Community Health Centers on the Eve of the COVID-19 Pandemic: An Overview of Findings from the 2019 Uniform Data System

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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 2019, on the eve of the COVID-19 pandemic, federally-funded and look-alike community health centers served over 30 million medically underserved patients across thousands of rural and urban communities. In 6 states and the District of Columbia, community health centers cared for at least 3 in 10 Medicaid/CHIP beneficiaries. Since the start of the COVID-19 crisis, community health centers have played a vital role in making COVID-19 testing and care available in the poorest and most at-risk communities. They also have experienced financial losses estimated at nearly $2.9 billion to date as the pandemic has forced a major rollback in other services, site closures, and staff layoffs. The Community Health Center Fund — accounting for over 70 percent of federal health center operating grant revenue — will expire at the end of November 2020, even as patient revenue remains far below levels needed to sustain services.

Introduction

Community health centers represent the nation's single most important source of comprehensive primary health care in medically underserved rural and urban communities. Community health centers also play a vital role as health care first responders in times of public health emergency; the most recent example of this role is the COVID-19 pandemic, whose worst impact has been experienced by the very communities and populations that depend on health centers for their care.

Findings from the 2019 Uniform Data System

The federal Uniform Data System (UDS) reports annually on community health center patients, services, staffing, and revenue, along with measures focused on the quality of their care. The latest data from calendar year 2019 show that, on the eve of the pandemic, community health centers were positioned to assume an integral role in the national coronavirus response.

Community health centers serve one in eleven people in the U.S.

In 2019, 1,385 federally-funded community health

Community Health Centers: A National Snapshot, 2019

1,385 federal grantees operating in 12,785 sites

58% of grantees in urban locations
42% of grantees in rural locations

29.8 million patients served

122.8 million clinic and virtual visits, including:

81.3 million medical visits
17.3 million dental visits
14.1 million behavioral health visits
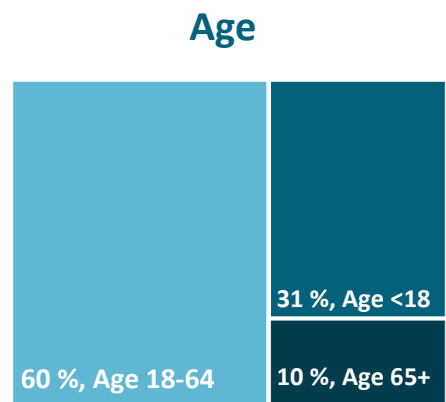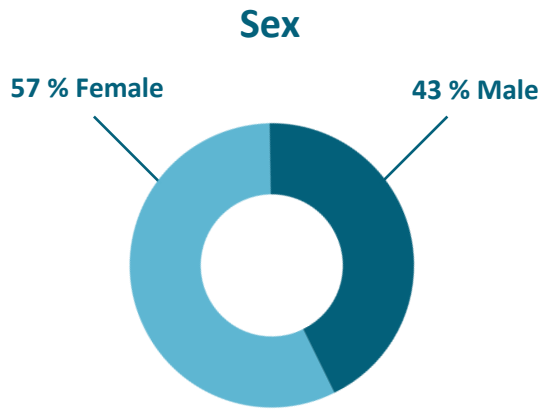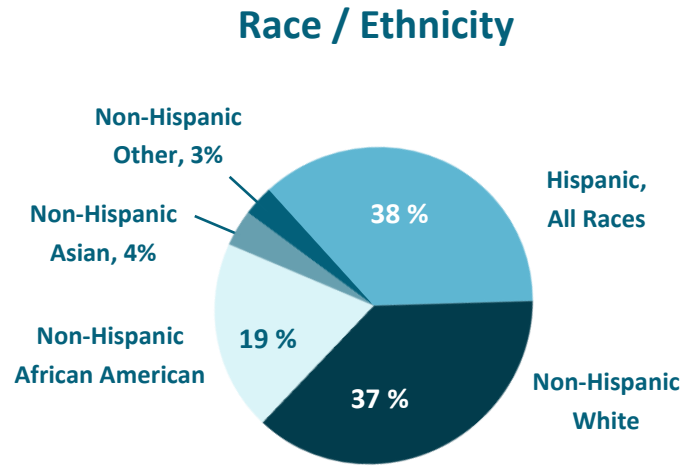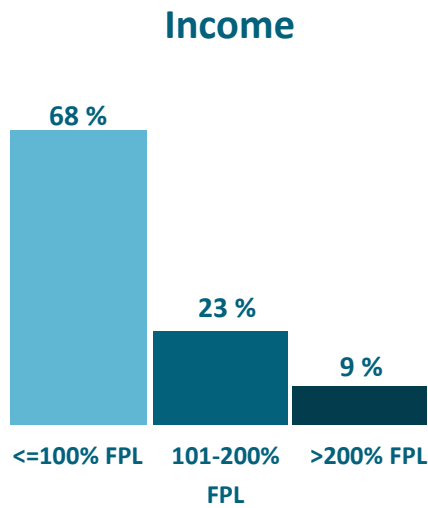*6.4 million enabling services visits*

72 "look-alikes" operating 237 sites

595,030 patients
2.36 million visits

SOURCE: Health Resources and Services Administration. (2020). 2019 Health Center Data: National Data. https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2019; Health Resources and Services Administration. (2020). 2019 National Health Center Data: Health Center Program Look-Alike Data. https://data.hrsa.gov/tools/data-reporting/program-data/national-lookalikes/table?tableName=Full&year=2019; GW analysis of 2019 Uniform Data System (UDS) data, Health Resources and Services Administration.

centers served more than 29.8 million patients across 12,785 sites,[1] one in 11 residents nationwide.[2] Another 72 "look-alike" health centers, which meet federal grant funding requirements but receive base grant funding from other sources, served an additional

Figure 1. A Profile of Community Health Center Patients, 2019

Income

68 % — <=100% FPL
23 % — 101-200% FPL
9 % — >200% FPL

Race / Ethnicity

Hispanic, All Races — 38 %
Non-Hispanic White — 37 %
Non-Hispanic African American — 19 %
Non-Hispanic Asian, 4%
Non-Hispanic Other, 3%

Sex

57 % Female   43 % Male

Age

60 %, Age 18-64
31 %, Age <18
10 %, Age 65+

Notes: Percentages may not sum to 100% due to rounding. Income distribution reflects 21.4 million patients with known income. Race/ethnicity distribution reflects 28 million patients with known race and/or ethnicity (excluding patients reported as non-Hispanic unreported race and patients with unreported race and ethnicity). Source: Health Resources and Services Administration. (2020). *2019 Health Center Data: National Data.* https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2019

595,030 patients across 237 sites.[3] In all, both types of community health centers served over 30.4 million patients and provided over 125 million patient visits.

