

# Community Health Centers Ten Years After the Affordable Care Act: A Decade of Progress and the Challenges Ahead

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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 [www.rchnfoundation.org](http://www.rchnfoundation.org).

## Executive Summary

By insuring the poorest Americans and creating a Community Health Center Fund to directly support expansion, the Affordable Care Act (ACA) enabled community health centers to reach millions of new patients. Between 2010 and 2018, the number of patients served by health centers grew by 8.9 million, from 19.5 million to 28.4 million. As the ACA reaches its tenth anniversary, the enormous growth of community health centers represents one of its greatest achievements. Community health centers located in Medicaid expansion states have experienced the most robust transformation in size and capacity, but in all states, community health centers have added locations, expanded the range of services they offer, and are treating more complex patients, including those with HIV/AIDS and substance use disorders. Several key factors will determine the continued strength of community health centers: the survival of the Affordable Care Act; stable Medicaid policies and a rejection of eligibility restrictions; adoption of the ACA Medicaid expansion by all states; sustaining and stabilizing the CHC Fund; and a workforce that is able to grow to meet the need.

### From Health Experiment to Health Care Anchor in Medically Underserved Communities

With roots in pioneering work in South Africa's homelands<sup>1</sup>, community health centers were launched in 1965 as a small experiment with a large aim: to improve the health of populations and communities experiencing deep poverty, elevated health risks, and a severe shortage of comprehensive primary care.<sup>2</sup> Guided by the needs of the populations they served, community health centers sought to bridge public health and health care, combining comprehensive primary care with a broader effort to improve the underlying social and health conditions affecting their patients and the residents of their service areas. Early evaluations documented their positive impact on access to care and on key health outcomes such as infant mortality.<sup>3</sup>

In 1975, community health centers were formally established in law as part of the Public Health Service Act, and their growth became a key element of health policy for successive Presidential administrations. By 2010, more than 1,100 community health centers operating in nearly 7,000 locations served nearly 19.5 million patients.

### How the Affordable Care Act Expanded and Strengthened Community Health Centers

The ACA contained a series of policy reforms that dramatically expanded and strengthened community health centers.

*Expanding coverage for the poor.* First and foremost, by expanding Medicaid and establishing a new pathway to coverage through subsidized Marketplace plans, the ACA provided health coverage to millions of community health center patients. Because of the concentrated nature of U.S. poverty,<sup>4</sup> those assisted disproportionately resided in urban and rural communities designated as medically underserved and more likely to be served by community health centers.<sup>5</sup>

*Permanent authorization of health centers program and establishment of the Community Health Center Fund.* Second, the ACA permanently authorized the community health centers program and created a long-term funding system to propel health center growth.<sup>6</sup> By permanently authorizing the program, Congress eliminated the need for periodic reauthorization and underscored the essential nature

<sup>1</sup> Thomas J. Ward, 2017. *Out in the Rural: A Mississippi Health Center and its War on Poverty* (Oxford University Press); see also, Adele Oltman. (May 3, 2017). For Health and Freedom. *Jacob Magazine*. <https://www.jacobinmag.com/2017/05/good-doctors-out-in-the-rural-review-freedom-summer>

<sup>2</sup> Eli Adashi, Jack Geiger, and Michael Fine, 2010. Health Care Reform and Primary Care — The Growing Importance of the Community Health Center. *New Engl. Jour. Med.* 362:2047 (June 3, 2010).

<sup>3</sup> Karen Davis and Cathy Schoen, 1977. *Health and the War on Poverty* (Brookings Press).

<sup>4</sup> Elizabeth Kneebone and Natalie Holmes, 2016. U.S. concentrated poverty in the wake of the Great Recession (Brookings Institution), <https://www.brookings.edu/research/u-s-concentrated-poverty-in-the-wake-of-the-great-recession/>

of health centers as a permanent and key feature of the U.S. health care landscape. Furthermore, by establishing the Community Health Center (CHC) Fund – and providing the first five years of funding – Congress sought to ensure that, ahead of full implementation of the ACA in January 2014, communities could jump-start health center expansion in order to be ready for an expected surge in new patients. Following creation of the CHC Fund, Section 330 health center funding more than doubled, from \$2.2 billion in FY 2010 to \$5.6 billion in FY 2019.<sup>7</sup>

Together, these two coverage reforms were designed to aid all low-income Americans. However, in the case of the Medicaid expansion, decisions by some states to reject the expansion after the United States Supreme Court's 2012 ruling that effectively made expansion optional initially left over 5 million, including many health center patients, without coverage.<sup>8</sup> Today, the number of Medicaid-eligible residents of non-expansion states stands at 2.3 million – down from its height, but considerable nonetheless.<sup>9</sup> Over 90 percent of those affected live in the South, and half live in just two states – Texas and Florida.<sup>10</sup>

In addition to the CHC Fund, the ACA created special funding for the National Health Service Corps – a major source of health center clinical staffing – as well as the Teaching Health Centers Graduate Medical Education (THCGME) program, whose purpose was to strengthen the ties between health centers and health professions and medical residency training programs. Together, these additional reforms were aimed at expanding near-term clinical workforce capacity, while creating a longer-term clinical staffing recruitment strategy.

