

Community Health Centers Continue Steady Growth, But Challenges Loom

**Geiger Gibson / RCHN Community Health Foundation
Research Collaborative**

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Jessica Sharac, MSc, MPH

Peter Shin, PhD, MPH

Sara Rosenbaum, JD

Teodor Handarov

Milken Institute School
of Public Health

THE GEORGE WASHINGTON UNIVERSITY



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community health foundation

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 www.rchnfoundation.org.

Executive Summary

In 2018, 1,362 health centers operating in over 11,700 locations cared for more than 28 million patients – one in 12 people nationwide, one in three poor people, and one in five rural residents. The number of patients served by health centers has tripled since 2000. Between 2013 and 2018, the percentage of uninsured patients declined to less than one quarter nationally (23 percent). Medicaid expansion largely accounts for this decline; in 2018, Medicaid insured nearly half (48 percent) of all health center patients. However, these national estimates mask key differences between expansion and non-expansion states; in 2018, 35 percent of health center patients in non-expansion states were uninsured, a rate virtually twice as high as in expansion states. Like all providers, health centers grow when revenue rises; as a result, with a higher uninsured population, community health centers in non-expansion states serve fewer patients, employ fewer staff, and offer more limited services.

Health centers are highly vulnerable to federal policies affecting Medicaid and grant programs to improve health care for underserved populations. One area of current uncertainty is the Community Health Center Fund, which accounts for over 70 percent of federal health center grant funding and must be extended in 2019. The public charge rule holds key implications for health centers serving communities with sizable immigrant populations, found throughout the U.S. Also important to one in four health centers is the Title X family planning program; recent federal rules bar health centers from appropriately communicating with their patients, raising serious implications for their continued participation. Finally, Medicaid §1115 experiments that restrict eligibility and coverage threaten both patients and health centers.

Introduction

Community health centers are the nation's single largest source of comprehensive primary health care for medically underserved communities and populations experiencing elevated poverty and health risks, as well as a serious shortage of accessible primary care. All community health

Community Health Centers: A National Snapshot, 2018



1,362 federal grantees operating in over 11,700 sites

55% of grantees in urban locations
45% of grantees in rural locations



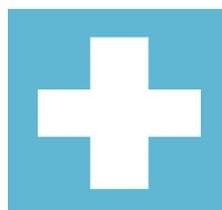
28.4 million patients served

One in 12 people in the U.S.



115.8 million visits, including:

77.1 million medical visits
16.5 million dental visits
12.3 million behavioral health visits
6.5 million enabling services visits



84 look-alike FQHCs

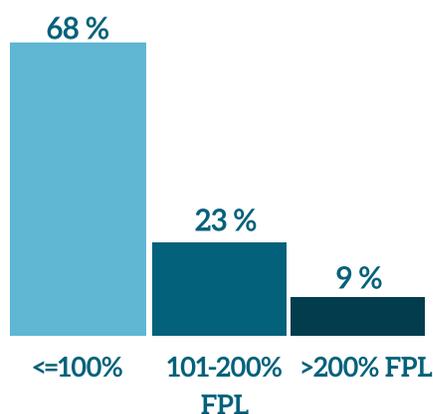
885,031 patients served

Source: Bureau of Primary Health Care. (2019). *2018 Health Center Data: National Data*. Health Resources and Services Administration. <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=>; Bureau of Primary Health Care. (2019). *2018 National Health Center Data: Health Center Program Look-Alike Data*. Health Resources and Services Administration. <https://bphc.hrsa.gov/uds/lookalikes.aspx?q=tall&year=2018&state=>; GW analysis of 2018 Uniform Data System (UDS) data

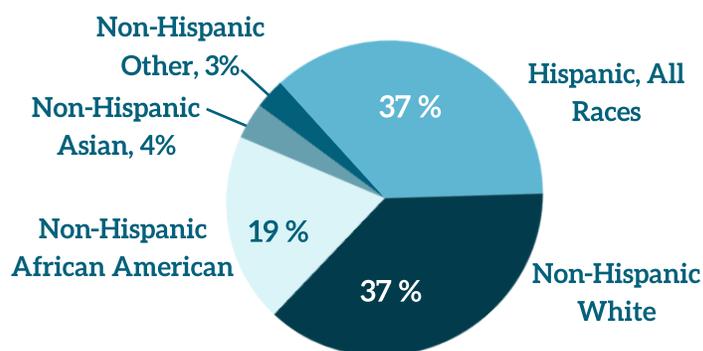
centers, whether federally funded or financed through state and local grant funding (and known as “look-alike” health centers) report extensive data to the federal government annually through the Uniform Data System (UDS); this

Figure 1. Demographic Profile of Health Center Patients, 2018

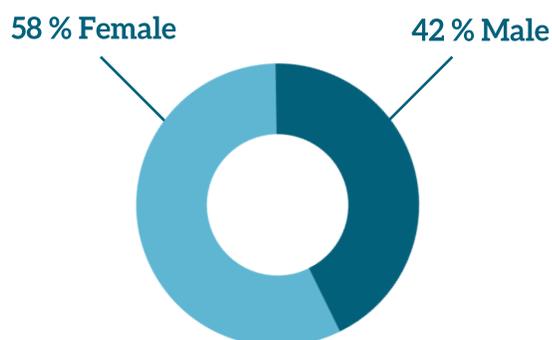
Income



Race / Ethnicity



Sex



Age



Notes: Income distribution reflects 20.4 million patients with known income. Race/ethnicity distribution reflects 26.8 million patients with known race and/or ethnicity (excluding patients reported as non-Hispanic unreported race and patients with unreported race and ethnicity). Source: Bureau of Primary Health Care. (2019). *2018 Health Center Data: National Data*. Health Resources and Services Administration. <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=>

information covers patients, staffing, revenue, performance measures, and other matters.¹

In 2018, 1,362 federally-funded community health centers served over 28 million patients. Another 84 million “look-alike” community health centers, which meet all health care center requirements but do not receive federal grant funding, served an additional 885,031 patients.²

Community health centers provide comprehensive primary health care in both urban and rural communities, and for this reason, they play a critical role in efforts to improve the health of medically underserved and at-risk populations.

Fifty-five percent of all health centers provide care in urban settings, while 45 percent serve rural communities.

