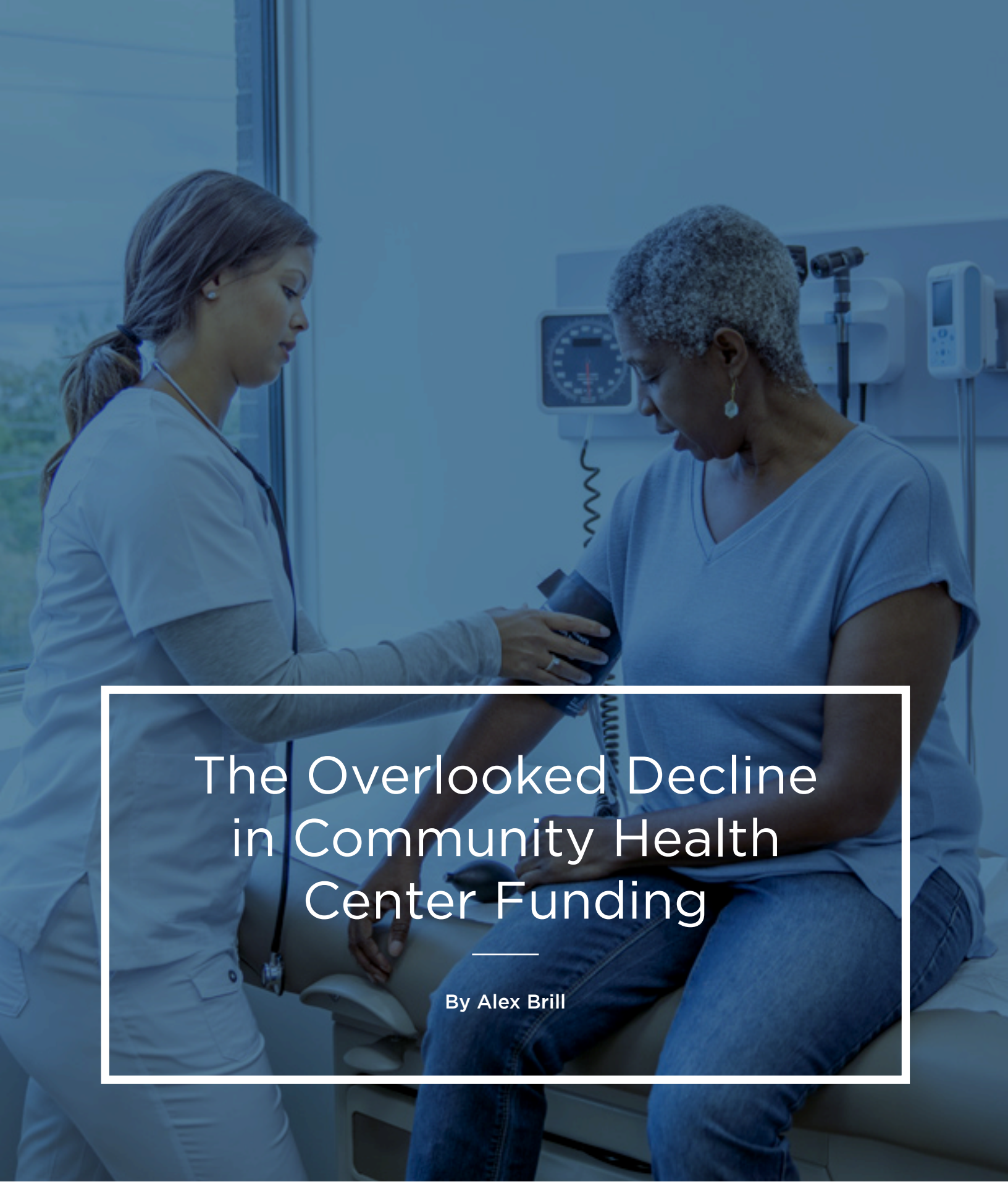

The Overlooked Decline in Community Health Center Funding

By Alex Brill

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MATRIX GLOBAL ADVISORS

Introduction

The federal Health Center Program supports qualified community healthcare facilities providing care in medically underserved areas or to medically underserved populations. These centers have been shown to provide vital and cost-efficient healthcare. While federal funding for Community Health Centers has increased in nominal terms over the years, medical care inflation and an increase in health-center patients have resulted in a decline in funding in inflation-adjusted terms and an even larger decline on a real, per-patient basis.

