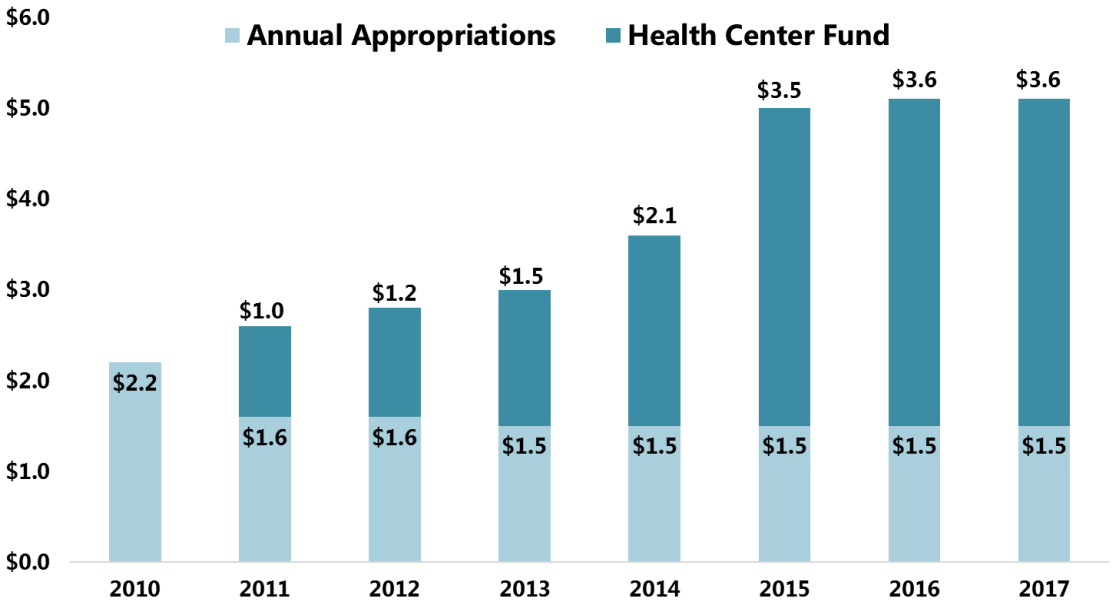
Note: Percentages may not sum to 100% due to rounding.
SOURCE: Bureau of Primary Health Care. (2017). 2016 Health Center Data: National Data. Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=

Federal health center grants authorized by Section 330 of the Public Health Service Act make up the biggest share of grant revenue, comprising 60 percent of the grant funds (including state and local grants and contracts) received by health centers from all sources. In 2016, as **Figure 1** shows, the federal health center grant program accounted for nearly one in five dollars received by health centers.

[1] Bureau of Primary Health Care. (2017). 2016 Health Center Data: National Data. Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=

For Fiscal Year 2017, federal health center grants total $5.1 billion. Of this amount, $1.5 billion (29 percent) comes through annual discretionary appropriations (**Figure 2**). The remaining $3.6 billion (70 percent) comes through the Community Health Center Fund (CHC Fund).

Figure 2. The Community Health Center Fund and Appropriations (in Billions), FY2010-FY2017



Source: Congressional Research Service (CRS). (2017). Discretionary Spending Under the Affordable Care Act; CRS (2017) Federal Health Centers: An Overview; Department of Health and Human Services. (2017). Fiscal Year 2017 Justification of Estimates for Appropriations Committees. https://www.hrsa.gov/sites/default/files/about/budget/budgetjustification2017.pdf