Key Findings

Health centers’ nationwide reach. In 2018, health centers served one in 12 people nationally, one in three people living in poverty and one in five rural residents.³

Health center patients span all ages and are overwhelmingly low income. Six in 10 patients are working-age adults, more than three in 10 are children, and one in 11 (9 percent) are age 65 and older (Figure 1). Patients are

¹ Bureau of Primary Health Care. (2019). 2018 National Health Center Data: *National Data*. Health Resources and Services Administration. <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=>

² Bureau of Primary Health Care. (2019). 2018 National Health Center Date: *Health Center Program Look-Alike Data*. Health Resources and Services Administration. <https://bphc.hrsa.gov/uds/lookalikes.aspx?q=tall&year=2018&state=>

³ Health Resources and Services Association. (2019). HRSA Health Center Program. <https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf>

overwhelmingly low income; 91 percent have family incomes at or below twice the federal poverty level (FPL) (\$41,560 for a family of three in 2018)⁴ while 68 percent have below-poverty income (\$20,780 for a family of three in 2018). Reflecting the communities health centers serve, as well as their significantly higher poverty levels, nearly two-thirds (63 percent) of patients are members of racial/ethnic minority groups (Figure 1).

Health centers have grown to meet the needs of communities and patients. Over the 2000-2018 time period, the number of health center patients nearly tripled, from 9.6 million to 28.4 million (Figure 2). As health centers

have grown, they have maintained an approach to health care that continues to reflect the original model,⁵ which integrates health care with services and activities that promote health. Health centers offer comprehensive medical and dental care, services that promote access to transportation and translation, and services such as nutrition assistance that help ameliorate health risks themselves.⁶

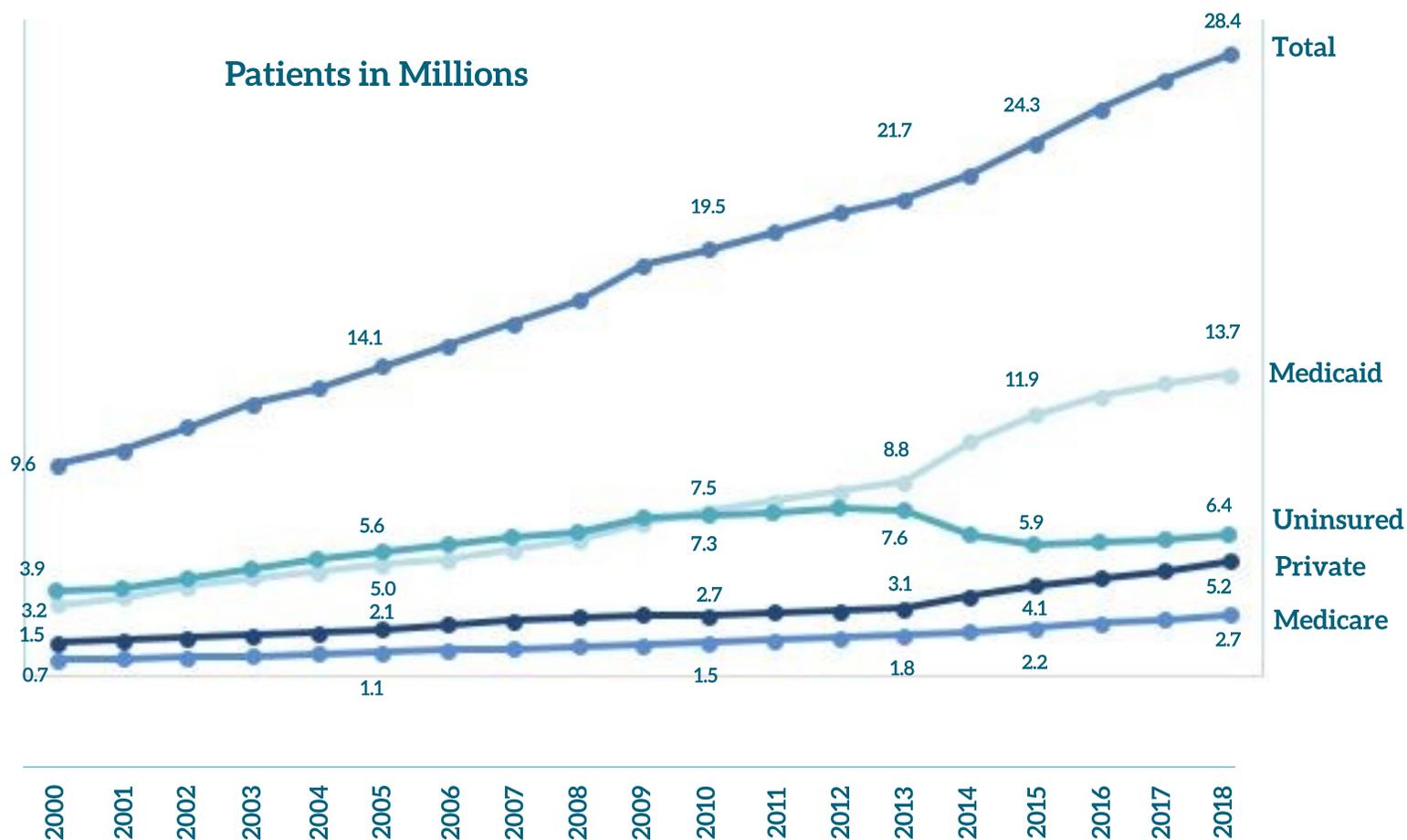
Increasingly, health centers have added services designed to address the needs of patients with complex physical and mental health conditions. Today's health centers provide routine primary health care for children and adults, are a

⁴ Office for the Assistant Secretary for Planning and Evaluation. 2018 Poverty Guidelines. U.S. Department of Health and Human Services. <https://aspe.hhs.gov/2018-poverty-guidelines>

⁵ Adashi, E. Y., Geiger, H. J., & Fine, M. D. (2010). Health care reform and primary care—the growing importance of the community health center. *New England Journal of Medicine*, 362 (22), 2047-2050.

⁶ Institute for Alternative Futures. (2012). Community health centers leveraging the social determinants of health. <http://www.altfutures.org/pubs/leveragingSDH/IAF-CHCsLeveragingSDH.pdf>

Figure 2. Health Center Patient Volume, By Payer, 2000-2018



Notes: Patients with other public insurance not shown. Numbers (in millions) are shown for 2000, 2005, 2010, 2013, and 2018