Community health center patients are overwhelmingly low-income and are disproportionately minority (Figure 1). In 2019, as in earlier years, 91 percent of all patients had incomes at or below 200 percent of the federal poverty level ($42,660 for a family of three in 2019) and nearly 70 percent had below-poverty income (defined as family income for a family of three at or below $21,330 in 2019).[4] About two in three patients (63 percent) in 2019 were racial/ethnic minorities.[5]

Community health center patients have increased steadily over time

Between 2000 and 2010 – prior to passage of the Affordable Care Act – the community health centers program had more than doubled **(Figure 2)**, rising from 9.6 million to 19.5 million patients. The Affordable Care Act (ACA) led to significant further growth, from 19.5 million to 29.8 million patients

[1] Bureau of Primary Health Care. (2020). 2019 National Health Center Data: *National Data*. Health Resources and Services Administration. https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2019; GW analysis of 2019 Uniform Data System (UDS) data
[2] HRSA. (2020). HRSA Health Center Program. https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf
[3] Bureau of Primary Health Care. (2020). 2019 National Health Center Data: Health Resources and Services Administration. https://data.hrsa.gov/tools/data-reporting/program-data/national-lookalikes/table?tableName=Full&year=2019; GW analysis of 2019 Uniform Data System (UDS) look-alike data. With the exception of this sentence, this brief's findings are limited to federally-funded health centers.
[4] The 2019 poverty guidelines was $12,490 for one person and $21,330 for a family of three. Office of the Assistant Secretary for Planning and Evaluation. (2019). 2019 Poverty Guidelines. https://aspe.hhs.gov/2019-poverty-guidelines
[5] HRSA. (2020). National Health Center Data. https://data.hrsa.gov/tools/data-reporting/program-data/national

served by federally-funded health centers, as a result of two policies: expansion of Medicaid; and establishment of the Community Health Center Fund, the purpose of which was to ensure that health center capacity could grow in advance of full implementation of the ACA insurance reforms, when the demand for health care was expected to increase dramatically. As expected, health centers achieved high overall growth between 2010 and 2019, with particularly striking growth in Medicaid patients — 341 percent over the entire 2000-2019 time period **(Figure 2)**. The number of privately-insured patients rose by 280 percent, underscoring health centers' role as a source of health care for patients insured through the ACA's health insurance Marketplaces. Notably, while the elderly remain a relatively modest proportion of health center patients (ten percent in 2019), the 2000-2019 time period also witnessed a 321 percent growth in the number of Medicare patients served.

Figure 2 also shows that the number of uninsured health center patients has been growing; after falling to 5.9 million in 2015, the number then gradually increased to 6.8 million in 2019. Some of this growth is likely attributable to overall patient growth, but it also mirrors a nationwide increase in the proportion of U.S. residents without health insurance, from 9.1 percent in 2017 to 9.5 percent in the first half of 2019.[6] Growth in the number of uninsured patients may also reflect underlying Medicaid trends; national data show a sizable decline in Medicaid-insured residents over this time period,[7] even as the proportion of poor workers with employer coverage remained flat. This suggests a loss of coverage rather than movement from Medicaid into employer plans. Factors that may contribute to declining Medicaid coverage include tighter eligibility rules and stricter

Figure 2. Patient Volume, By Payer, 2000-2019: Federally-Funded Community Health Centers
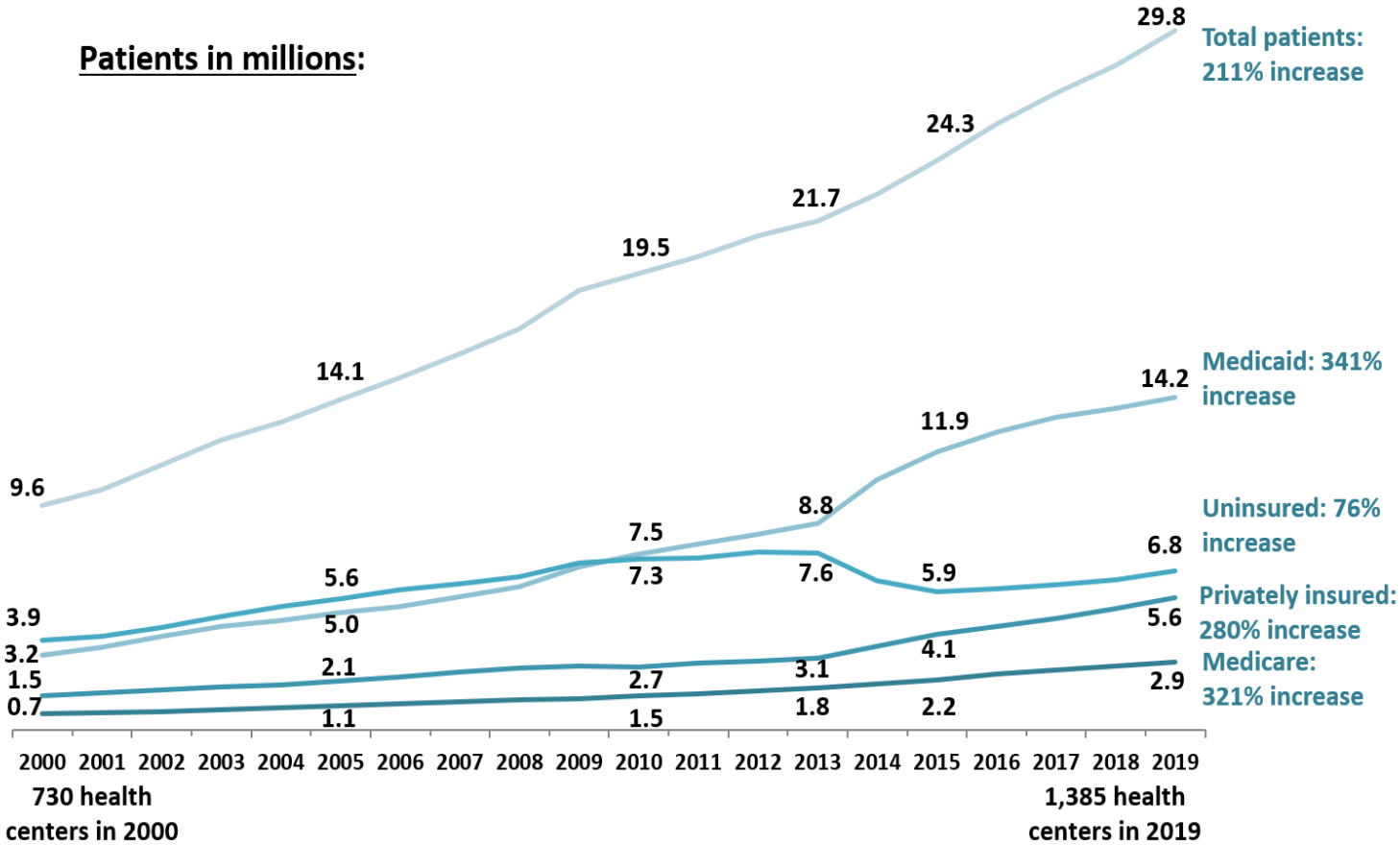
Notes: Patients with other public insurance are not shown. Numbers (in millions) are shown for 2000, 2005, 2010, 2013, 2015, and 2019.
Source: GW analysis of data reported in the 2000-2019 UDS national reports, Health Resources and Services Administration.

[6] Cohen, R.A., Terlizzi, E.P., Martinez, M.E., Cha, A..E. (2020). Health insurance coverage: early release of estimates from the National Health Interview Survey, January-June 2019. Washington, DC: National Center for Health Statistics. https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202005-508.pdf
[7] Kaiser Family Foundation. (2019). Analysis of Recent Declines in Medicaid and CHIP Enrollment. https://www.kff.org/medicaid/fact-sheet/analysis-of-recent-declines-in-medicaid-and-chip-enrollment/

requirements governing enrollment and renewal, as well as the Trump administration's public charge rule, which can result in denial of permanent legal residency status for immigrants who use Medicaid and other government benefits. This policy has had a major, documented chilling effect on enrollment in programs that can trigger such a finding.[8]

Continuing growth in the number of uninsured patients is also consistent with the results of an earlier survey of community health centers, carried out in partnership with the Kaiser Family Foundation. This 2019 survey found that nearly half (44 percent) of health center respondents reported an increase in coverage lapses for Medicaid or Children's Health Insurance Program (CHIP) patients in the past year, and that 32 percent reported an increase in coverage lapses for privately-insured patients.[9] The survey also found that 22 percent of responding health centers reported a decrease in Medicaid patients, with contributing factors being concerns among immigrant families about applying for or keeping Medicaid for themselves or their children, new procedural restrictions on enrollment and renewal, and new Medicaid eligibility requirements, such as the use of premiums and work requirements. The impact of the public charge rule has been especially important; a separate analysis of the survey data found that nearly half (47 percent) of health centers reported that some or many immigrant patients were refusing to enroll in Medicaid, while 38 percent reported that some or many children in immigrant families were refusing to enroll.[10] Similarly, 32 percent of health centers reported that some or many immigrant patients were dropping or refusing to renew their Medicaid coverage and 28 percent reported that some or many children in immigrant families were dropping or not renewing Medicaid.