Specifically, since 2015, federal funding for health centers has dropped 12 percent in inflation-adjusted terms while the number of patients served has jumped 24 percent. Taken together, these changes have resulted in a 30 percent decline in inflation-adjusted, per-patient funding.

In short, Community Health Centers' reach and impact are increasing, but federal funding is not keeping pace with rising costs and a growing patient population. To achieve the same real, per-capita spending level established in 2015, annual federal funding would need to be increased by $2.1 billion.

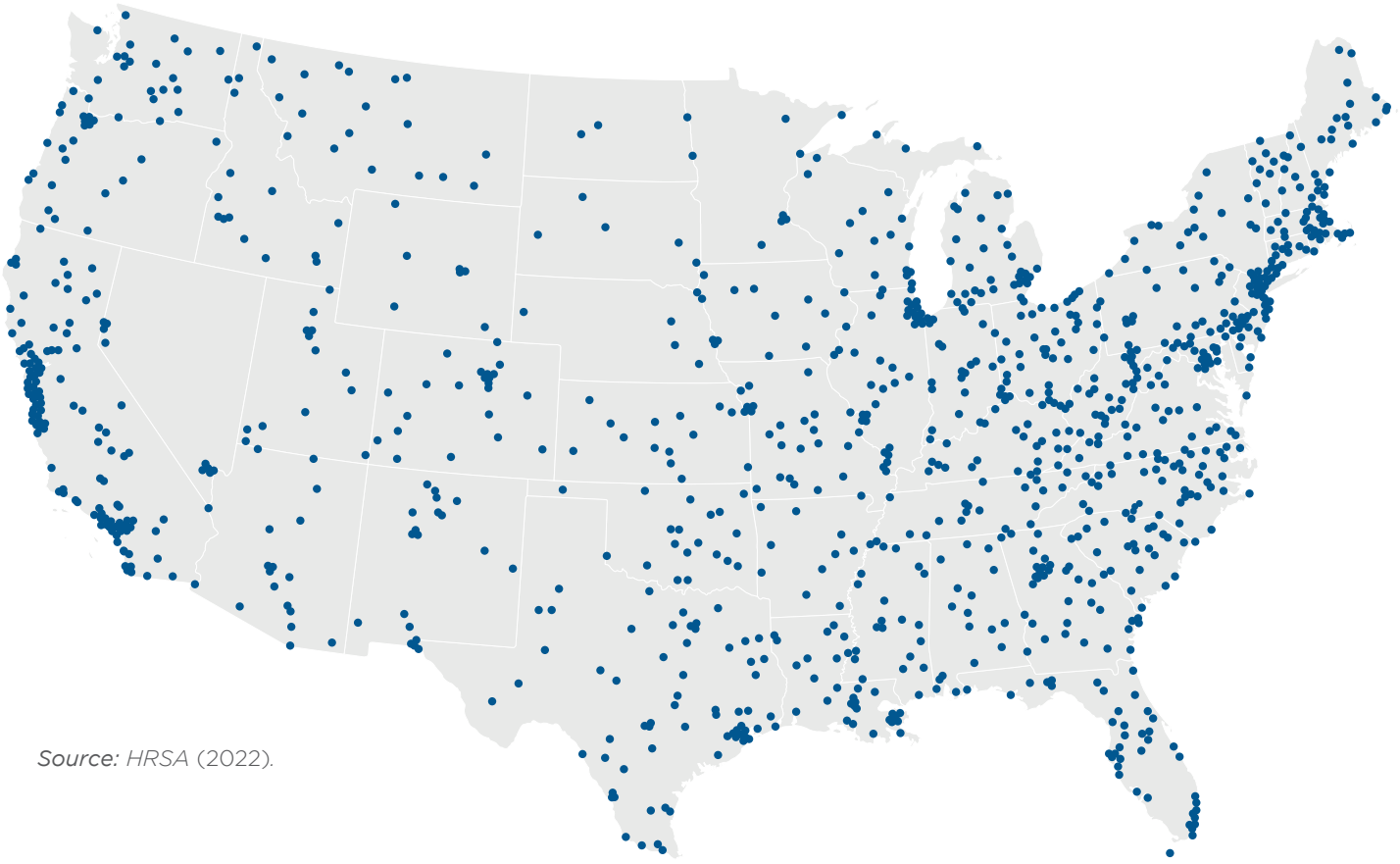
Background

The Health Center Program, operated by the Health Resources and Services Administration (HRSA), was created in the 1960s to provide healthcare to low-income individuals. Most centers are Community Health Centers, but the program also includes health centers for the homeless, for residents of public housing, and for migrants (*Heisler, 2017*). **Figure 1** shows the location and number of federally funded health centers around the United States.