Source: GW analysis of data reported in the UDS national reports 2000-2018

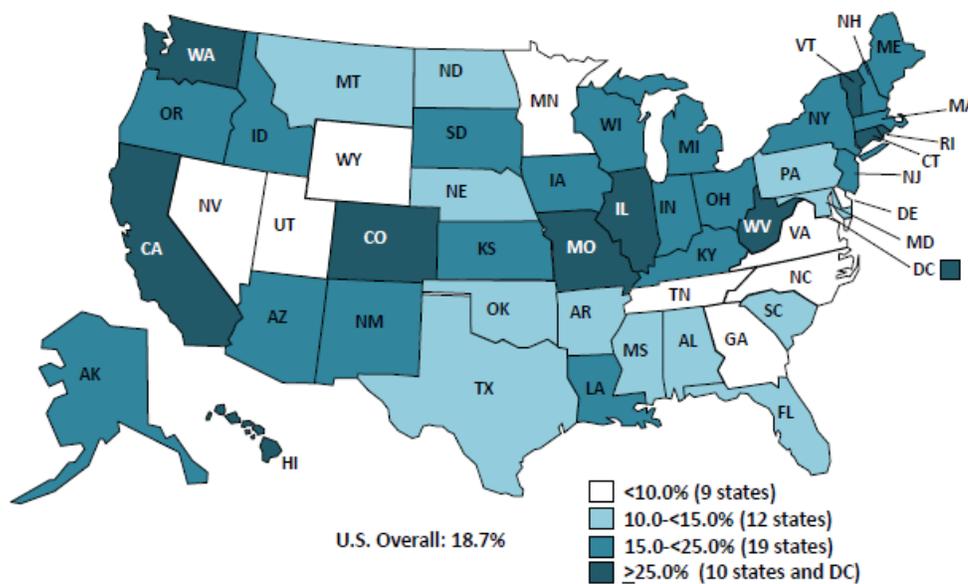
major source of well-woman’s preventive care and family planning, and provide comprehensive maternity care. They are also key providers of community-based care for the frail elderly and comprehensive care for patients with serious and chronic physical and mental health conditions.

Health centers serve 30 percent of all low-income women of childbearing age (ages 15-44)⁷ and 16 percent of patients living with HIV.⁸ They are often the only source of affordable dental care in their communities, and they have played a central role in expanding the availability of treatment for patients recovering from opioid addiction⁹ as well as those who experience both physical and behavioral health conditions.

The unique relationship between Medicaid and community health centers. In 2018, community health centers served nearly one in five Medicaid and Children’s Health Insurance Program (CHIP) patients nationwide (18.7 percent). In 10

states and the District of Columbia (**Figure 3**), health centers served more than one in four Medicaid and CHIP beneficiaries. From 2000 to 2018, the number of Medicaid patients grew from 3.2 to 13.7 million – a 327 percent increase (**Figure 2**). This growth can be attributed to numerous factors: high poverty; a shortage of other sources of health care; a growing number of health centers operating in multiple locations; and, of course, the Affordable Care Act (ACA) Medicaid expansion. Their size and reach means that community health centers have become an integral part of Medicaid managed care, providing the primary care service base on which managed care rests. In 2018, (figure not shown) health centers furnished over 103 million member months of Medicaid-managed care services.¹⁰ In turn, Medicaid represents the single largest source of health center operating revenue, accounting for 44 percent of total health center revenue in 2018.

Figure 3. Proportion of Medicaid and CHIP Enrollees Receiving Care at Community Health Centers, By State, 2018



Notes: US percentage does not include US territories. Source: GW analysis of 2018 UDS data (numerator) and CMS Medicaid/CHIP enrollment numbers for December 2018 (denominator); Kaiser State Health Facts. (2019). <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=6&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

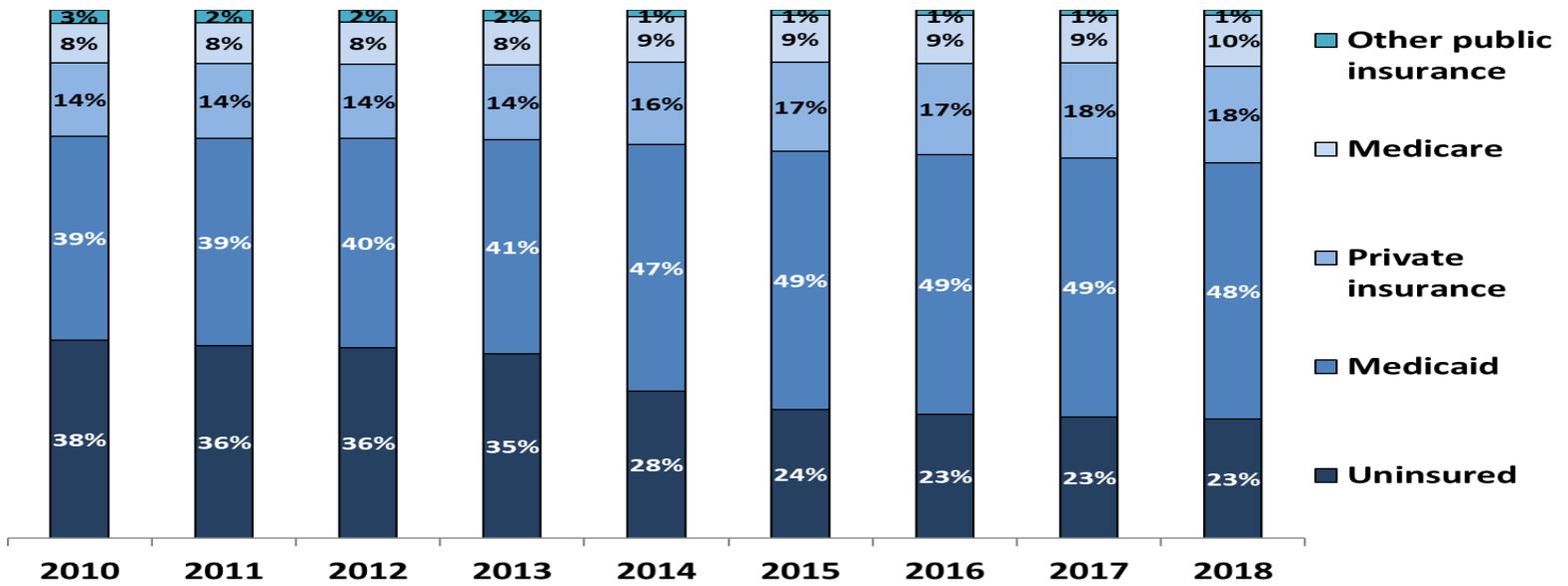
⁷Wood, S. F., Strasser, J., Sharac, J., Wylie, J., Tran, T.C., Rosenbaum, S., Rosenzweig, C., Sobel, L., & Salganicoff, A. (2018). Community Health Centers and Family Planning in an Era of Policy Uncertainty. Kaiser Family Foundation. <https://www.kff.org/womens-health-policy/report/community-health-centers-and-family-planning-in-an-era-of-policy-uncertainty/>

⁸Rosenbaum, S., Sharac, J., Shin, P., & Gunsalus, R. (2019). Community Health Centers and the President’s HIV Initiative: Issues and Challenges Facing Health Centers in High-Burden States and Communities. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 56. <https://rchnfoundation.org/?p=7834>

⁹Zur, J., Tolbert, J., Sharac, J., & Marcus, A. (2018). The Role of Community Health Centers in Addressing the Opioid Epidemic. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/the-role-of-community-health-centers-in-addressing-the-opioid-epidemic/>

¹⁰Bureau of Primary Health Care. (2019). 2018 Health Center Data: National Data. Health Resources and Services Administration. <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=>