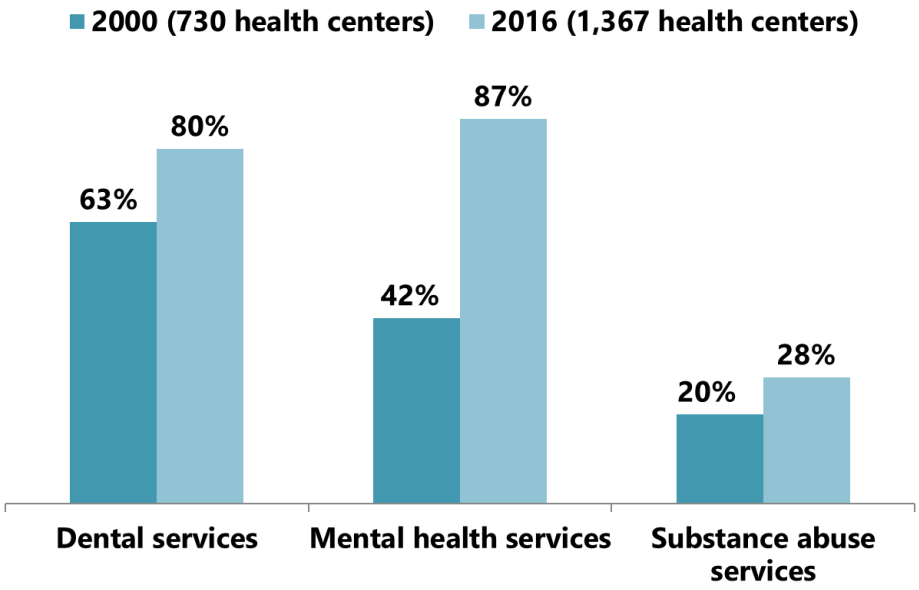
Established in 2010 as part of the Affordable Care Act, the CHC Fund boosted health center grant funding while also reducing reliance on a sometimes uncertain annual discretionary appropriations process. Its purpose was to strengthen primary health care in medically underserved rural and urban communities by establishing new health centers where they are needed and by expanding the capacity of existing health centers.

Section 330 grant funds are essential to serving uninsured patients and furnishing services such as oral health care and care management for patients with serious and chronic health conditions that frequently are not covered by health insurance. Furthermore, grant funds enable growth. With approximately 100 million people living in communities designated by the federal government as medically underserved, strengthening primary care remains a key national health priority.[2] Grant funding supports all of the activities needed in order to expand the reach and

[2] Rosenbaum, S, Jones, E, Shin, P, and Ku, L. (2009). National Health Reform: How will Medically Underserved Communities Fare? http://www.rchnfoundation.org/wp-content/uploads/2013/02/medically-underserved-

scope of health center services. Grants allow communities to establish new health centers and get them operational. They also allow established health centers to open new sites, purchase new equipment and supplies, hire additional personnel, and launch new services not previously offered. Between 2000 and 2016, the number of health centers grew by 87 percent, from 730 to 1,367, while the proportion of health centers offering mental health care increased from 42 percent to 87 percent and the proportion offering substance abuse services increased from 20 percent to 28 percent during this time period. Dental services also expanded, from 63 percent in 2000 to 80 percent in 2016. Meanwhile, the number of uninsured patients served over this time period increased by 57 percent, from 3.9 million in 2000 to 6.1 million in 2016.

Figure 3. Percentage of Health Centers Providing Dental and Behavioral Health Services, 2000 and 2016



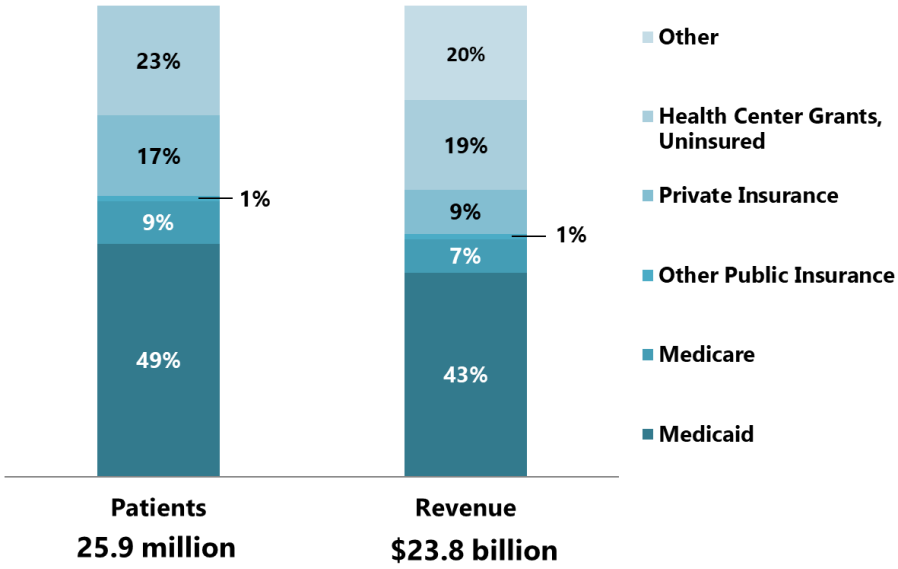
Note: Data reflect health centers that reported any dental, mental health, or substance abuse treatment staff.
SOURCE: GW analysis of 2000 and 2016 UDS data.