The impact of the ACA's Medicaid expansion has been greatest in ACA Medicaid expansion states, but community health centers are major Medicaid providers in all states

The impact of the ACA's Medicaid reforms can be seen clearly on health center patients, underscoring both the reach of the expansion into the low-income population and the importance of community health centers, like other safety net providers, for insured patients living in underserved communities.

Between 2010 and 2019, Medicaid-insured patients grew by 9 percentage points (from 39 percent to 48 percent) while uninsured patients dropped by 15 percentage points (from 38 percent to 23 percent) **(Figure 3)**. This coupling of rising Medicaid and declining uninsured health center patients is an indicator of the extent to which, for the poorest Americans, the Medicaid reforms have provided a source of health insurance.

However, as **Figure 4** shows, growth in Medicaid patients has been concentrated in ACA Medicaid expansion states. In 2010, 41 percent of the patients served by community health centers in the 33 states and District of Columbia that adopted the ACA Medicaid expansion by 2019[11] were insured through Medicaid; by 2019, the proportion of Medicaid-insured patients in these jurisdictions had grown to 53 percent. By contrast, in 2010, the proportion of Medicaid patients in non-expansion states stood at 31 percent (a lower pre-ACA baseline compared to states that ultimately adopted the ACA expansion, since non-expansion states historically have tended to elect narrower Medicaid coverage).[12] By 2019, the proportion stood at 32 percent — a three percent increase from 2010 levels and virtually unchanged from 2013 (32 percent).[13]

[8] Bernstein, H., Gonzalez, D., Karpman, M., & Zuckerman, S. (2020). Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019. Urban Institute. https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019

[9] Sharac, J., Markus, A., Tolbert, J., & Rosenbaum, S. (2020). Community Health Centers in a Time of Change: Results from an Annual Survey. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/community-health-centers-in-a-time-of-change-results-from-an-annual-survey/

[10] Tolbert, J., Artiga, S., & Pham, O. (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-medicaid-enrollment-and-utilization-of-care-among-health-center-patients/

[11] Expansion status as of 2019. Note that five states that either implemented or acted to implement Medicaid expansions in 2020 (ID, MO, NE, OK, and UT) were categorized as non-expansion in this analysis. See Kaiser State Health Facts. (2020). Status of State Action on the Medicaid Expansion Decision. https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act

[12] Heberlein, M., Brooks, T., Artiga, S., & Stephens, J. (2013). Getting into gear for 2014: shifting new Medicaid eligibility and enrollment policies into drive. Kaiser Family Foundation. https://www.kff.org/medicaid/report/getting-into-gear-for-2014-shifting-new-medicaid-eligibility-and-enrollment-policies-into-drive/

[13] GW analysis of 2013 UDS data.

Figure 3. Health Insurance Coverage, Community Health Center Patients, 2010-2019
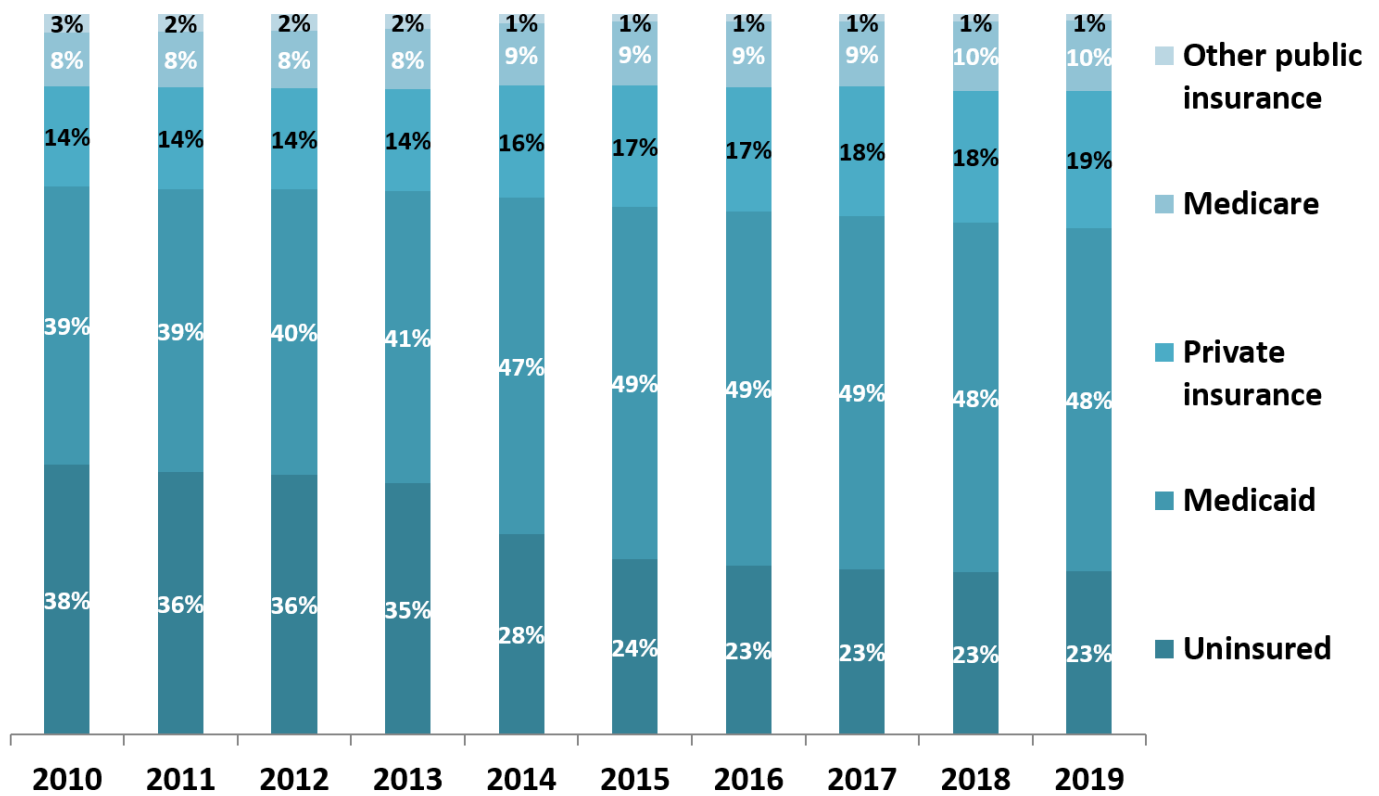
Notes: Percentages may not sum to 100% due to rounding. Source: GW analysis of data reported in the 2010-2019 UDS national reports, Health Resources and Services Administration.