Federally qualified health centers serve an ever-increasing number of people, both adults and children. The patient population now totals more than 30 million, with the majority at or near the federal poverty level (*HRSA, 2021*). More than 80 percent of patients are either uninsured or covered by Medicaid, Children's Health Insurance Program (CHIP), Medicare, or other public health insurance (*ibid.*).

Health centers receive funding from a variety of sources, including Medicare, Medicaid, private insurance, self-pay, state and local grants, and federal and other grants. The largest dedicated source of funding and the second-largest funding source overall (after Medicaid) is the federal Community Health Center Fund (CHCF), which was created by the Affordable Care Act and established in 2011. The CHCF was initially authorized for five years but has been extended and expanded several times. It is currently funded at $4 billion annually through fiscal year 2023.

FIGURE 1. **Health Center Grantees (Continental US), 2022**



Source: *HRSA* (2022).

A CLOSER LOOK AT COMMUNITY HEALTH CENTERS: CARE IN AN URBAN TEXAS COMMUNITY

HEALTH SERVICES OF NORTH TEXAS
Medical Care for You

Health Services of North Texas (HSNT) has been providing essential healthcare to its communities for 35 years. During the 2008–2009 recession, HSNT leadership saw small nonprofit clinics in the area struggling to stay afloat. In 2010, HSNT expanded to safeguard one of these important community resources and incorporated it into their model of care. That same year, finding the Community Health Center model appealing and wanting to achieve greater stability in funding, HSNT decided to apply to become a federally qualified health center (FQHC). HSNT received its FQHC designation in 2012 and, since then, has grown sevenfold.

Today, HSNT operates six clinical locations — four in Denton, one in Plano, and one in Wylie — as well as an administrative site supporting health-center operations. In 2022, HSNT's roughly 20 clinicians provided care for more than 16,800 local seniors, adults, and children in primary care, pediatrics, women's health, behavioral health, and infectious disease. Among HSNT patients, 48 percent have Medicaid, 37 percent are uninsured, 12 percent have commercial insurance, and 3 percent have Medicare.

HSNT is acutely aware of the need to increase access to healthcare services in their communities through additional sites, but funding remains a challenge, even for the health center's current sites. To provide care and cover expenses not reimbursed by Medicaid, Medicare, or commercial insurance or paid for by patients, HSNT receives government and private grants. HSNT receives $1.6 million in FQHC funding, representing 6 percent of their total budget, requiring them to operate with insufficient resources to bridge the gap in community need.

Since 2012, however, the number of patients HSNT serves has increased 572 percent and medical care inflation by 32 percent. This means that the FQHC funding HSNT receives has declined 75 percent on a per-capita, inflation-adjusted basis in the last decade.

A CLOSER LOOK AT COMMUNITY HEALTH CENTERS: CARE IN A RURAL NEW YORK COMMUNITY

HUDSON HEADWATERS HEALTH NETWORK

In the 1970s, residents of many rural Adirondack towns relied on doctors in solo practices for healthcare. As these physicians retired and shuttered their practices, people living in rural areas were left without easy access to primary care. To fill this gap, Hudson Headwaters Health Network was formed in 1981 as a federally qualified health center (FQHC). Today, Hudson Headwaters operates across almost 7,400 square miles, an area slightly smaller than the state of New Jersey. In many places, the health network is the only provider. With more than 900 employees, it is one of the largest employers in the area.

The Adirondacks are home to the second-oldest population in the country. Among Hudson Headwaters' patients, 24 percent have Medicare coverage, while 47 percent have commercial insurance, 25 percent have Medicaid, and 3 percent are uninsured. Most of the services Hudson Headwaters provides — whether at its 21 health centers; its one mobile unit; or at schools, occupational sites, or nursing homes — are in primary care and internal medicine. The network also offers dental services and select specialty services — including nephrology, neurology, sports medicine, rheumatology, and women's health — as well as opioid addiction treatment and treatment for patients with hepatitis C.

Hudson Headwaters receives $6.2 million in FQHC funding, representing 4 percent of their total budget. Other sources of funding, in addition to reimbursement from Medicare, Medicaid, and commercial insurance, include federal and state grants, private contracts, and donations.

Hudson Headwaters has seen extraordinary growth, particularly in recent years. The number of patients has increased more than 32 percent — from 82,866 in 2017 to 109,570 in 2021 — while medical care inflation has increased by 10 percent. Meanwhile, federal funding has increased only 5 percent. In short, Hudson Headwaters' FQHC funding has declined 29 percent on a per-capita, inflation-adjusted basis in the past five years.