## How has the ACA affected community health centers and the patients and communities they serve?

Because of the major expansion of insurance coverage and the infusion of revenue it produced for medically underserved communities, the ACA had an enormous impact on community health center growth and patient care capacity. By ensuring payment for covered services, insurance expansions, together with the CHC Fund investment in new sites and operations, have enabled community health center grantees to grow in number. The revenue produced by the ACA's insurance expansions, along with increased direct investment under the CHC Fund, also allowed existing grantees to increase capacity by adding new service sites, and to expand the scope of services they are able to offer, particularly for patients with long-term, serious health problems encompassing both physical and behavioral conditions, including opioid addiction.

*Health center patients have gained insurance coverage.* Even as they have maintained their leading role in health care for the uninsured, community health centers serve as a major source of care for uninsured patients. Their expanded role for insured patients likely is the result of several factors: the primary care shortage areas in which health centers operate; their accessible locations and flexible hours; their accessibility to uninsured family members as well as their affordability for patients who periodically may experience periods without health insurance coverage; their expansive scope and range of services; and the availability of patient support services such as translation, transportation, onsite enrollment into health insurance and other health, social, and nutrition programs for which patients may be eligible.

Insurance gains have been dramatic. In 2010, 38 percent of health center patients were uninsured, 39 percent had Medicaid, and 14 percent were covered by private insurance (**Figure 1**). By 2018, the proportion with Medicaid had grown to 48 percent, the proportion with private insurance had risen to 18

<sup>5</sup> Sara Rosenbaum et al., 2009. National Health Reform: How Will Medically Underserved Communities Fare? (Geiger Gibson Program in Community Health Policy, Research Brief #10), <https://www.rchnfoundation.org/wp-content/uploads/2013/02/medically-underserved-reform-FINAL.pdf>

<sup>6</sup> Pub. L. 111-148, § 5602; see Elayne Heisler, 2017. Federal Health Centers: An Overview (Congressional Research Service), <https://fas.org/sgp/crs/misc/R43937.pdf>

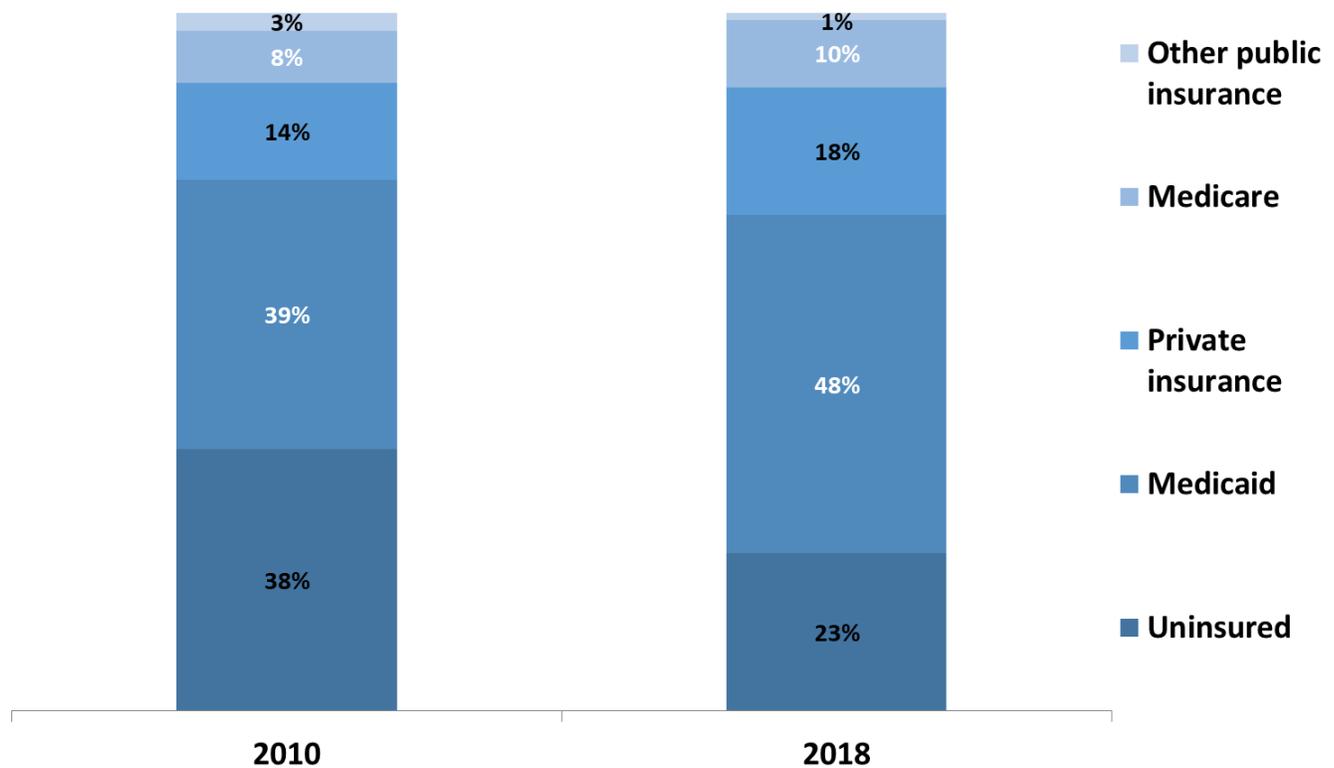
<sup>7</sup> Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained. <https://www.kff.org/report-section/community-health-center-financing-the-role-of-medicare-and-section-330-grant-funding-explained-issue-brief/>

<sup>8</sup> Galewitz, P. (October 16, 2013). Report: 5.2 Million Adults Will Fall Into ACA Coverage Gap Next Year, Kaiser Health News. <https://khn.org/news/report-5-2-million-adults-will-fall-into-aca-coverage-gap-next-year/>

<sup>9</sup> Rachel Garfield et al., The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid (Kaiser Family Foundation, 2020), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicare/>

<sup>10</sup> Id.