As health centers have grown, so has the nation's dependence on the health care services they offer. As **Figure 4** shows, in 2016, 1,367 health centers served 25.9 million patients, 23 percent of whom were uninsured. Health centers served approximately one in six Medicaid/CHIP

reform-FINAL.pdf ; "Designation of Medically Underserved Populations and Health Professional Shortage Areas; Proposed Rule." Federal Register (29 February 2008), pp 11232-11281. https://www.gpo.gov/fdsys/pkg/FR-2008-02-29/pdf/E8-3643.pdf

beneficiaries,[3] one in ten children under age 18,[4] one in 10 women of childbearing age (15-44)[5] and one in 6 residents of rural communities.[6] More than nine in ten (92 percent) health center patients have incomes at or below 200 percent of the federal poverty level (FPL).[7]

Figure 4. Health Center Patients and Revenue, 2016



Note: Percentages may not sum to 100% due to rounding.
Source: National Uniform Data System Reports for 2016, Bureau of Primary Health Care, Health Resources and Services Administration, USDHHS

Compared to the U.S. population, health center patients are more likely to be non-white, uninsured, and low-income (**Table 1**).

[3] GWU analysis of 2016 UDS data and CMS Medicaid/CHIP enrollment numbers for December 2016. https://www.medicaid.gov/medicaid/program-information/downloads/updated-december-2016-enrollment-data.pdf (updated February 2017).
[4] HRSA. (2017). Health center program. https://bphc.hrsa.gov/about/healthcenterfactsheet.pdf
[5] US Census Bureau. (2017). Current Population Survey, Annual Social and Economic Supplement, and GWU analysis of 2016 UDS data
[6] HRSA. (2017). Health center program. https://bphc.hrsa.gov/about/healthcenterfactsheet.pdf
[7] Bureau of Primary Health Care. (2017). 2016 Health Center Data: National Data. Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=

Table 1. Health Center Patients Compared to the U.S. Population, 2016[8]

	U.S. Population (%)	Health Center Patients (%)
Ethnic/Racial minority	38.7	**62.3**
Uninsured	8.8	**23.4**
At or below 200% of the FPL	29.8	**92**

Recognizing the need for continued growth in health center services to meet community need, Congress in 2015 extended the CHC Fund through the end of Fiscal Year 2017, along with the funding extension for the Children's Health Insurance Program (CHIP). Like CHIP, the CHC Fund must once again be extended in order to avert a 70 percent loss of Section 330 grant funds beginning in Fiscal Year 2018.

What Could Happen if the CHC Fund is Not Extended?

Because grant funding is crucial to enabling health center growth, a 70 percent drop in Section 330 grant funding is likely to have far-reaching effects on the number of patients that can be served as well as on the capacity to reach additional communities. Grant funds power program growth and also pay for uninsured populations and services. Uninsured services are critical even in the case of insured patients, because insurance payments cover less than – and in some cases, significantly less than – the cost of care as a result of uncovered services (such as dental care), uncovered deductibles and copayments, and payment discounting. For example, in 2016, as **Figure 4** shows, private insurance covered 17 percent of patients but accounted for only 9 percent of revenue.