Health Economics Evidence

A variety of empirical studies have shown that Community Health Centers have positive effects for patients and yield cost savings by reducing the need for other healthcare services (see *Bruen and Ku, 2017*). To explain the effectiveness of Community Health Centers in reducing use of other costly medical services, health policy experts have pointed out that "the enabling services provided by health centers may result in physical and mental health issues being addressed earlier and in a more coordinated manner" (*Nocon et al., 2016*).

Health centers have been shown to significantly reduce prescription-drug spending as well as the need for emergency room visits and outpatient and inpatient care (*ibid.*). Overall, costs for health-center patients with Medicaid coverage have been found to be lower than costs for non-health-center Medicaid patients by 8.4 percent (*Mundt and Yuan, 2014*) to 24 percent (*Nocon et al., 2016*).

Other studies have looked at patients more broadly than those with only Medicaid coverage. Richard et al. (*2012*) found that Community Health Center patients have 24 percent lower overall medical expenditures and 25 percent lower ambulatory expenditures than non-health-center patients. Bruen and Ku (*2019*) had particularly robust findings among children receiving care at Community Health Centers; compared with children receiving care outside of Community Health Centers, children receiving care at these centers had significantly lower total medical expenditures (–35 percent), ambulatory expenditures (–40 percent), and prescription-drug expenditures (–49 percent).

Analysis

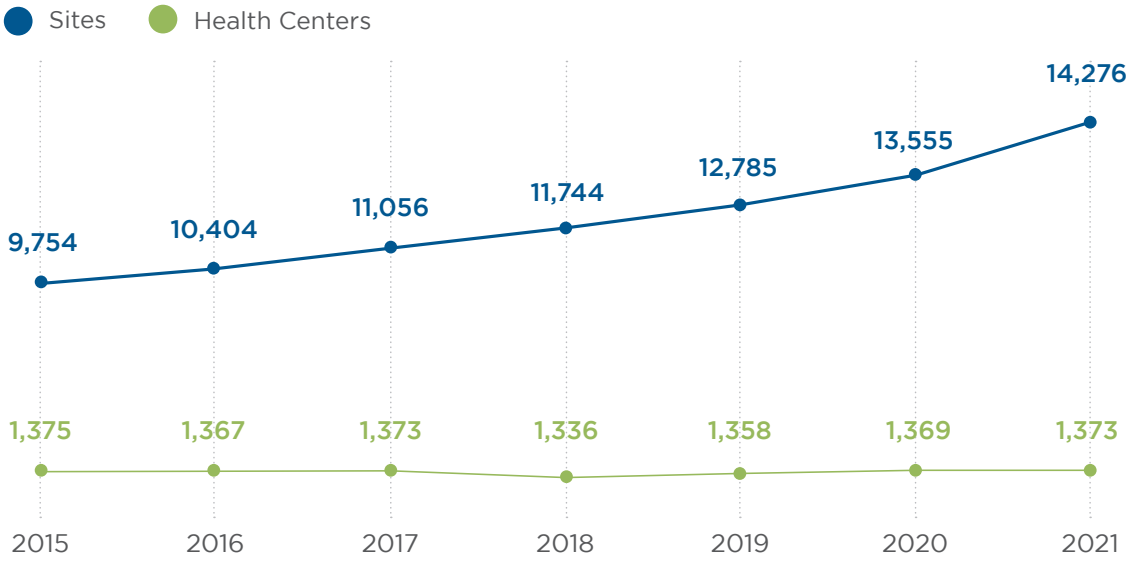
While CHCF greatly increased funding for the Health Center Program, the number of health-center sites and the number of patients served have increased significantly (*Heisler, 2019*). Additionally, an increase in the inflation index for medical care has eroded the purchasing power of health-center funding. As a result, per-patient spending has declined 27 percent in real terms since 2015, as the analysis presented here shows.

TRENDS IN HEALTH CENTER SITES AND PATIENT POPULATION

The number of health centers in the United States has remained relatively constant since 2015, but the number of sites operated by these centers has increased significantly, from fewer than 10,000 in 2015 to nearly 16,000 in 2021. (**See Figure 2.**)

Per-patient spending has declined 27 percent in real terms since 2015.