Figure 4. Health Coverage of Health Center Patients, 2010-2018



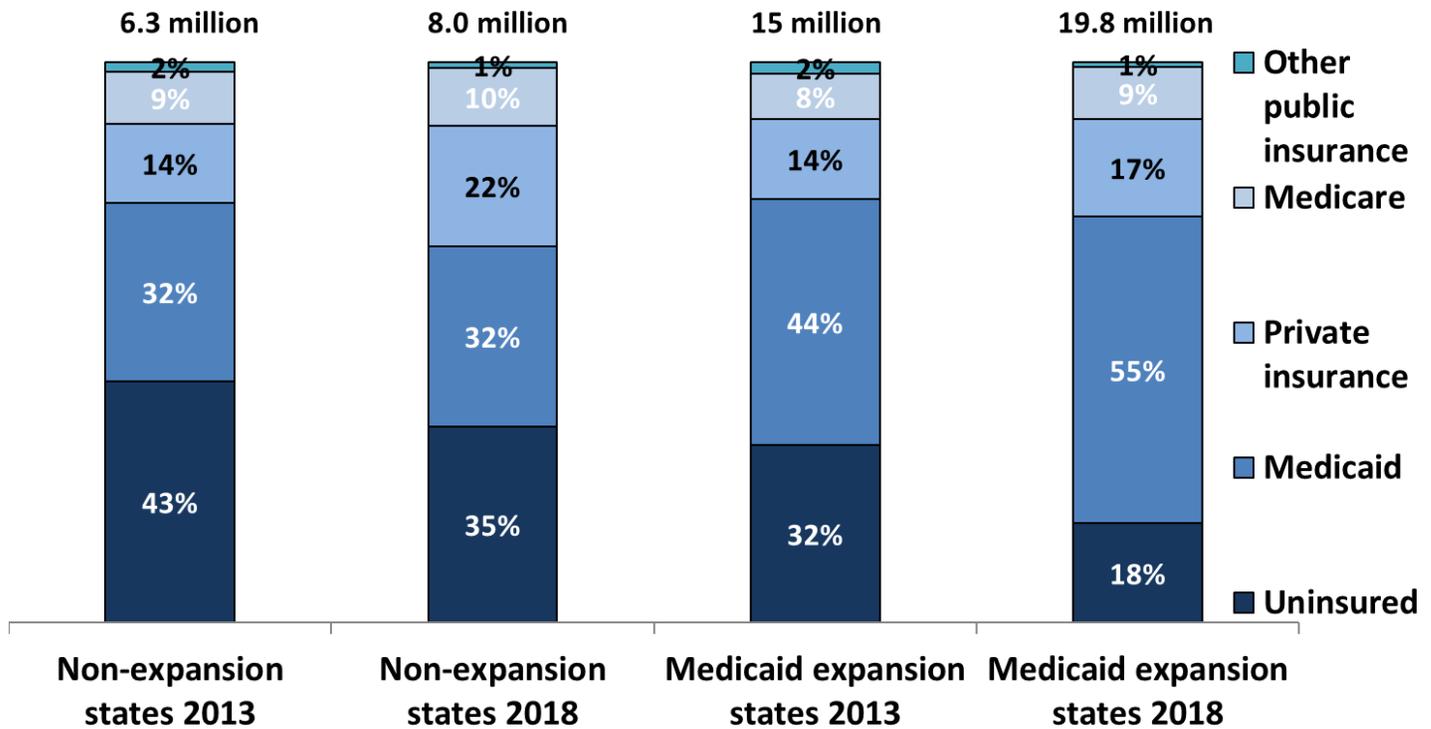
Source: GW analysis of UDS national reports 2010-2018

The relative importance of Medicaid and private health insurance in reducing the percentage of uninsured health center patients. In 2018, 23 percent of all health center patients were uninsured, a major decline from where this figure stood in 2010, when 38 percent of all patients were uninsured (Figure 4). Even in states not adopting the ACA Medicaid expansion, coverage has grown as a result of streamlined enrollment and renewal procedures coupled with greater outreach, something that virtually all health centers offer. In 2018, nearly half of all patients were insured by Medicaid (Figure 4). But these figures mask important differences. In Medicaid non-expansion states, the proportion of uninsured patients stood at 35 percent in 2018 (Figure 5). By contrast, as Figure 5 shows, in Medicaid expansion states, the uninsured rate dropped from 32 percent in 2013 to 18 percent in 2018. As shown in Figure 5, in 2018, Medicaid insured 55 percent of patients in Medicaid expansion states compared to 32 percent in non-expansion states.

Private insurance in expansion and non-expansion states similarly shows key differences. As can be seen in Figure 4, between 2013 and 2018, the share of patients with private insurance increased by 30 percent, from 14 percent to 18 percent. But in non-expansion states, as shown in Figure 5, private insurance grew from 14 percent to 22 percent, while in expansion states, it grew from 14 percent to 17 percent. This can be attributed to the fact that in non-expansion states, eligibility for Marketplace insurance subsidies begins at 100 percent of poverty, compared to 139 percent of poverty in expansion states.

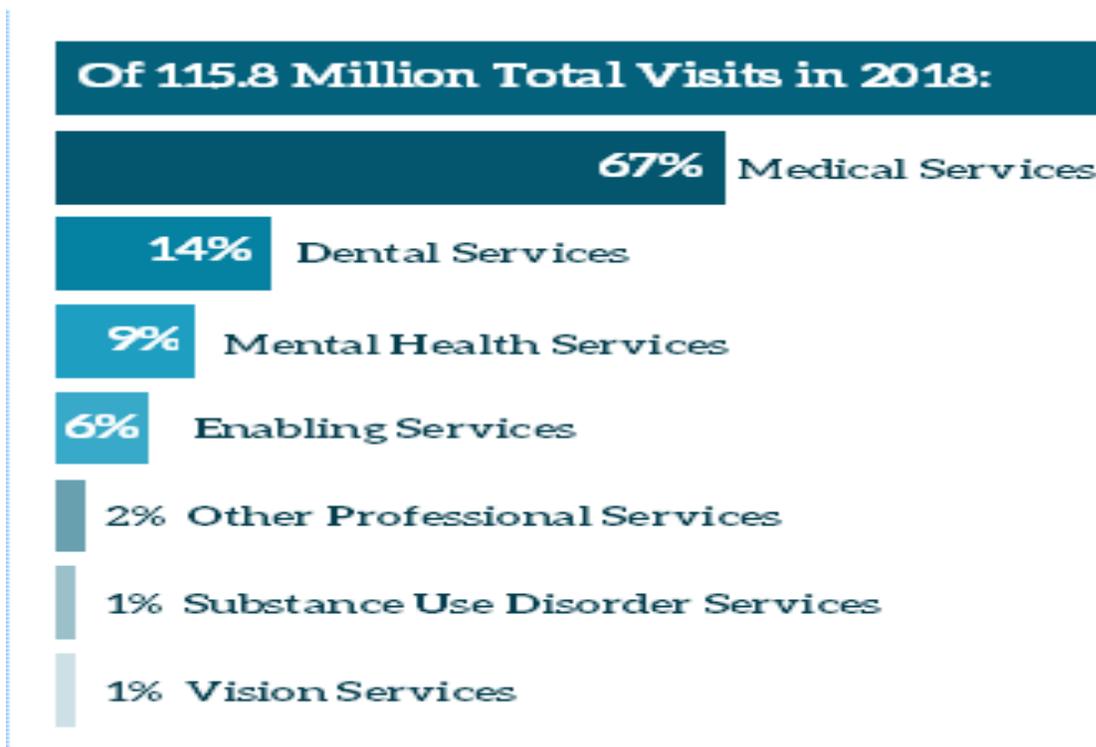
With growing Medicaid financing and increased grant funding, health center capacity has grown. In 2018, health centers logged 115.8 million patient visits; two thirds of all visits were for medical care, 14 percent were for dental care, and one in nine involved behavioral health care (Figure 6). Increased capacity has been especially great in Medicaid expansion states, as a result of the additional revenue Medicaid enrollment brings.