Health centers at greatest risk if the CHC Fund ends

All health centers are at risk from the loss of grant funding. But those most at risk – that is, most dependent on grant funds to keep their doors open, sites operating, and service capacity maintained – can be expected to have certain characteristics. These characteristics are: location in a non-Medicaid-expansion state (**Map, Appendix Figure A1**), rural location, and small size

[8] US Census Bureau. Population estimates, July 1, 2016, (V2016). https://www.census.gov/quickfacts/fact/table/US/PST045216; Semega, J.L., Fontenot, K.R., &. Kollar, M.A. (2017). *Income and Poverty in the United States: 2016*. U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2017/demo/P60-259.pdf; Barnett, J.C. & Berchick, E.R. (2017). Health Insurance Coverage in the United States: 2016. U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf; Bureau of Primary Health Care. (2017). 2016 Health Center Data: Health Center Program Grantee Data. Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx

(fewer than 5,000 patients in 2016). These factors all tend to be associated with lower insurance revenue and greater reliance on grants.

Our estimates show that overall, the immediate loss of the CHC Fund would place 13 percent of all health center revenue at risk in Fiscal Year 2018 (70 percent of annual appropriated revenue). Health centers located in non-expansion states face the risk of losing 19 percent of all revenue, while in Medicaid expansion states 11 percent of all revenue would be at risk. Health centers in rural locations risk losing 17 percent of revenue, compared to 12 percent for health centers operating outside of rural areas. Small health centers risk the loss of 27 percent of all revenue compared to 10 percent for large health centers.[9]

With the loss of revenue of this magnitude, the follow-on consequences can be expected to be significant. According to the federal government,[10] a 70 percent cut in health center grant funding can be expected to lead to a total reduction in the number of patients served of 9 million patients – more than one-third of all patients served.

Staffing implications if the CHC fund ends

To support expansion of sites and services, health centers added thousands of clinical, administrative, and patient support staff. Over the past decade, as **Table 2** shows, health center medical staff increased from 34,412 to 72,454 full-time equivalents (FTEs). Growth rates were even greater for dental professionals and dramatically higher for mental health professionals. Overall, total health center staff more than doubled over the past decade, not only strengthening capacity but bringing jobs and economic development into medically underserved communities.

Table 2. Health Center Staffing Growth 2006-2016

Staff in FTEs	2006	2016	Growth
Medical	34,412	72,454	111%
Dental	6,250	16,142	158%
Mental health	2,363	9,192	289%
Substance abuse	655	1,163	78%
Enabling Services	9,627	20,497	113%
Total staff (FTE)	97,440	207,656	113%

Source: 2006 and 2016 Uniform Data System, Health Resources and Services Administration, Bureau of Primary Health Care.

[9] Small health centers (n=323) indicated by fewer than 5000 patients and large health centers (n=314) with greater than 25,000 patients.

[10] Health Resources and Services Administration. (December 20, 2016). Response to Congressional request. "Community Health Centers."

The $3.6 billion drop in health center funding on October 1, 2017 that could occur if the CHC Fund expires translates into staffing losses of 51,000 positions.[11] How these staff reductions would be allocated across staff service classes, such as substance abuse counselors, dental professionals, and enabling services, cannot be known but the loss in staffing is expected to significantly limit the ability of health centers to maintain their service capacity.

Patient care implications of ending the CHC Fund

Along with staffing growth has come growth in the number of new health centers and health center practice sites. As shown in Table 3, the number of health center grantees grew by 36 percent, while the number of health center service sites grew by 69 percent. Over the past decade, the number of patients increased by 72 percent, or more than 10 million patients; this included an increase of 7.4 million Medicaid patients and 2.2 million privately insured patients.

Table 3. Growth in Health Centers, Sites, and Patients, 2006-2016

	2006	2016	Growth
Number of Health Centers	1,002	1,367	36%
Number of Sites	6,139	10,404	69%
Number of Patients	15,034,123	25,860,296	72%
Uninsured	5,988,537	6,059,126	1%
Medicaid	5,275,937	12,715,455	141%
Private Insurance	2,288,861	4,448,200	94%
Medicare	1,134,251	2,384,323	110%

Source: 2006 and 2016 Uniform Data System reports, Health Resources and Services Administration, Bureau of Primary Health Care.