Figure 4. Health Insurance Coverage, Community Health Center Patients by State Medicaid Expansion Status, 2010 and 2019
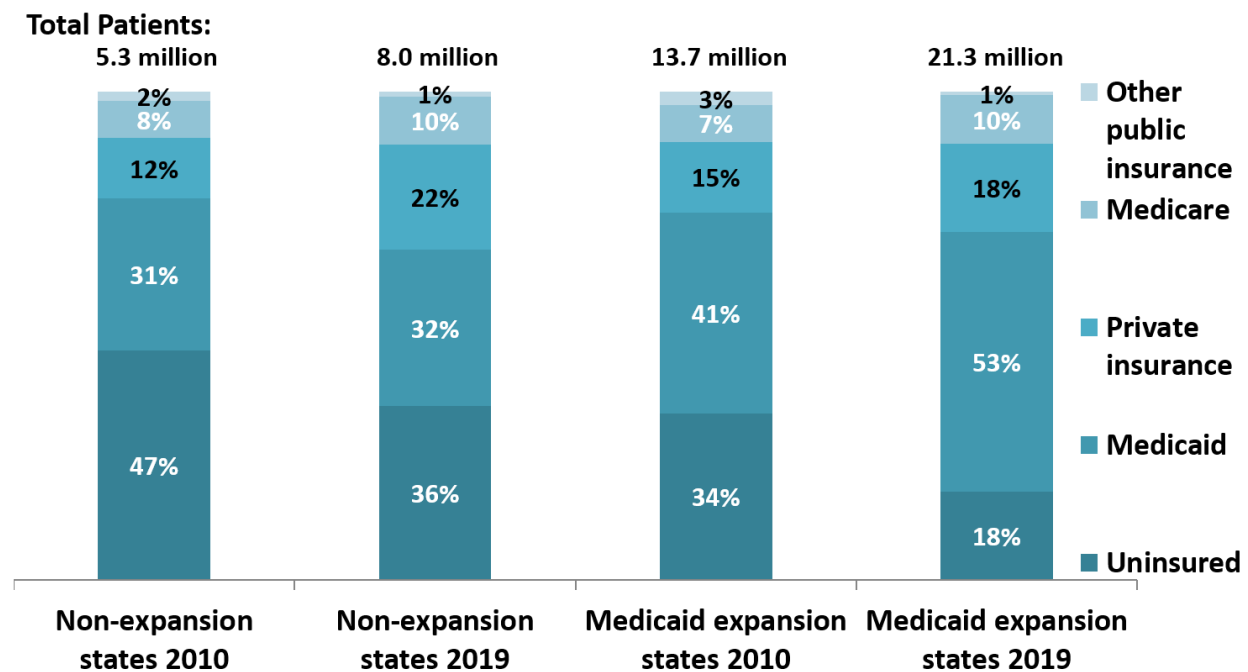
Note: Medicaid expansion as of 2019 (ID, MO, NE, OK, and UT were categorized as non-expansion). Data does not include health centers in U.S. territories/COFA states. Percentages may not sum to 100% due to rounding. Source: GW analysis of 2010 and 2019 UDS data, Health Resources and Services Administration.

Whether serving communities located in ACA Medicaid expansion or non-expansion states, health centers play a major role in Medicaid patient care, serving 1 in 5 Medicaid patients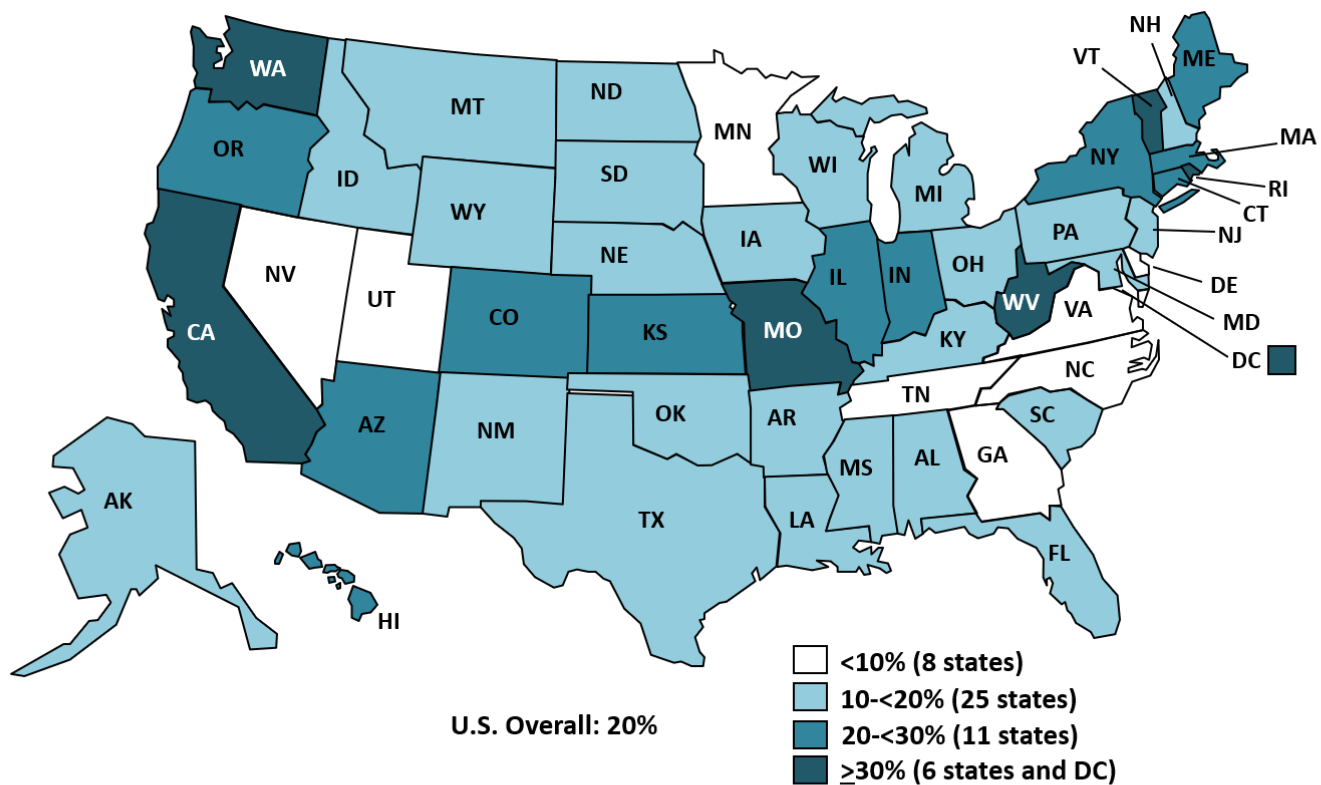 nationally.[13] In 2019, health centers in six states and the District of Columbia (DC) served at least 3 in 10 Medicaid/CHIP patients **(Figure 5)**.

Community health centers provide comprehensive care and are major community employers

Community health centers' care spans preventive and primary medical, dental health, vision care, and mental health and substance use disorder services, along with enabling services such as transportation and translation that make care accessible **(Figure 6)**. In 2019, health centers employed 252,868 full-time equivalent (FTE) staff members **(Figure 7)**, 34 percent of whom were medical providers. Their larger proportion of insured patients means that community health centers in Medicaid expansion states are able to provide significantly higher average staff-to-patient ratios, see significantly more patients on average, and average significantly more visits **(Table 1)**. Of note, in 2019, nearly all (99.6 percent) visits were conducted face-to-face in clinical settings rather than virtually (0.4 percent).