Figure 1. Health Coverage of Health Center Patients, 2010 and 2018



Note: Percentages may not add to 100% due to rounding. In line with the UDS, CHIP Medicaid is included with Medicaid, while non-Medicaid CHIP enrollees are counted under “Other Public Insurance.”  
 Source: George Washington University analysis of data reported in the UDS national reports for 2010 and 2018 UDS data

percent, and the proportion without insurance had declined to 23 percent. Given the documented relationship between insurance coverage and access to more advanced treatments and specialty care when appropriate,<sup>11</sup> expanded insurance coverage has led to measurable improvements in both how health centers perform for patients with serious health conditions and the accessibility of specialty services. Improvements have been especially notable in ACA Medicaid expansion states.<sup>12</sup>

After the Medicaid expansion effectively became optional, health insurance coverage patterns among health center patients began to diverge depending on whether health centers operated in expansion or non-expansion states. In 2018, in non-expansion states, the percentage of Medicaid-enrolled patients was virtually identical to the 2010 rate, while the percentage of privately insured had increased significantly (**Figure 2**). By contrast, in expansion states, the percentage insured through Medicaid rose

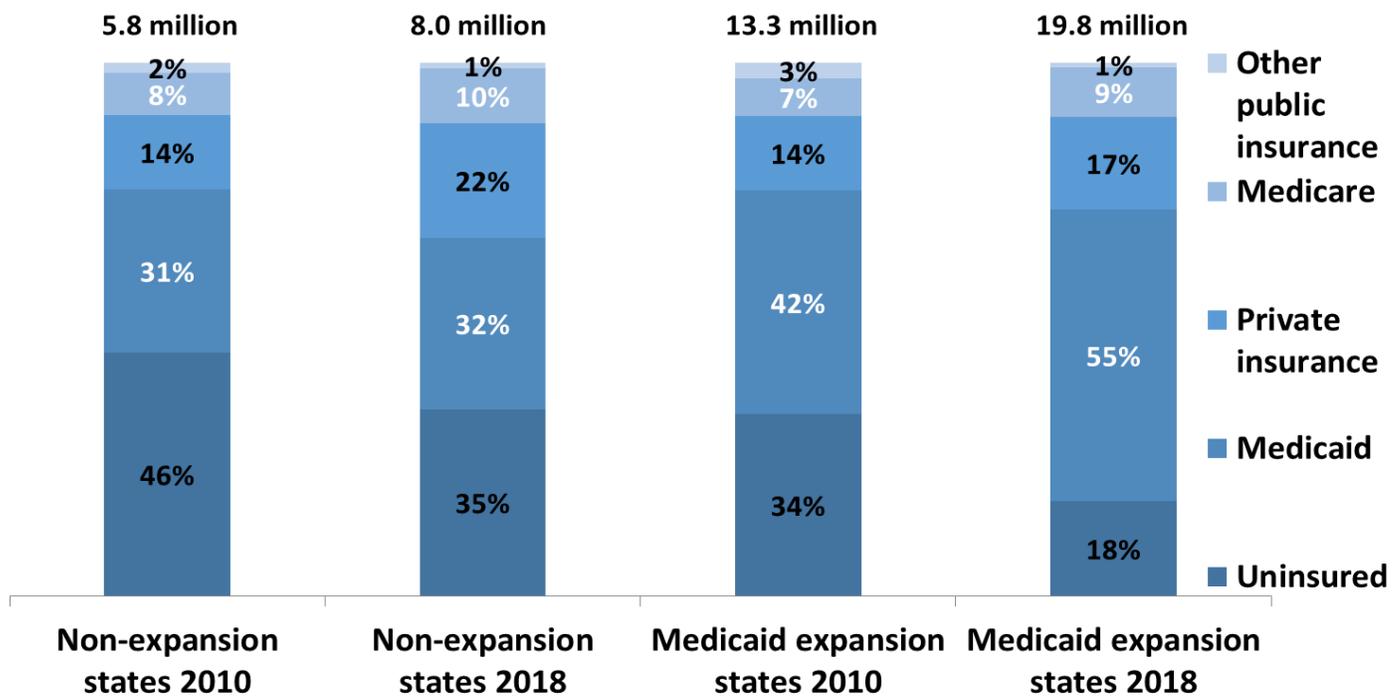
from 42 percent to 55 percent while growth in the privately insured share was more modest. These key differences in Medicaid and Marketplace coverage rates are likely the result of two factors: first, the absence of a Medicaid coverage pathway in non-expansion states for working-age adults not eligible under traditional coverage categories; and second, the fact that in non-expansion states, the threshold for subsidized marketplace coverage drops to 100 percent of the federal poverty level compared to 138 percent of poverty in Medicaid expansion states. Despite their patients’ greater access to marketplace coverage, however, health centers in non-expansion states continued to treat a far greater share of uninsured patients by 2018 — virtually double the percentage (35 percent vs. 18 percent).