FIGURE 2. Number of Health Centers and Sites, 2015–2021

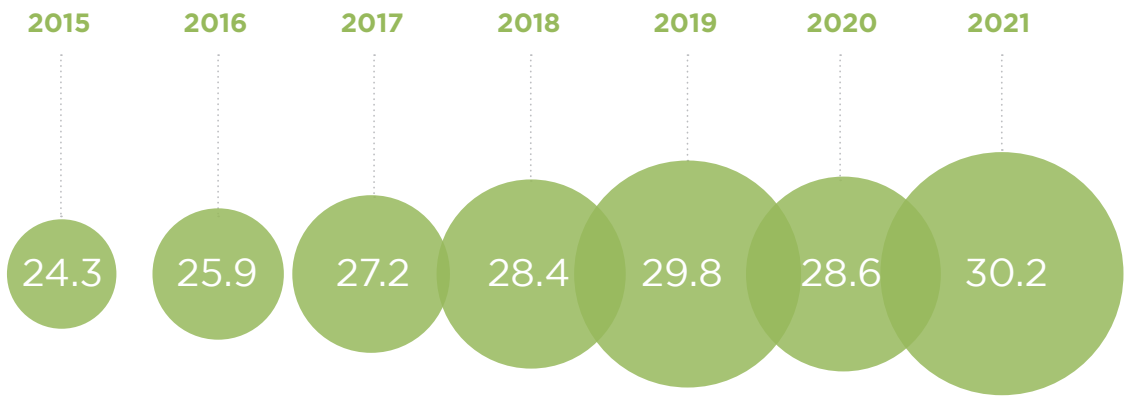


Source: HRSA National Health Center Program Uniform Data System.

Meanwhile, the number of patients served by Community Health Centers has increased dramatically, rising by nearly 6 million, or 24 percent, from 2015 to 2021. (**See Figure 3.**)

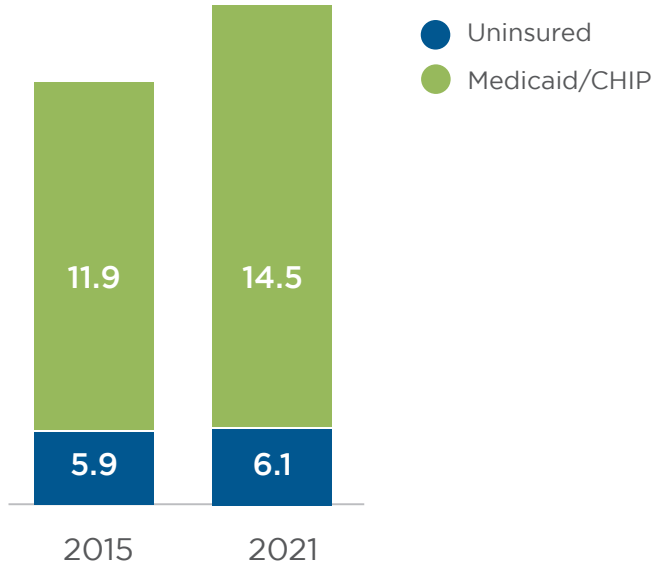
The number of uninsured and Medicaid or CHIP patients served by Community Health Centers increased by 2.8 million, or more than 15 percent, during this period. (**See Figure 4.**)

FIGURE 3. Health Center Patient Population, 2015–2021 (Millions)



Source: HRSA National Health Center Program Uniform Data System.

FIGURE 4. Health Center Medicaid/CHIP and Uninsured Patients (Millions)



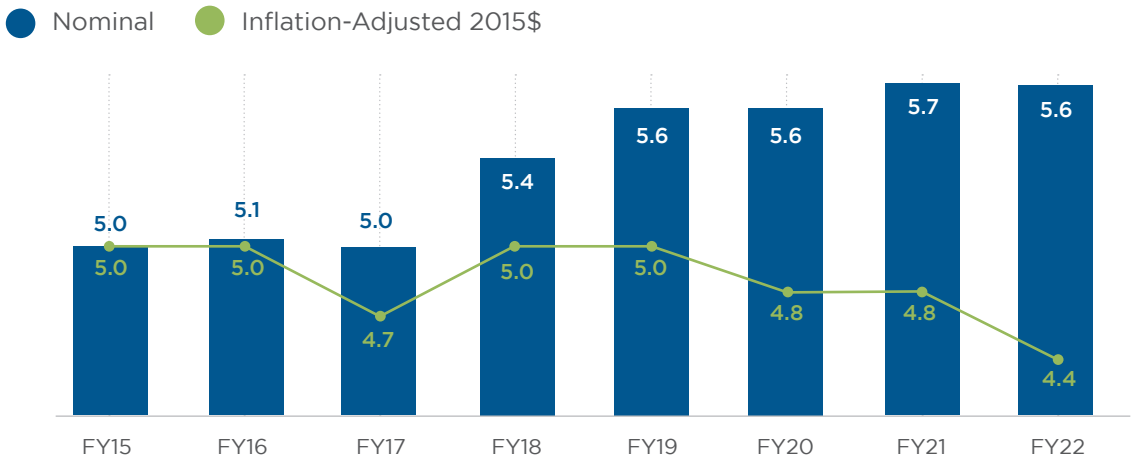
Source: 2015 data from NACHC (2022); 2021 data from HRSA (2021).