Figure 5. Health Coverage of Health Center Patients, By State Medicaid Expansion Status, 2013 and 2018



Note: Medicaid expansion as of 2018 (ID, ME, NE, VA, and UT were categorized as non-expansion). Data does not include health centers in U.S. territories.
 Source: GW analysis of 2013 and 2018 UDS data.

Figure 6. Health Center Visits, By Type of Service, 2018



Source: Bureau of Primary Health Care. (2019). *2018 Health Center Data: National Data*. Health Resources and Services Association. <https://bpca.hrsa.gov/uds/>

Table 1 compares health centers in expansion and non-expansion states in terms of staffing, sites, and scope of services offered. Health centers in Medicaid expansion states are significantly more likely than those in non-expansion states to provide mental health and substance use disorder services. They also report significantly higher average ratios of full-time equivalent (FTE) staff members to patients across medical, dental, mental health, and enabling services that promote access to care. As **Figure 7** shows, in 2000, 63 percent of health care centers offered dental care; by 2018, 83 percent offered dental services. Over this time,

the share of health centers providing mental health services rose from 42 percent to 95 percent, while the availability of substance use disorder services grew from 20 percent to 50 percent of all health centers.¹¹ These services increasingly are offered at community health centers, as HRSA in recent years has dedicated grant funding to health centers to increase access to mental health and substance use disorder services,¹² particularly for opioid use disorder.¹³

The major sources of health centers' operating revenue. As **Figure 8** shows, Medicaid in 2018 represented 44 percent of all health center revenue, a figure somewhat lower than the

Table 1. Health Center Sites, Staff, and Service Provision, By State Medicaid Expansion Status, 2018

	Health centers in non-expansion states	Health centers in Medicaid expansion states
Average number of health center sites	8.1	9.1
Average number of full-time equivalent (FTE) staff per 10,000 patients		
Medical staff*	27.7	31.2
Dental staff*	6.4	7.6
Mental health services staff*	3.6	6.2
Substance use disorder services staff	0.8	1.2
Enabling services staff*	8.4	11.1
Total staff*	81.1	99.5
Share of health centers providing:		
Dental services	81%	83%
Mental health services*	92%	96%
Substance use disorder services*	46%	52%

*Significant difference (p<0.05) by Medicaid expansion status

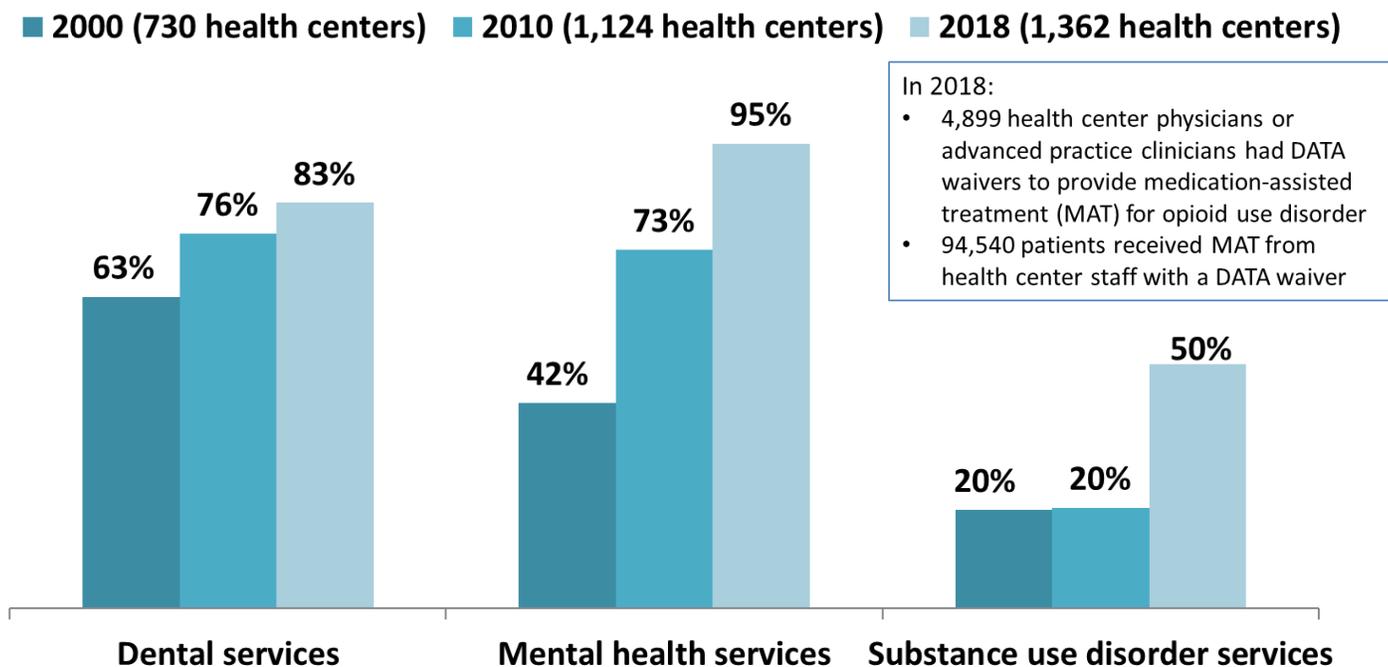
Source: GW analysis of 2018 UDS data. Data does not include health centers in U.S. territories. Medicaid expansion as of 2018 (ID, ME, NE, VA, and UT were categorized as non-expansion). Service provision based on the percentage of health centers that reported any dental, mental health, or substance use disorder service staff.