Community health centers play a critical role in serving Medicaid and uninsured patients. Overall, health centers serve nearly one in five (19%) Medicaid and CHIP enrollees, and in ten states and the District

<sup>11</sup> Mabel Ezeonwu, 2018. Specialty-care access for community health clinic patients: processes and barriers, *JMultidiscip Healthc* 11:109-119, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5826087/>

<sup>12</sup> Megan B. Cole et al., 2017. At Federally Funded Health Centers, Medicaid Expansion Was Associated With Improved Quality Of Care, *Health Affairs* 36:1 pp. 40-48.

Figure 2. Health Coverage of Health Center Patients, by State Medicaid Expansion Status, 2010 and 2018



Note: Percentages may not add to 100% due to rounding. Medicaid expansion status as of 2018. Data does not include health centers in U.S. territories.  
 Source: George Washington University analysis of 2010 and 2018 UDS data

of Columbia, health centers serve one in four or more.<sup>13</sup> For the uninsured population, health centers continue to play a central role, furnishing care to an estimated 22 percent of uninsured people in 2018.<sup>14</sup>

*Health centers have grown in size, service sites, staffing, and patient capacity.* In 2018 (the most recent year for which data from the Department of Health and Human Services Uniform Data System [UDS] are available), the number of community health center grantees reached 1,362, a 21 percent increase in grantees from 2010, and the total number of grantee service sites grew by 69 percent from 6,949 to 11,744 (**Table 1**). Table 1 also shows that federally funded community health centers served 28.4 million patients in 2018; an additional 84 “look-alike” health centers (community health centers whose operating grants come from state and local funds) served nearly 900,000 more patients.<sup>15</sup> Between 2010 and 2018 the

number of patients served by federally funded health centers increased by 46 percent, while patient visits rose to 116 million visits, an increase of 50 percent from 77 million visits in 2010.

Such a dramatic expansion of care has been possible because the number of health center staff surged. Between 2010 and 2018, the number of full-time equivalent (FTE) physicians grew by 40 percent, behavioral health staff increased 165 percent, FTE nurses grew 62 percent, and dental staff nearly doubled (**Table 2**).

Given their larger percentage of uninsured patients, health centers in non-expansion states have experienced more modest growth. They remain somewhat smaller, maintain fewer operating sites, have fewer staff, and generate lower overall operating revenue, with a greater dependence on grant funds. In

<sup>13</sup> Sharac, J., Shin, P., Rosenbaum, S., & Handarov, T. (2019). Community Health Centers Continue Steady Growth, But Challenges Loom. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 60. <https://www.rchnfoundation.org/?p=8436>

<sup>14</sup> National Association of Community Health Centers. (2018). Community Health Center Chartbook 2020. Figure 2-8. <http://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf>

<sup>15</sup> 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=>

**Table 1. Health Center Grantees, Sites, Patients, and Visits, 2010-2018**

	2010	2018	Percentage change 2010-2018
Health center grantees	1,124	1,362	21%
Health center grantee sites	6,949	11,744	69%
Total visits	77,069,234	115,816,238	50%
Total patients	19,469,467	28,379,680	46%

Source: George Washington University analysis of 2010 and 2018 UDS data

**Table 2. Health Center Staff FTEs, 2010-2018**

Staff Category	2010 (FTEs)	2018 (FTEs)	Percentage change 2010-2018
Physicians	9,592	13,394	40%
Nurses	11,365	18,445	62%
Dental staff	9,452	18,715	98%
Behavioral health staff	5,095	13,518	165%

Source: George Washington University analysis of 2010 and 2018 UDS data

**Table 3. Average Number of Health Center Sites and Patients, by Medicaid Expansion Status, 2010-2018**

Averages	Non-expansion		Medicaid expansion	
	2010	2018	2010	2018
Number of sites	5.8	8.1	7.3	9.1
Total patients	14,815	17,767	18,743	22,599

Source: George Washington University analysis of 2010 and 2018 UDS data. Medicaid expansion status as of 2018.

expansion states, health centers report, on average, 22,600 patients and operate in over 9 locations; by contrast, each non-expansion state community health center serves slightly fewer than 17,800 patients and maintains slightly more than 8 sites, on average (**Table 3**).