TRENDS IN FEDERAL FUNDING

Since 2015, federal funding (discretionary and CHCF funding combined) for Community Health Centers has increased 14 percent in nominal terms, from $5 billion to $5.7 billion in fiscal year 2021 and $5.6 billion in fiscal year 2022. However, medical care inflation has increased 27 percent from 2015 through fiscal year 2022, leading to a 12 percent decrease in funding in real terms. (**See Figure 5.**)

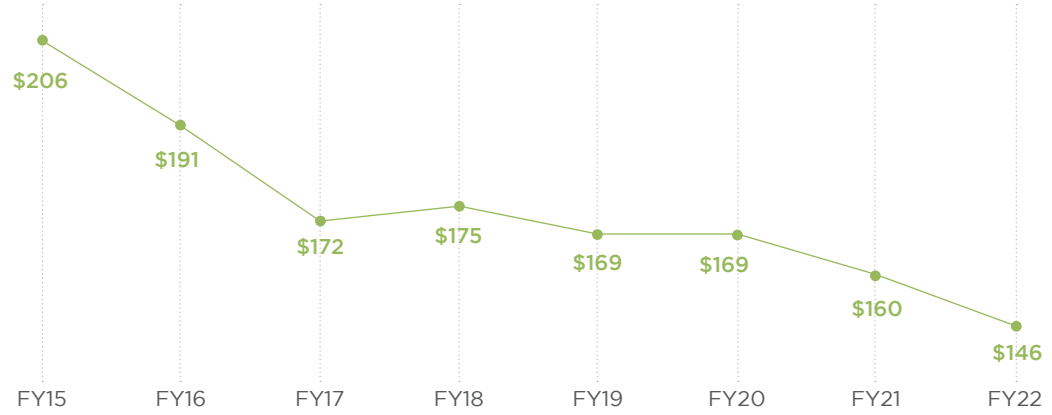
In addition, the growth in the number of patients treated in health centers has reduced per-capita federal spending. Taken together, these effects yield a 30 percent decline in per-patient funding in real terms. (**See Figure 6.**)

FIGURE 5. Federal Health Center Funding, Nominal vs. Inflation-Adjusted, 2015–2022 ($ Billions)



Source: *FY15–FY21 data from NACHC (2022); FY22 data from HHS (2022).*
Note: *Inflation adjustments use the Consumer Price Index for medical care from the Bureau of Labor Statistics. Funding amounts reflect the impact of sequestration in FY15, FY17, and FY22. Totals shown here comprise CHCF and discretionary funding. CHCF funding in nominal terms was $3.6 billion for FY15–FY18, $4 billion for FY19–FY21, and $3.9 billion for FY22.*

FIGURE 6. Real Per-Patient Federal Health Center Funding



Source: *Author's calculations.*
Note: *Patient data are not yet available for 2022. The number of patients treated in 2022 is assumed to be the same as in 2021.*

Conclusion

Community Health Centers play an important role in providing quality healthcare to those in need, and evidence shows that these centers generate cost savings. While federal funding for health centers has increased in nominal terms since 2015, inflation in the cost of medical care and the growth in the patient population these centers serve have resulted in a 30 percent funding decline in per-patient inflation-adjusted terms. For this reason, an increase in funding for Community Health Centers is warranted. Specifically, to achieve the same real, per-capita spending level established in 2015, federal funding should be increased by $2.1 billion.

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ABOUT MGA

MGA is an economic policy consulting firm in Washington, DC. Founded by Alex Brill in 2007, MGA specializes in healthcare, tax, and fiscal policy. Drawing on years of policy experience, the MGA team uses analytics to help identify, quantify, and solve economic policy problems. On behalf of clients, MGA conducts original data analysis, constructs economic models, conducts research, writes white papers and expert reports, and offers strategic advice.

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