Figure 5. Proportion of Medicaid and CHIP Enrollees Receiving Care at Community Health Centers, by State, 2019

U.S. Overall: 20%

Legend:
- <10% (8 states)
- 10-<20% (25 states)
- 20-<30% (11 states)
- ≥30% (6 states and DC)

Note: US percentage does not include health centers in U.S. territories/COFA states.
Sources: GW analysis of 2019 UDS data (numerator), Health Resources and Services Administration, and CMS Medicaid/CHIP enrollment numbers for December 2019 (denominator); Kaiser State Health Facts. (2020). https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=4&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[13] HRSA. (2020). HRSA Health Center Program. https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf

Figure 6. Community Health Center Patient Visits, by Type of Service, 2019

Vision services, 1%
Other professional services, 2%
Substance use disorder services, 2%
Enabling services 5%
Mental health services, 10%
Dental services 14%
Medical services 66%
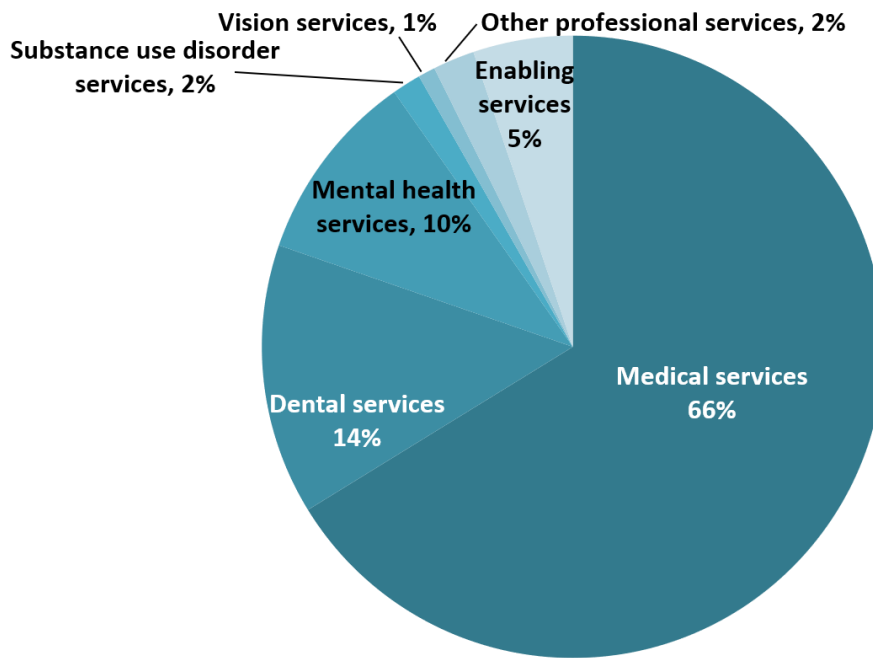
Total = 122,782,082 visits, including 122,303,749 clinic visits and 478,333 virtual visits

Source: Health Resources and Services Administration. (2020). *2019 Health Center Data: National Data.* https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2019

Figure 7. Community Health Center Personnel, by Service Category, 2019

Other staff, 4%
Pharmacy staff, 2%
Vision and other professional services staff, 1%
Behavioral health staff, 6%
Dental staff, 8%
Facility and non-clinical support staff, 35%
Enabling services, 10%
Medical staff, 34%
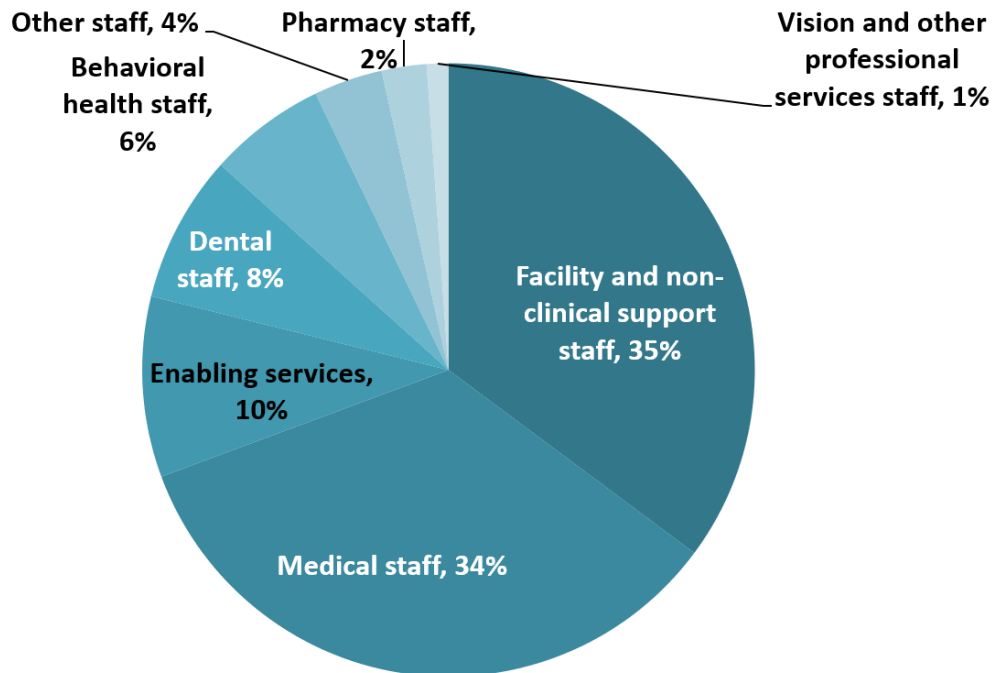
Total of 252,868 FTE staff members in 2019

Note: "Other staff" includes other programs/services and quality improvement staff. Source: Health Resources and Services Administration. (2020). *2019 Health Center Data: National Data.* https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2019

Table 1. Community Health Center Sites, Patients, Visits, and Staffing, by State Medicaid Expansion Status, 2019

	Health centers in non-expansion states	Health centers in Medicaid expansion states
Average number of health center sites	9.1	9.5
Average number of total patients*	19,409	22,670
Average number of total visits*	70,495	97,467
Average number of visits per patient*	3.6	4.3
Average number of full-time equivalent (FTE) staff per 10,000 patients		
Medical staff*	27.2	31.3
Dental staff*	6.3	7.6
Mental health services staff*	4.0	6.7
Substance use disorder services staff*	0.9	1.4
Enabling services staff*	8.2	11.0
Total staff*	81.0	100.5

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

Note: total visits include both clinic and virtual visits. Data excludes health centers in U.S. territories/COFA states. Medicaid expansion as of 2019 (ID, MO, NE, OK, & UT were categorized as non-expansion). Source: GW analysis of 2019 UDS data, Health Resources and Services Administration.