In Medicaid expansion states, total patients and total visits increased by 50 percent and 56 percent, respectively, while non-expansion state health centers experienced 39 percent growth in patients and patient visits between 2010 and 2018 (**Table 4**). Most striking, perhaps, between 2010 and 2018, community health

**Table 4. Health Center Visits, Total Patients, and Patients by Insurance Type, by State Medicaid Expansion Status, 2010-2018**

Visit/Coverage Category	Non-expansion 2010	Non-expansion 2018	Non-expansion percentage change 2010-2018	Medicaid expansion 2010	Medicaid expansion 2018	Medicaid expansion percentage change 2010-2018
Total visits	20,942,224	29,021,697	39%	54,260,002	84,876,080	56%
Total patients	5,777,758	8,048,406	39%	13,251,091	19,841,735	50%
Uninsured	2,629,896	2,817,139	7%	4,549,649	3,506,377	-23%
Medicaid	1,777,335	2,584,435	45%	5,508,918	10,874,303	97%
Private insurance	783,818	1,731,239	121%	1,856,535	3,416,994	84%
Medicare	477,062	821,317	72%	950,528	1,873,470	97%
Other public insurance	109,647	94,276	-14%	385,461	170,591	-56%

Source: George Washington University analysis of 2010 and 2018 UDS data. Medicaid expansion status as of 2018.

centers in non-expansion states actually experienced a 7 percent growth in the number of uninsured patients while the number of uninsured patients fell by 23 percent in expansion states.

*Health centers have expanded the range of services they offer.* With the additional revenue and in the face of growing patient needs, health centers have broadened the range of services they offer, especially in Medicaid expansion states. By 2018, 95 percent of all health centers offered some level of behavioral health care onsite, and 57 percent of all health centers had onsite staff authorized to provide medication-assisted treatment for opioid use disorder.<sup>16</sup> That year, 77 percent of all health centers had achieved recognition as patient centered medical homes with the capacity to provide integrated, continuous care for both physical and behavioral health conditions. Sixty percent of all health centers with telehealth services

were using telehealth for specialist provider consultation, 54 percent for patient interaction, and over 400 health centers were using telehealth to expand behavioral health capacity.<sup>17</sup> In 2018, 44 percent of all health centers offered four or more services onsite in addition to medical care, such as case management, dental care, behavioral health, vision, and pharmacy services.

*As the ACA has expanded coverage and increased operating revenue, the patients served by health centers have become more complex.* Historically, community health center patients have experienced higher health risks than the low-income population generally, a not-unexpected pattern given the fact that sicker people generally are more likely to seek health care, particularly at health centers, where their open access policies remove considerable barriers to care. As the ACA has enabled more people to seek medical

<sup>16</sup> National Association of Community Health Centers. (2018). Community Health Center Chartbook 2020. <http://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf>

<sup>17</sup> 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=>

**Table 5. Health Center Patients and Patients with Selected Diagnoses, 2013-2018**

Year	Total patients	Patients with HIV	Patients with diabetes	Patients with overweight and obesity	Patients with alcohol-related and other substance use disorders	Patients with depression, other mood, or anxiety disorders
2013	21,726,965	115,421	1,882,608	2,228,089	506,279	2,740,638
2014	22,873,243	134,540	2,005,338	2,822,118	566,634	3,020,562
2015	24,295,946	154,994	2,118,178	3,396,723	666,503	3,381,315
2016	25,860,296	158,323	2,283,360	4,472,815	713,829	3,805,893
2017	27,174,372	165,745	2,441,686	5,491,407	803,510	4,311,722
2018	28,379,680	191,717	2,566,358	6,520,928	908,984	4,724,691
<b>Increase 2013 –18</b>	31%	66%	36%	193%	80%	72%

Source: George Washington University analysis of 2013-2018 UDS national reports

care, and as health centers have increased the range of services they offer, their patients have grown more complex and high-need. The growth in capacity to serve high need patients also has coincided with the rise of significant community health risks such as those created by the opioid epidemic and its consequences for both physical and mental health. Compared to the low-income population generally, health center patients are more likely to have diabetes, asthma, or hypertension and are far more likely to exhibit health risks such as smoking and obesity.<sup>18</sup> Health center patients are substantially more likely to experience two or more health conditions over their lifetimes and are more than twice as likely to report being in fair to poor health.<sup>19</sup>

The confluence of Medicaid expansion financing,

greater insurance coverage, and growing health risks means that over the past half-decade, health centers have come to play a growing role in caring for people with serious health problems and an aging patient population. Between 2013 and 2018, the total number of health center patients increased by 31 percent, while the number of CHC patients with complex medical diagnoses involving physical and behavioral health problems exhibited greater increases. Overall, UDS data show that between 2013 and 2018, the number with HIV increased by 66 percent, the number with alcohol and other substance use disorders by 80 percent, and the number with depression, other mood, and anxiety disorders by 72 percent (**Table 5**). The number of patients with diabetes rose by 36 percent, while the number of overweight/obese

<sup>18</sup> Shin, P., Alvarez, C., Sharac, J., Rosenbaum, S., Van Vleet, A., Paradise, J., Garfield, R. (2013). A profile of community health center patients: implications for policy. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation and the RCHN Community Health Foundation. <http://kff.org/medicaid/issue-brief/a-profile-of-community-health-center-patients-implications-for-policy/>

<sup>19</sup> National Association of Community Health Centers. (2018). Community Health Center Chartbook 2020. Figure 1-10. <http://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf>

patients – a health condition that leads to major complications – grew by 193 percent.

## The Challenges Ahead

Health centers, their patients, and the broader communities they serve have made extraordinary gains under the ACA. They also face major challenges in the coming decade. Their response to the HIV and opioid epidemics, as well as their history of response to public health disasters such as hurricanes and flooding, underscore their nimbleness in the face of community health threats. In the face of the new threat from coronavirus, community health centers can expect to be tested again, as critical providers in the nation's most underserved rural and urban communities.