Potential loss of clinic capacity if the CHC Fund ends

Other effects can be expected to follow. A recent survey of health centers asked how they expected to respond to potential revenue losses: 59 percent said they would close one or more service sites, 96 percent would reduce or layoff staff, 91 percent would reduce or eliminate services, and 54 percent would reduce their operating hours.[12] In addition, those health center

[11] Health Resources and Services Administration. (December 20, 2016). Response to Congressional request. "Community Health Centers."; Li, S, Pines, JM, et al. The relationship of financial pressures and community characteristics to closure of private safety net clinics. Medical Care Research and Review, 2016, 73(5): 590-605.
[12] Rosenbaum, S., Sharac, J., Tran, C., Markus, A. R., Reynolds, D., & Shin, P. (2017). How Could Repealing Key Provisions of the Affordable Care Act Affect Community Health Centers and their Patients? Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 46. http://www.rchnfoundation.org/?p=5869

services that rely on grants to be sustainable are at risk of being reduced or eliminated. For example, grants help to support mental health and substance abuse treatment services, which often include social supports and care management not covered by health insurance payments. Without these additional social supports and care management, the overall effectiveness of care diminishes. Even the continued survival of billable clinical care may be threatened, thereby implicating not only a health center's ability to maintain the grant-related aspects of a particular service, but the clinical activity that in turn generates insurance payments.

The broader economic implications of ending the CHC Fund

The economic impact of health centers is considerable. Health centers are economic engines, generating jobs and economic activity in the poorest rural and urban communities.[13] As a result, these funding losses would have a substantial multiplier effect. Each dollar of lost revenue can be expected to affect both jobs at health centers themselves as well as in the local community. For example, 21 South Carolina health centers generated 4,396 jobs and $473 million in economic benefits across the state in 2015.[14] Similarly, 66 New York health centers served over 2 million patients and generated 17,971 jobs and over $2 billion in economic benefits in 2015.[15]

Using previous methodologies for calculating the national economic impact of health center investments,[16] we estimate that a 70 percent loss of Section 330 health center grant funding translates to approximately $7.5 billion in lost revenue overall.[17] The loss of funding also has serious long-term economic implications given that health centers are located in communities struggling to promote business development and services to the community. Lower spending by families and businesses, fewer job opportunities, and the potential closing of businesses can further depress the local economy.

The downstream consequences of ending the CHC Fund

Finally, studies have shown that health centers generate significant cost savings by helping to lower emergency care and hospital costs.[18] The loss of the CHC Fund and the associated

[13] Kotelchuck, R., et al. (2011). Community Health Centers and Community Development Financial Institutions: Joining Forces to Address Determinants of Health. Health Affairs. 30(11): 2090-2097.
[14] 2015 estimates by Capital Link at http://www.scphca.org/media/120730/sc_2016_eia_state.pdf
[15] 2015 estimates by Capital Link at http://www.chcanys.org/clientuploads/2016_Advocacy/EIA_NYS.pdf
[16] National Association of Community Health Centers, Funding cliff calculator (https://d3n8a8pro7vhmx.cloudfront.net/nachc/pages/297/attachments/original/1486144245/2017_Funding_Cliff_Impact_Estimator.xlsx?1486144245); Capital Link (https://cdn.americanprogress.org/wp-content/uploads/issues/2010/08/pdf/chc.pdf) and National Association of Community Health Centers (http://www.graham-center.org/content/dam/rgc/documents/publications-reports/monographs-books/rgcmo-access-granted.pdf).
[17] The estimated overall revenue loss reflects the reduction of $3.6 billion in federal funding alone.
[18] Richard, P., Ku, L., et al. (2012). Cost savings associated with the use of community health centers. Journal of Ambulatory Care Management, 35(1):50-59; Bruen, B., and Ku, L. (2017). Community Health Centers Reduce the

reduction in health center capacity can be expected to affect downstream health care costs, in particular by increasing community dependence on hospital emergency care. Based on an earlier report that showed health centers save approximately $24 billion annually, the projected loss of health center funding translates to roughly $11 billion in lost health care cost-savings.[19] As other studies have demonstrated, the loss of health center funding has broader consequences for the health system, including state and federal Medicaid costs. [20]