In 2019, certain trends regarding the nature of visits were notable, as shown in **Figure 8**, when mental health services were the dominant type of virtual visits (52 percent) and physical health conditions dominated (66 percent) in-office clinical visits. As **Figure 9** shows, by 2019, 60 percent of all community health centers employed substance use disorder services staff – triple the share offering such services in both 2000 and 2010.[14] In 2019, nearly 7,100 community health center physicians and advanced practice clinicians were certified to provide medication-assisted treatment (MAT) for opioid use disorder (OUD) and furnished care to 142,919 patients. Our recent nationwide survey of health centers found that, consistent with other services, community health centers in Medicaid expansion states were significantly more likely than those in non-expansion states to provide on-site MAT (70 percent

compared to 50 percent).[15] Similarly, based on an analysis of 2019 UDS data, health centers in expansion states were more likely to report having any clinical staff, either on-site or contracted, with the special certification (DATA waiver) required to furnish MAT services (75 percent versus 52 percent for health centers in non-expansion states), even though several of the non-expansion states rank among those with the highest opioid overdose death rates.[16]

Medicaid and federal health center grants are the financial base on which community health center operations rest

Health centers reported $31.4 billion in total revenue for 2019. As **Figure 10** shows, Medicaid was the largest source of health center revenue (43 percent) followed by federal grant funding under Section 330

[14] This method was used to make a comparison with 2000 and 2010 data. HRSA reported that "in 2019, 93 percent of health centers provided mental health counseling and treatment and 70 percent of health centers provided substance use disorder services"; these percentages were calculated by taking the number of health centers reporting these services in the scope of their project and dividing by the total number of active health centers (personal communication, BPHC). https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf

[15] Corallo, B., Tolbert, J., Sharac, J., Markus, A., & Rosenbaum, S. (2020). Community Health Centers and Medication-Assisted Treatment for Opioid Use Disorder. Kaiser Family Foundation. https://www.kff.org/uninsured/issue-brief/community-health-centers-and-medication-assisted-treatment-for-opioid-use-disorder/

[16] Kaiser Family Foundation. (2019). Medicaid's Role in Addressing the Opioid Epidemic. https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/

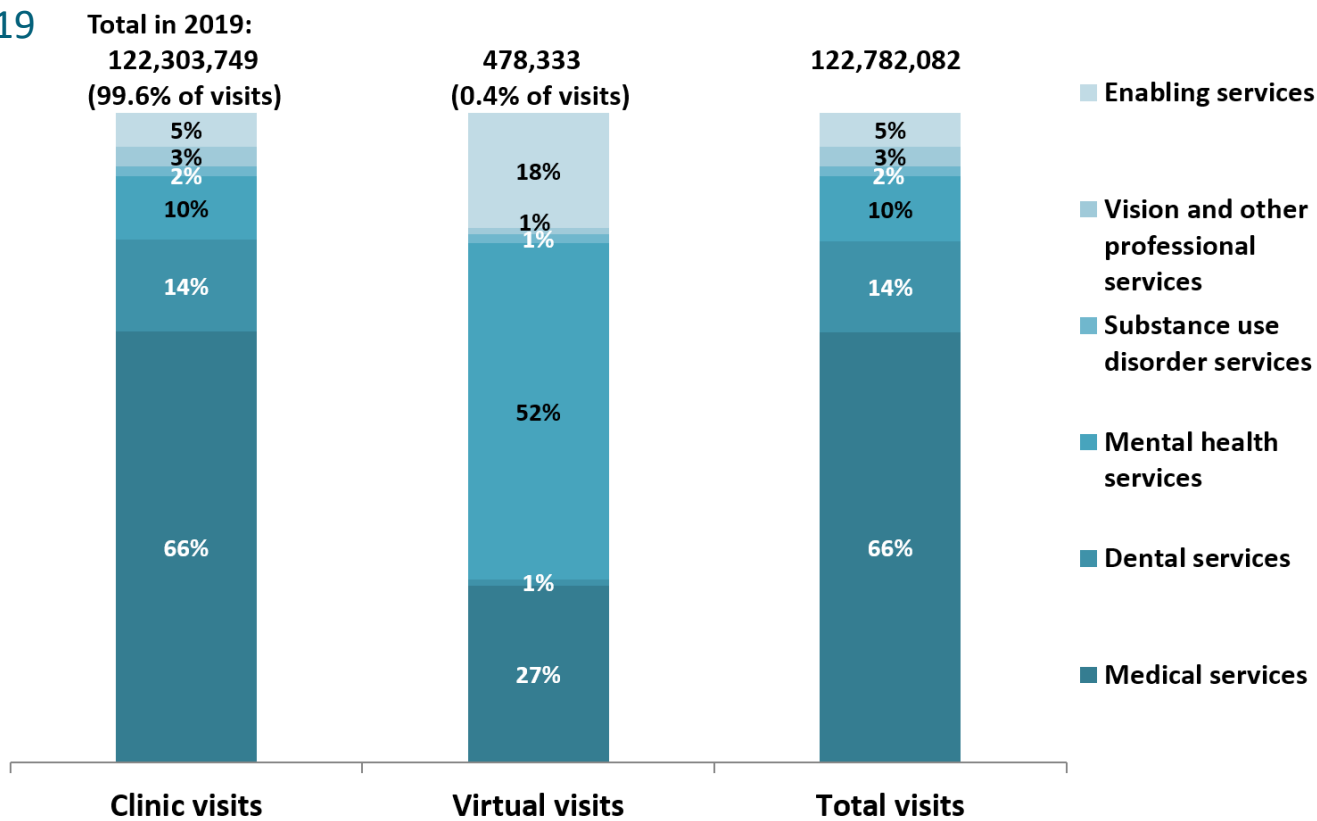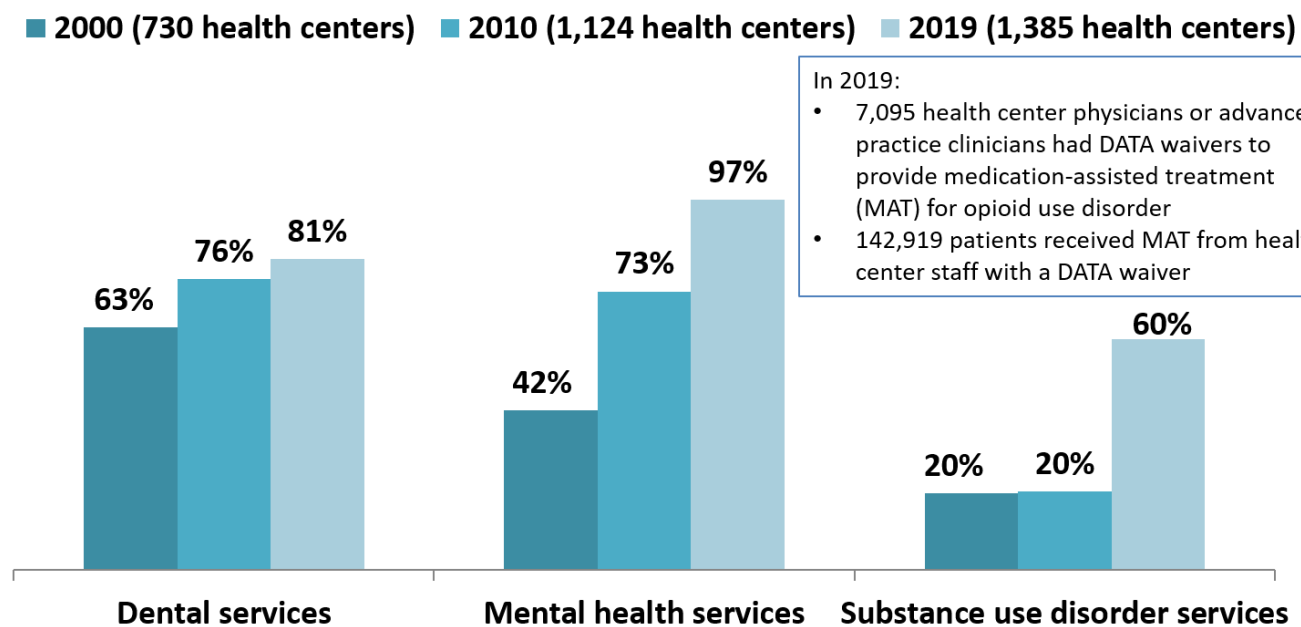## Figure 8. Community Health Center Clinic, Virtual, and Total Visits, by Type of Service, 2019