### How to sustain a far larger program with larger revenue and workforce needs

*Medicaid and Marketplace coverage.* With health center growth has come the challenge of sustaining a program robust enough to serve as health care providers for one in twelve Americans, one in five Medicaid/CHIP beneficiaries, and one in five uninsured individuals. Sustainability requires special attention on the two most important sources of health center financing – Medicaid, which in 2018 accounted for 44 percent of total CHC revenue nationally; and federal grant funding under Section 330 of the Public Health Service Act, which represented 17 percent of total revenue that year.<sup>20</sup>

Where Medicaid policy is concerned, the problems faced by health centers operating in non-expansion states persist, of course. But recent developments present cause for concern on a broader scale. First, is the survival of the ACA itself. The United States Supreme Court has agreed to review (likely during its

2021 term beginning October 2020) a lower court decision that opens the door to a complete repeal of the law. Should the ACA be repealed, this would end the insurance expansions that have proven pivotal for health center patients, along with the CHC Fund itself. Such a result would be existential to the future of community health centers themselves, since the Fund accounts for 70 percent of all health center grant funding and the insurance reforms have led to a major expansion of health center capacity nationwide.

Even should the ACA survive this constitutional challenge, challenges loom. After years of growth, Medicaid enrollment among both adults and children began to decline in 2017.<sup>21</sup> According to experts, the rate of decline appears to be too large to be solely attributable to an improving economy and higher wages; indeed, unemployment rates have not changed appreciably over the time period in which the enrollment decline has been occurring.<sup>22</sup> Especially worrisome, this decline is coming at a time when the nation faces a major public health threat from the coronavirus, which adds new urgency to rapid access to testing and treatment.

A number of factors have emerged as potentially significant contributors to declining enrollment: the chilling effect from the public charge rule, issued by the Trump administration's Department of Homeland Security, that penalizes certain legal immigrants for using Medicaid benefits and that has caused extensive uncertainty and confusion within communities and among health center patients;<sup>23</sup> tightened eligibility verification procedures that are beginning to reverse the effects of the ACA's enrollment and renewal streamlining for Medicaid beneficiaries;<sup>24</sup> and the potential effects of §1115 eligibility restriction experiments, such as those imposing work requirements as a condition of coverage, that may be

<sup>20</sup> Sharac, J., Shin, P., Rosenbaum, S., & Handarov, T. (2019). Community Health Centers Continue Steady Growth, But Challenges Loom. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 60. <https://www.rchnfoundation.org/?p=8436>; see, also, General Accounting Office, 2019. Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund (GAO-19-496), <https://www.gao.gov/products/gao-19-496>

<sup>21</sup> Berchick, 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://census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>

<sup>22</sup> Matt Broaddus, 2019. Research Note: Medicaid Enrollment Decline Among Adults and Children Too Large to Be Explained by Falling Unemployment (Center on Budget and Policy Priorities), <https://www.cbpp.org/research/health/medicaid-enrollment-decline-among-adults-and-children-too-large-to-be-explained-by>

<sup>23</sup> Jennifer Tolbert et al., 2019. Impact of Shifting Immigration Policy on Medicaid Enrollment and Utilization of Care among Health Center Patients (Kaiser Family Foundation), <https://www.kff.org/medicaid/issue-brief/impact-of-shifting-immigration-policy-on-medicicaid-enrollment-and-utilization-of-care-among-health-center-patients/>

<sup>24</sup> Research Note: Medicaid Enrollment Decline Among Adults and Children Too Large to Be Explained by Falling Unemployment, *op. cit.*

perceived as being in effect even when they are not, thereby leading to widespread confusion over Medicaid's availability.

The impact on community health centers of broader Medicaid enrollment trends is reflected in the results of a 2019 community health center survey. This survey found that between 2018 and 2019, one in five health centers (22 percent) experienced a decline in Medicaid patients and more than two in five (44 percent) experienced an increase in the share of Medicaid/CHIP patients with a coverage lapse.<sup>25</sup>

Declining Medicaid enrollment may be compounded by the adoption of policies that reduce access to heavily-subsidized Marketplace coverage. Among reforms being considered by the Trump administration in its annual 2021 Proposed Payment Notice is ending the Obama administration's policy of automatically renewing enrollment for people with incomes low enough to qualify for zero-premium health plans.<sup>26</sup> The administration cites as the basis for such a policy a desire to encourage greater shopping for lower-priced deals, but consumers may interpret this strategy as the loss of eligibility for premium subsidies altogether, and their coverage could lapse. It is too early to know if this policy will be adopted, but it is an important development to monitor, particularly since virtually all community health centers play a critical role as enrollment assisters in order to maximize access to coverage and avert unnecessary coverage losses. Such assistance will grow in importance if automatic marketplace renewal practices cease and streamlined Medicaid renewal policies are threatened.

*Recruiting and retaining the necessary workforce.* A community health center is only as strong as its staff – from the outreach worker and insurance enrollment assister who is multi-lingual and trained in effective communication across multiple cultures, to its chief information and financial officers who keep the health center operating effectively and efficiently, to the chief medical officer and the medical, nursing, dental, social work, mental health and addiction counseling, family

planning counseling, maternity care and support, nutrition, and other public health professionals who furnish care. Care teams have received a good deal of attention over the years; community health centers depend on them.