¹¹Data reflect health centers that reported any dental, mental health, or substance use disorder services staff. This may underestimate the percentage of health centers providing substance use disorder services (see Zur et al., 2018 [p. 3] <https://www.kff.org/medicaid/issue-brief/the-role-of-community-health-centers-in-addressing-the-opioid-epidemic/>). HRSA reported that 93 percent of health centers provide mental health counseling and treatment and 67 percent provide substance use disorder services. See Health Resources and Services Administration. (2019). HRSA Health Center Program. <https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf>

¹²FY2016: <https://www.hhs.gov/hepatitis/blog/2016/03/17/hrsa-awards-200-million-to-health-centers-to-help-treat-the-prescription-opioid-abuse-and-heroin-epidemic-in-america.html>; FY2017: <https://www.hhs.gov/about/news/2017/09/14/hrsa-awards-200-million-to-health-centers-nationwide.html>; FY2018: <https://bphc.hrsa.gov/program-opportunities/funding-opportunities/sud-mh>; FY2019: <https://www.hhs.gov/about/news/2019/08/08/hhs-awards-nearly-400-million-to-fight-opioid-crisis.html>

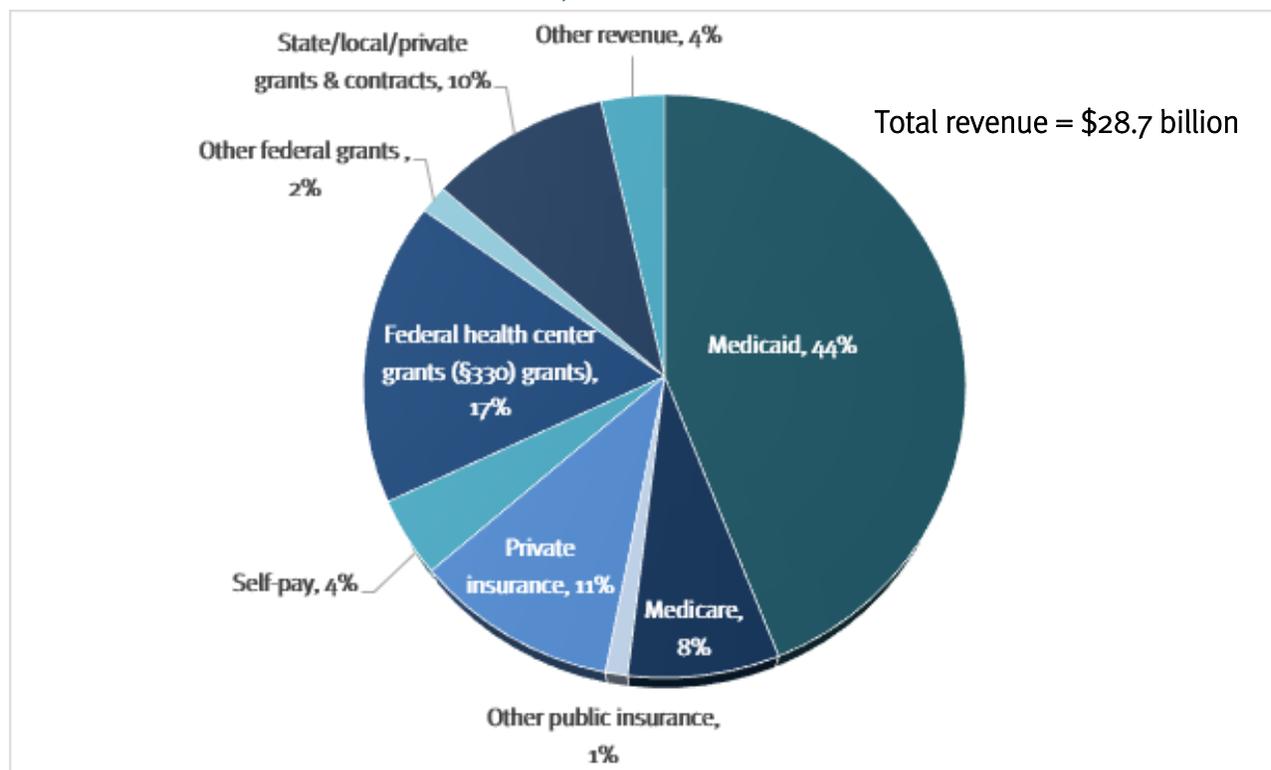
¹³Zur, J., Tolbert, J., Sharac, J., & Marcus, A. (2018). The Role of Community Health Centers in Addressing the Opioid Epidemic. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/the-role-of-community-health-centers-in-addressing-the-opioid-epidemic/>

Figure 7. Health Centers Providing Dental and Behavioral Health Services in 2010, 2010, and 2018



Note: Data reflect health centers that reported any dental, mental health, or substance use disorder services staff. This may underestimate the percentage of health centers providing substance use disorder services (see Zur et al., 2018 [p. 3] <https://www.kff.org/medicaid/issue-brief/the-role-of-community-health-centers-in-addressing-the-opioid-epidemic/>) Source: GW analysis of 2000, 2010, and 2018 UDS data; Bureau of Primary Health Care. (2019). *2018 Health Center Data: National Data, Table ODE: Other Data Elements*. Health Resources and Services Administration. <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tode&year=2018&state=&fd=>

Figure 8. Health Center Revenue, By Source, 2018



Note: Percentages may not sum to 100 % due to rounding.

Source: Bureau of Primary Health Care. (2019). *2018 Health Center Data: National Data*. Health Resources and Services Administration. <http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=>

Table 2. Health Center Revenue, By Source, 2010-2018

Revenue	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total revenue (in billions)	\$12.7	\$13.9	\$15.0	\$15.9	\$18.0	\$21.0	\$23.8	\$26.3	\$28.7
Medicaid	38%	38%	38%	40%	42%	44%	43%	44%	44%
Medicare	6%	6%	6%	6%	6%	7%	7%	7%	8%
Private	7%	7%	7%	8%	8%	9%	9%	10%	11%
Self-Pay	6%	6%	6%	6%	5%	4%	4%	4%	4%
Federal health center grants	16%	17%	17%	18%	18%	18%	19%	18%	17%
Other revenue	28%	27%	25%	23%	20%	18%	17%	17%	16%

Note: "Other revenue" includes other public insurance revenue, other federal grants, non-federal grants and contracts, and other revenue
 Source: GW analysis of 2010-2018 national UDS reports

proportion of all patients enrolled in Medicaid that year (48 percent). That these figures remain relatively closely aligned is a reflection of Medicaid’s special “federally qualified health center” prospective payment system that also applies to Medicare and CHIP and ensures that payment levels reasonably approximate the cost of care. This special formula, in turn, helps ensure that health center grant funds are used to underwrite care for necessary uninsured care that remains uncovered by Medicaid or private insurance, such as adult vision and dental care.¹⁴

Federal grants appropriated under Section 330 of the Public Health Service Act account for 17 percent of total revenue and are the primary source of funding for uninsured populations and services. Additional funding

comes from private insurance, state and local grant funding, and Medicare. Self-pay, a substantial part of operating revenue for private medical practices, represents only four percent of health center revenue.