Total in 2019:

Clinic visits	Virtual visits	Total visits
122,303,749 (99.6% of visits)	478,333 (0.4% of visits)	122,782,082

Clinic visits: 5%, 3%, 2%, 10%, 14%, 66%

Virtual visits: 18%, 1%, 1%, 52%, 1%, 27%

Total visits: 5%, 3%, 2%, 10%, 14%, 66%

Legend (top to bottom):
- Enabling services
- Vision and other professional services
- Substance use disorder services
- Mental health services
- Dental services
- Medical services

Source: Health Resources and Services Administration. (2020). *2019 Health Center Data: National Data.* https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2019

Figure 9. Community Health Centers Providing Dental and Behavioral Health Services in 2000, 2010, and 2019

■ 2000 (730 health centers) ■ 2010 (1,124 health centers) ■ 2019 (1,385 health centers)

Dental services: 63%, 76%, 81%

Mental health services: 42%, 73%, 97%

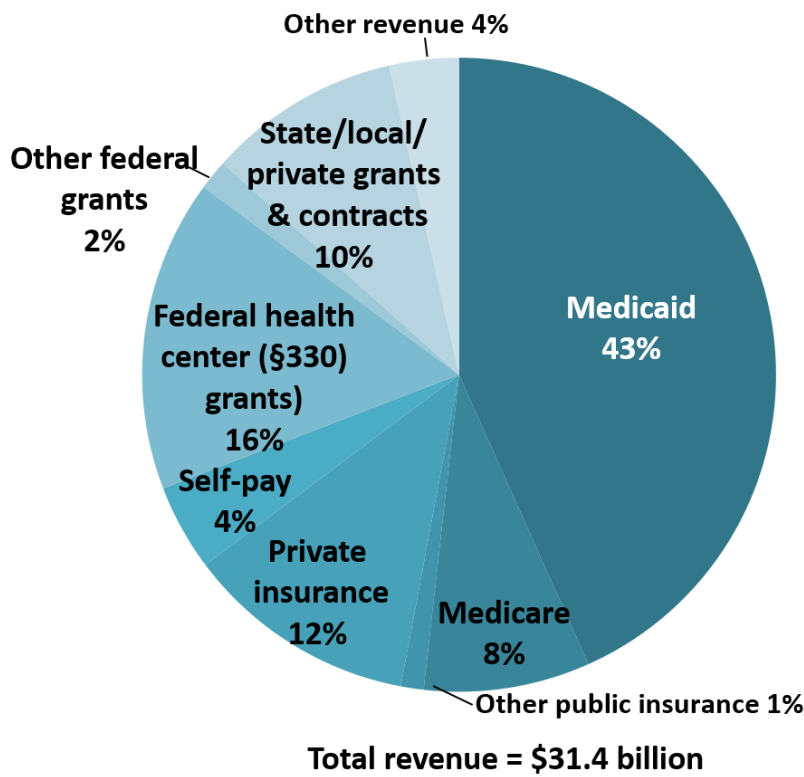**Substance use disorder services:** 20%, 20%, 60%

In 2019:
- 7,095 health center physicians or advanced practice clinicians had DATA waivers to provide medication-assisted treatment (MAT) for opioid use disorder
- 142,919 patients received MAT from health center staff with a DATA waiver

Note: Data reflect health centers that reported any dental, mental health, or substance use disorder (SUD) services staff. The 2019 UDS dataset also reports the number of MAT providers and patients, medical staff providing mental health services and medical and mental health staff providing SUD services, and mental health and SUD services provided through telemedicine, but these were not included in the calculation for 2019 for comparability with 2000 and 2010 data. SOURCES: GW analysis of 2000, 2010, and 2019 UDS data; Health Resources and Services Administration. (2020). *2019 Health Center Data: National Data, Table ODE: Other Data Elements.* https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=ODE&year=2019

Figure 10. Community Health Center Revenue, by Source, 2019

Other revenue 4%

State/local/ private grants & contracts 10%

Other federal grants 2%

Federal health center (§330) grants) 16%

Self-pay 4%

Private insurance 12%

Medicaid 43%

Medicare 8%

Other public insurance 1%

Total revenue = $31.4 billion

Source: Health Resources and Services Administration. (2020). *2019 Health Center Data: National Data.* https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2019

Figure 11. Community Health Center Revenue, by State Medicaid Expansion Status, 2010 and 2019

Total Revenue: $3.0 billion

| | 27% |
| 21% |
| 8% |
| 6% |
| 6% |
| 31% |

Non-expansion states 2010

$6.8 billion

15%, 23%, 7%, 18%, 9%, 28%

Non-expansion states 2019

$9.5 billion

29%, 14%, 5%, 7%, 6%, 40%

Medicaid expansion states 2010

$24.2 billion

17%, 14%, 4%, 10%, 8%, 48%

Medicaid expansion states 2019

Legend:
- Other grants and revenue
- BPHC grants
- Self-Pay
- Private insurance
- Medicare
- Medicaid
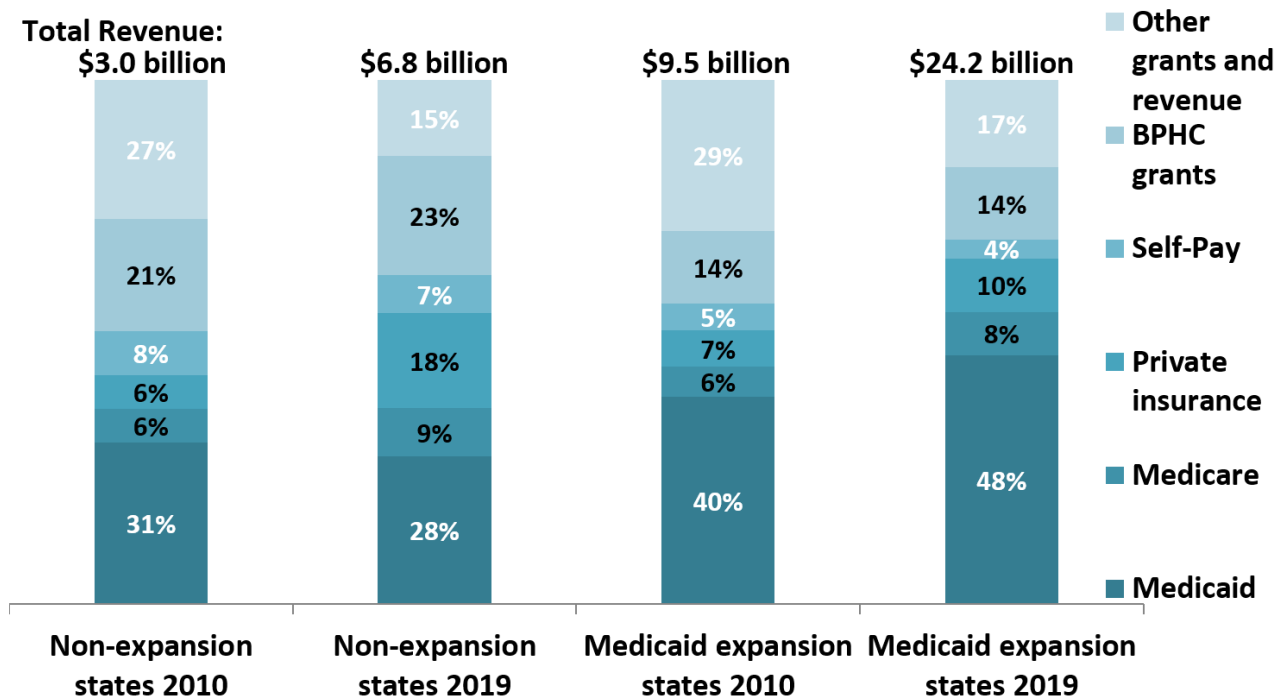
Note: Medicaid expansion as of 2019 (ID, MO, NE, OK, & UT were categorized as non-expansion). Data excludes health centers in U.S. territories/ COFA states. Percentages may not sum to 100% due to rounding. "Other grants and revenue" includes other public insurance revenue, other federal grants, non-federal grants and contracts, and other revenue. Source: GW analysis of 2010 and 2019 UDS data, Health Resources and Services Administration.