Costs of Children's Health Care. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 48. http://www.rchnfoundation.org/?p=6012; Mukamel, DB, White, LM, et al. (2016). Comparing the Cost of Medicare Beneficiaries in Federally Qualified Health Centers to Other Care Settings. Health Services Research, 51(2):625-644.

[19] Based on estimates from Ku, et al., (2009) Using Primary Care to Bend the Curve: Estimating the Impact of Health Center Expansion on Health Care Costs. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 14. http://www.rchnfoundation.org/?p=876

[20] Nocon, RS, et al. (2016) Health care use and spending for Medicaid enrollees in federally qualified health centers versus other primary care settings. American Journal of Public Health. 106(11): 1981-1989.

APPENDIX

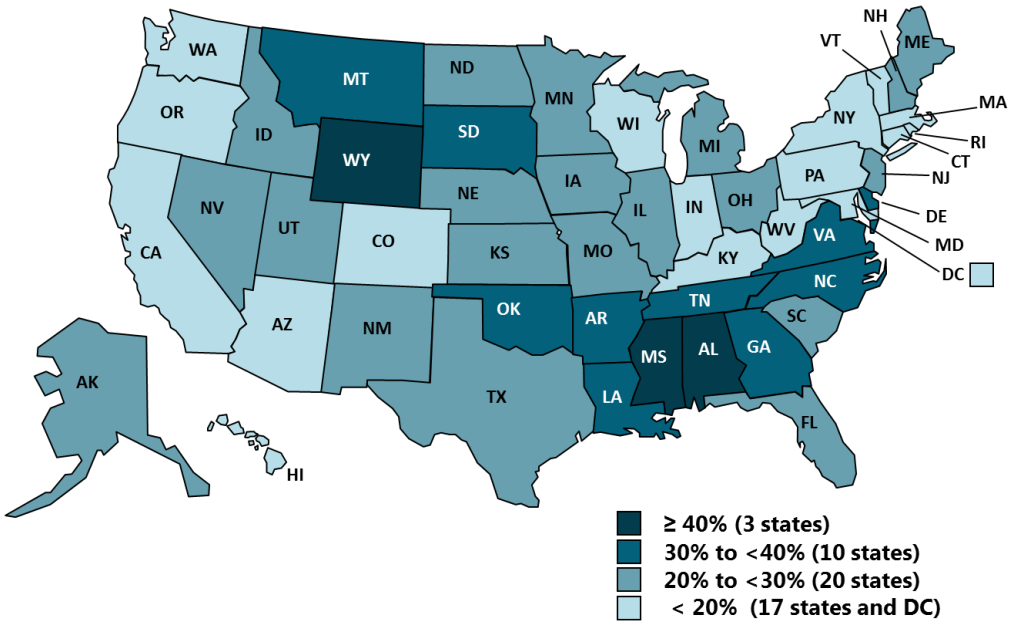
Methods

Health center estimates are derived from the Uniform Data System (UDS), which is administered by the Bureau of Primary Health Care, Health Resources Services Administration. The UDS includes tabulated data on patient demographics, staffing mix and utilization, revenue and expenditures, and quality of care for each health center receiving federal health center funding.

Medicaid non-expansion states include AL, FL, GA, ID, KS, ME, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, VA, WI, and WY. Expansion states include AK, AR, AZ, CA, CO, CT, DC, DE, HI, IL, IN, IA, KY, LA, MD, MA, MI, MN, MT, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV.

Figure A1 shows the extent to which health centers in each state rely on Section 330 federal funding.

Figure A1. Health Center Reliance on Federal Section 330 Funding, 2016



Source: GWU analysis of 2016 UDS data