Community health centers reported \$28.7 billion in total revenue in 2018, a figure more than double the number reported in 2010 (Table 2). Over this eight-year time period, Medicaid as a percentage of total revenue climbed dramatically, in both absolute terms and as a percentage of total revenue. Federal 330 grant funding held steady under the Community Health Center Fund,¹⁵ established under the Affordable Care Act and extended twice since then, which accounts for over 70 percent of all federal health center grant revenue.

¹⁴United States Government Accountability Office. (2019). Trends in Revenue and Grants Supported by the Community Health Center Fund. <https://www.gao.gov/assets/700/699394.pdf>

¹⁵Rosenbaum, S., Sharac, J., Shin, P., & Tolbert, J. (2019). Community Health Center Financing: the Role of Medicaid and Section 330 Grant Funding Explained. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/community-health-center-financing-the-role-of-medicare-and-section-330-grant-funding-explained/>

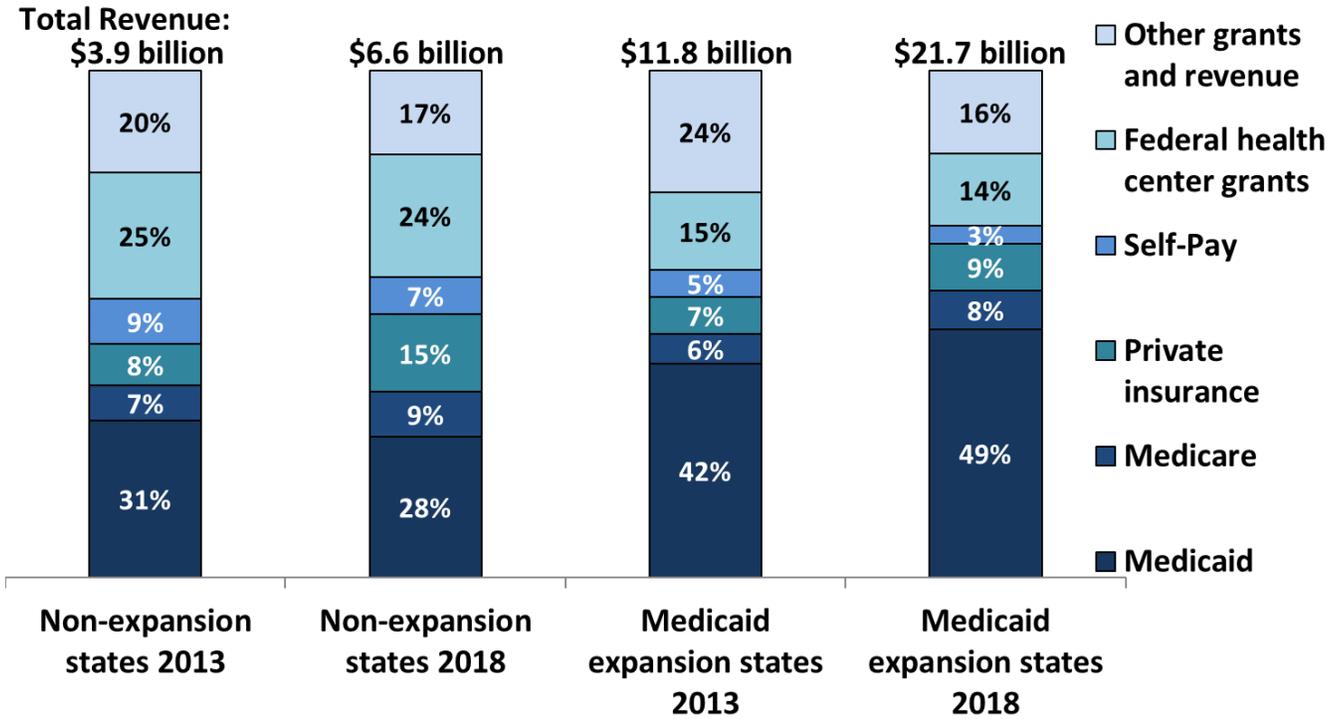
The effect of the Medicaid expansion can be seen clearly in the comparison of revenue sources for health centers in non-expansion and Medicaid expansion states (Figure 9). In Medicaid expansion states, slightly less than half (49 percent) of total revenue came from Medicaid in 2018; in non-expansion states, Medicaid accounted for just 28 percent of total revenue. Given the lower income threshold for Marketplace subsidies in non-expansion states, health centers in these states treat more privately insured patients and derive a greater percentage of total revenue from private insurance (15 percent compared to nine percent in expansion states). The lack of Medicaid revenue in non-expansion states also makes health centers more reliant on federal health center grant funding (where it accounted for 24 percent of total revenue compared to 14 percent of total revenue in expansion states) (Figure 9).

Changes in revenue sources from 2013 to 2018 reflect

changes in insurance status (Figure 9). For health centers in non-expansion states, the share of revenue from Medicaid and Section 330 grants actually decreased slightly between 2013 and 2018, while private insurance revenue increased from eight percent to 15 percent. In Medicaid expansion states, the share of total revenue from Medicaid increased from 42 percent to 49 percent, while the share from private insurance increased only slightly, from seven to nine percent. Whereas Medicaid revenue reasonably approximates Medicaid patients nationally (Figures 4 and 8), the same is not true for private insurance; in 2018, 18 percent of all health center patients were privately insured, while 11 percent of all health center revenue came from private insurance.

A unified look at patients, revenue, and health center trends. Table 3 presents a unified look at patient and revenue growth by state Medicaid expansion status for

Figure 9. Health Center Revenue, By State Medicaid Expansion Status, 2013 and 2018



Note: Medicaid expansion status as of 2018 (ID, ME, NE, and VA were categorized as non-expansion). Data do not include U.S. territories. Percentages may not sum to 100% due to rounding. "Other grants and revenue" includes other public insurance revenue, other federal grants, non-federal grants and contracts, and other revenue. Source: GW analysis of 2013 and 2018 UDS data.

¹⁴United States Government Accountability Office. (2019). Trends in Revenue and Grants Supported by the Community Health Center Fund. <https://www.gao.gov/assets/700/699394.pdf>

¹⁵Rosenbaum, S., Sharac, J., Shin, P., & Tolbert, J. (2019). Community Health Center Financing: the Role of Medicaid and Section 330 Grant Funding Explained. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/community-health-center-financing-the-role-of-medicare-and-section-330-grant-funding-explained/>

2013-2018. What becomes clear is how much expansion matters to overall health center program strength. Between 2013 and 2018, the number of patients served increased by 28 percent in non-expansion states and by 32 percent in expansion states. The total number of uninsured patients actually was higher in 2018 in non-expansion states, a trend that mirrors new census data showing an increase in the number of uninsured Americans,¹⁶ heavily concentrated in the low-income population and heavily attributable to Medicaid enrollment declines. By contrast, uninsured patients *declined* by 26 percent in Medicaid expansion states, underscoring the importance of the expansion in reducing the uninsured rate among health center patients. As previously noted, growth of privately insured patients

was far higher in non-expansion states (95 percent compared to 60 percent), most likely a function of Marketplace coverage and the lower threshold for Marketplace subsidies in non-expansion states.