Health centers supported a staffing complement of more than 236,000 FTEs in 2018,<sup>27</sup> including more than 81,000 medical personnel, nearly 19,000 dental staff, and over 13,500 mental health and substance use disorder services providers. But CHCs face gaps in essential clinical staffing. The National Association of Community Health Centers estimated in 2016 that were all clinical vacancies filled, health center service capacity would grow by two million patients.<sup>28</sup> The National Health Service Corps provides a vital source of clinical staffing; more than half of all Corps professionals fulfill their service at health centers.<sup>29</sup> But clinical vacancies extend far beyond what the Corps can fulfill. Thus, while health centers need a fully-funded Corps, they also need an expanded Teaching Health Centers program, a training program that serves as a powerful pipeline and recruitment tool. According to a NACHC survey, 58 percent of all respondents reported that the health professions staff that they had hired in the previous two years had actually trained at their health center; another 30 percent reported that new hires had trained at another health center.

### Stabilizing and Extending the CHC Fund

The CHC Fund was initially financed for 5 years. The Fund subsequently has been extended twice (in 2015 and 2017) each time for two years. The agreement reached by the Trump administration and Congress at the end of 2019 provided only a brief funding extension for community health centers, the National Health Service Corps, and the Teaching Health Centers program. This brief extension lapses once again on May 22, 2020.

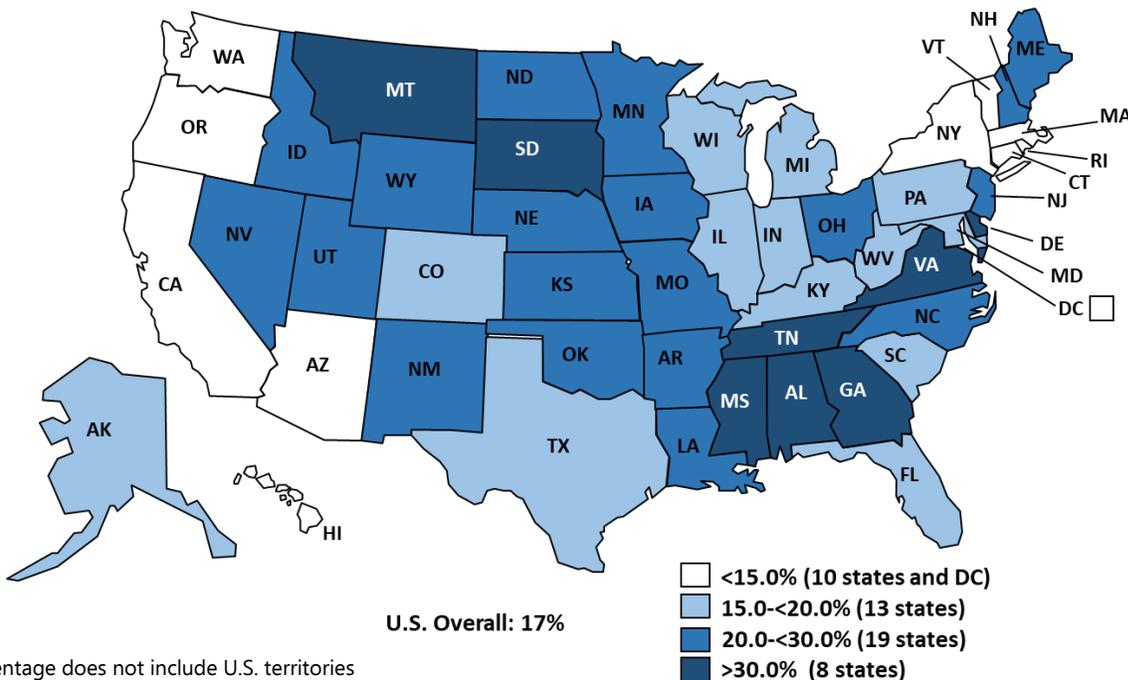
What is essential is stabilizing and extending the CHC Fund, given the fact that this Fund now accounts for approximately 70 percent of all health center grant funding.<sup>30</sup> In Medicaid non-expansion states, the

<sup>25</sup> Jessica Sharac et al., (Forthcoming, 2020). Community Health Centers in a Time of Change: Results from an Annual Survey. Kaiser Family Foundation

<sup>26</sup> Katie Keith, 2020. The 2021 Proposed Payment Notice, Part 2: Exchange Provisions (Health Affairs Blog), <https://www.healthaffairs.org/doi/10.1377/hblog20200201.566219/full/>

<sup>27</sup> 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=>

**Figure 3. Federal Section 330 Grants as a Share of Total Health Center Revenue, by State, 2018**



Note: U.S. percentage does not include U.S. territories  
 Source: George Washington University analysis of 2018 UDS data

Fund, in combination with the annual health center appropriation, accounts for a considerably greater share; in eight states, Section 330 grant funding represents 30 percent or more of total health center revenue (**Figure 3**).

Even if health center patients increasingly are insured, the need for the CHC Fund will remain. Community health centers have long been recognized for their efficiency, in addition to the quality of their care. But the law obligates them to serve patients regardless of their insured status and to provide a comprehensive range of primary care services. Even the most efficient health center requires a steady source of grant funding to meet the cost of uninsured patients, uninsured clinical services, and of patient supports such as translation, transportation, care management, and assistance in obtaining health, educational, and social services.

Health centers also need a steady and reliable revenue flow to recruit staff, to secure space, equipment and supplies, and to maintain operational stability.

Rural and urban communities served by community

health centers, as well as the National Health Service Corps and Teaching Health Centers program are, by definition, unable to bear the financial or health risks associated with periodic lapses in, or concerns over, health center grant funding. Indeed, if anything, the importance of the Fund has grown. Over the past decade, Congress has fundamentally altered what began as a fund to incubate program expansion, with annual appropriations supplying ongoing operational support. Today the CHC Fund is the principal source of ongoing operational funding and is not merely the means of jump-starting new operations.<sup>31</sup>

The Fund may merit a different financing approach. The immediate challenge is passage of a multi-year renewal of the CHC Fund in order to avert reduction in services, staffing, and patient supports. But a longer-term challenge is to develop a strategy for the CHC Fund that parallels the program’s status as a permanently authorized part of the health care system. In the case of the Children’s Health Insurance Program (CHIP), Congress adopted a longer-term funding strategy in 2018. Indeed, given the fact that

<sup>28</sup> NACHC, 2016. STAFFING THE SAFETY NET: Building the Primary Care Workforce at America’s Health Centers (Washington D.C.), [http://www.nachc.org/wp-content/uploads/2015/10/NACHC\\_Workforce\\_Report\\_2016.pdf](http://www.nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf)

<sup>29</sup> NACHC, 2016. STAFFING THE SAFETY NET: Building the Primary Care Workforce at America’s Health Centers (Washington D.C.), [http://www.nachc.org/wp-content/uploads/2015/10/NACHC\\_Workforce\\_Report\\_2016.pdf](http://www.nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf)

community health centers are now permanently authorized, this may warrant an approach similar to Medicaid's "disproportionate share hospital (DSH)" payment program, which is a basic and permanent feature of law.

### Addressing the needs of an increasingly complex patient population through delivery and payment reform

As the U.S. adult population experiences heightened risk of serious illness, disability, and premature death and disability from public health risk factors, this increasing risk tends to be concentrated in communities served by health centers. This is true in the case of substance use disorders, such as opioid use disorder. HIV infection rates also loom in these communities, and today community health centers serve 22 percent of all people living with HIV who are receiving HIV-related care.<sup>32</sup> Even as funding prospects grow more uncertain, the need for health centers to strengthen their services intensifies as multiply-burdened patients increase in number.

For community health centers confronting rising numbers of high-need patients, well-designed delivery and payment reform strategies are becoming especially important. Recent research shows that increasingly, community health centers are active participants in Medicaid initiatives to test new payment and delivery reform efforts designed to achieve greater patient satisfaction, to promote greater participation in integrated care delivery models, to increase delivery efficiency, and to integrate health care and social services.<sup>33</sup> Indeed, in some states, health centers have taken on a leading role in designing and implementing complex delivery and payment reform innovations in partnership with

their Medicaid agencies. This type of activity could be even more strongly encouraged through incentivizing supports to Medicaid programs and partnering health center associations and networks to jointly develop and undertake alternative payment models, as permitted under existing federal law.<sup>34</sup>

### Concluding Thoughts

The Affordable Care Act has had a remarkable impact, both direct and indirect, on community health centers and the communities and populations they serve. Insuring health center patients has proven transformational, not only for the patients themselves but for the health system through which they receive comprehensive primary care. Coupled with the insurance expansion, the CHC Fund has helped propel and sustain further growth. Now the challenge is to sustain and build on this growth, not only to reach the estimated 78 million residents living in primary care health professional shortage areas,<sup>35</sup> but also to maintain the successes that have been achieved for nearly 30 million patients.

<sup>30</sup> General Accounting Office, 2019. Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund (GAO-19-496), <https://www.gao.gov/products/gao-19-496>

<sup>31</sup> GAO, Trends in Revenue and Grants, op. cit.

<sup>32</sup> Sara Rosenbaum et al., 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, Milken Institute School of Public Health, Issue Brief #56), <http://gwhpmmatters.com/sites/default/files/2019-03/Community%20Health%20Centers%20and%20the%20President%E2%80%99s%20HIV%20Initiative%20%28Rosenbaum%2C%20Sharac%2C%20Shin%2C%20Gunsalus%29%202-26-19.pdf>

<sup>33</sup> Corinne Lewis et al., 2019. Changes at Community Health Centers, and How Patients Are Benefiting: Results from the Commonwealth Fund National Survey of Federally Qualified Health Centers, 2013–2018 (Commonwealth Fund), <https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/changes-at-community-health-centers-how-patients-are-benefiting>

<sup>34</sup> Sara Rosenbaum et al., 2019. Community Health Centers and Medicaid Delivery and Payment Reform: A Closer Look at Massachusetts and New York (Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Milken Institute School of Public Health, Issue Brief #57)

<sup>35</sup> Kaiser State Health Facts. (2019). Primary Care Health Professional Shortage Areas (HPSAs). <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>