Threats and Opportunities

The 2018 UDS data show continued health center growth nationally, especially in Medicaid expansion states. Yet even in non-expansion states, the number of patients served grew 28 percent between 2013 and 2018—including nearly 1.8 million more Medicaid patients—despite the growth in uninsured patients. Although revenue from privately insured patients increased at the fastest pace, Medicaid and federal health center grants remain the

Table 3. Health Center Patient and Revenue Growth, By State Medicaid Expansion Status, 2013 and 2018

Patient and revenue growth	Health centers in non-expansion states			Health centers in Medicaid expansion states		
	2013	2018	2013-2018 growth	2013	2018	2013-2018 growth
Total patients (in thousands)	6,290	8,048	28%	15,006	19,842	32%
Uninsured patients	2,710	2,817	4%	4,750	3,506	-26%
Medicaid patients	1,996	2,584	29%	6,586	10,874	65%
Private insurance patients	890	1,731	95%	2,138	3,417	60%
Total revenue (in millions)	\$3,900	\$6,643	70%	\$11,775	\$21,679	84%
Medicaid	\$1,208	\$1,846	53%	\$4,965	\$10,618	114%
Private insurance	\$316	\$1,016	222%	\$873	\$2,021	132%
Federal health center grants	\$972	\$1,605	65%	\$1,796	\$3,107	73%

Note: Medicaid expansion as of 2018 (ID, ME, NE, VA, and UT were categorized as non-expansion). Data does not include health centers in U.S. territories.

Source: GW analysis of 2013 and 2018 UDS data.

¹⁶Berchick, E.R., Barnett, J.C., & Upton, R.D. (2019). Current Population Reports, P60-267, Health Insurance Coverage in the United States: 2018. U.S. Government Printing Office, Washington, DC, <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>

largest sources of revenue. Much of the growth in health center capacity is owed to increases in federal health center grant funding and access to Medicaid over this time period.

Four key threats loom. Most immediately, the Community Health Center Fund will expire at the end of September 2019 unless it is extended. A recent survey found that community health centers have taken or are considering actions to address the potential loss of a sizable percentage of grant funding sources such as instituting hiring freezes, reducing staff or operating hours, and cutting or reducing services.¹⁷

The public charge rule presents another threat to the financial stability of health centers. Concerned that Medicaid will threaten their eligibility for legal permanent residency, an estimated one to 3.1 million legal immigrants or their eligible family members are expected to disenroll or forgo benefits.¹⁸ Disenrollment of this magnitude in turn is expected to result in Medicaid disenrollment by an estimated 165,000 and 495,000 health center patients. The resulting revenue impact would be significant enough to cause overall health center patient capacity to decline by an estimated 136,000 to 407,000 patients nationally.¹⁹

Additionally, given community health centers' importance in serving low-income women of childbearing age, the recently implemented changes to the Title X family program rules threaten continued participation by the estimated one in four health centers that receive Title X funding to broaden and strengthen its family planning and preventive health programs.²⁰ By barring health centers from appropriately counseling pregnant patients regarding all

treatment options, the Title X gag rule, as it is known, would lead to revenue losses that in turn are likely to affect service capacity.²¹

Finally are Medicaid Section 1115 experiments aimed at reducing eligibility and benefits. Federal courts have barred Secretarial approval of work experiments; in the three affected states to date (Kentucky, Arkansas, and New Hampshire), health center estimates show Medicaid disenrollment impact of between 31,000 and 49,000 (Kentucky), 3,400 and 3,900 (Arkansas) and 2,500 and 3,800 (New Hampshire) health center patients.²²

These cases are now on appeal. Separately, the administration appears to be about to issue guidance soliciting Medicaid block grant experimental proposals under §1115, and at least one state (Tennessee) appears poised to apply for approval. A block grant, by capping federal funding, is expected to trigger widespread loss of eligibility, coverage, and likely, elimination of Medicaid's special payment rules for health centers.

Concluding Thoughts

Despite these threats, health centers continue to grow and strengthen. From their modest beginnings as a small War on Poverty experiment,²³ health centers have grown into an essential feature of the American health care landscape, anchoring comprehensive primary health care in thousands of medically underserved communities. The health centers grant program is, of course, a key element of their success; in the end, however, their future health, like that of the communities they serve, will be determined by the deeper policy currents that move the American health care system as a whole.

¹⁷Geiger Gibson/RCHN Community Health Foundation Research Collaborative and the Kaiser Family Foundation. (2019). Community Health Centers Prepare for Funding Uncertainty. <https://www.kff.org/medicaid/issue-brief/community-health-centers-prepare-for-funding-uncertainty/>

¹⁸National Health Law Program. (2019). Declaration of Leighton Ku in *La Clinica de la Raza v. Trump*. <https://healthlaw.org/resource/declaration-of-Leighton-ku-in-la-clinica-de-la-raza-v-trump/>

¹⁹Shin, P., Sharac, J., Rosenbaum, S., & Velasquez, M. (2019). How will the Public Charge Rule Affect Community Health Centers and the Communities They Serve? (Updated Estimates). GW Health Policy Matters blog. <http://gwhpmatters.com/blog-how-will-public-charge-rule-affect-community-health-centers-and-communities-they-serve-updated>

²⁰Wood, S.F., Strasser, J., Sharac, J., Wylie, J., Tran, T.C., Rosenbaum, S., Rosenzweig, C., Sobel, L. & Salganicoff, A. (2018). Community Health Centers and Family Planning in an Era of Policy Uncertainty. Kaiser Family Foundation. <https://www.kff.org/womens-health-policy/report/community-health-centers-and-family-planning-in-an-era-of-policy-uncertainty/>

²¹Rosenbaum, S., Wood, S.F., Strasser, J., Sharac, J., Wylie, J., Tran, T.C. (2018). The Title X Family Planning Proposed Rule: What's At Stake For Community Health Centers? Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20180621.675764/full/>

²²Sharac, J., Shin, P., & Rosenbaum, S. (2019). How would Medicaid Losses in Approved Section 1115 Medicaid Work Experiment States Affect Community Health Centers? Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 59. <https://www.rchnfoundation.org/?p=8314>

²³Ward, T.J. (2017). *Out in the rural: A Mississippi health center and its war on poverty*. Oxford University Press.