of the Public Health Service Act (16 percent). However, these nationwide financing percentages vary significantly when Medicaid expansion is taken into account; in expansion states, Medicaid revenue accounted for 48 percent of total revenue in 2019, compared to 28 percent in health centers in non-expansion states that year **(Figure 11)**. In both cases, Medicaid's special cost-related payment rules for services furnished by "federally qualified health centers" (as community health centers are known for Medicaid funding purposes) ensured that the proportion of revenue mirrored the proportion of Medicaid patients, but the Medicaid revenue differences between expansion and non-expansion states are striking.

In the years following enactment of the ACA, as **Table 2** shows, the health center revenue picture changed in important ways, with Section 330 grant funding rising somewhat as a percentage of total operations and then falling back to 2010 levels, revenue from Medicaid, Medicare, and private insurance steadily rising, and the percentage of revenue from self-pay patients or other sources falling. Despite the growing importance of Medicare and private health insurance to health center operations, Medicaid and federal grants remain the principal drivers of community health center operations and revenue.

How is the pandemic impacting community health centers?

By virtue of their location and mission, community health centers are at the epicenter of the COVID-19 pandemic. The health profile of health center patients on the eve of the pandemic (updated since our March 2020 report[17]) shows a patient population that experiences the range of socioeconomic,[18] demographic,[19] and health factors[20] — alone or in combination — that place them at highest risk for grave illness and death from COVID-19: 10 percent are elderly; 91 percent are low-income; over one-third

Table 2. Community Health Center Revenue, by Source, 2010-2019

Revenue	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total revenue (in billions)	$12.7	$13.9	$15.0	$15.9	$18.0	$21.0	$23.8	$26.3	$28.7	$31.4
Medicaid	38%	38%	38%	40%	42%	44%	43%	44%	44%	43%
Medicare	6%	6%	6%	6%	6%	7%	7%	7%	8%	8%
Private	7%	7%	7%	8%	8%	9%	9%	10%	11%	12%
Self-Pay	6%	6%	6%	6%	5%	4%	4%	4%	4%	4%
Federal health center grants	16%	17%	17%	18%	18%	18%	19%	18%	17%	16%
Other revenue	28%	27%	25%	23%	20%	18%	17%	17%	16%	16%

Note: Percentages may not sum to 100% due to rounding. "Other revenue" includes other public insurance revenue, other federal grants, non-federal grants and contracts, and other revenue
Source: GW analysis of 2010-2019 national UDS reports, Health Resources and Services Administration.

[17] Sharac, J., Shin, P., Velasquez, M., & Rosenbaum, S. (2020). In the COVID-19 Pandemic, Community Health Centers Are the Front Line for High-Risk, Medically Underserved Communities. GW Health Policy & Management Matters blog. http://gwhpmmatters.com/covid-19-pandemic-community-health-centers-are-front-line-high-risk-medically-underserved

[18] Koma, W., Artiga, S., & Neuman, T. (2020). Low-income and communities of color at higher risk of serious illness if infected with coronavirus: Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/

[19] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html; https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

[20] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html
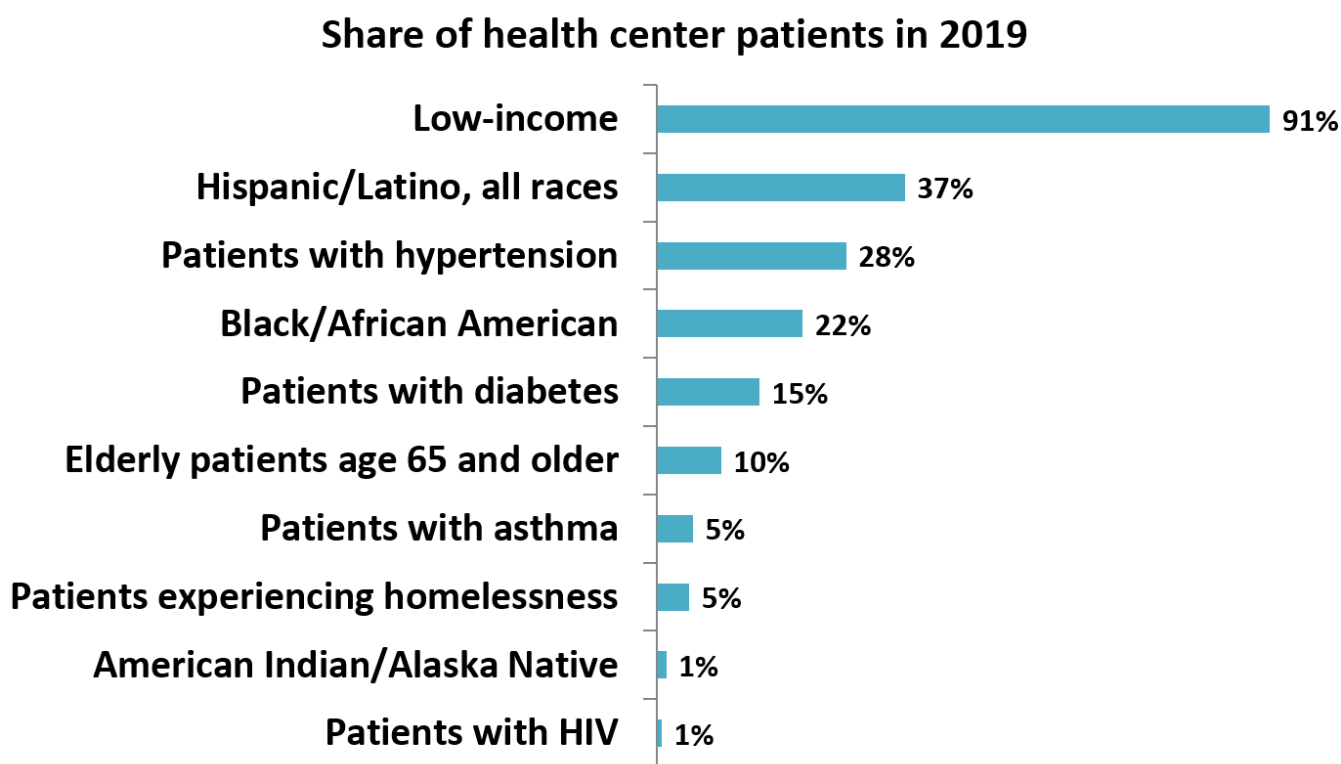
(37 percent) are Latino and 22 percent Black;[21] 28 percent of adults are diagnosed with hypertension; 15 percent of adults with diabetes; five percent of patients with asthma, one percent with HIV;[22] and five percent experience homelessness **(Figure 12)**.[23]

Weekly data collected by the federal Health Resources and Services Administration (HRSA) since early April 2020 has tracked community health centers' response to the pandemic. The HRSA survey measures focus on health centers' COVID-19 testing capacity, the number and race/ethnicity of patients tested for COVID-19 virus or antibodies, average turn-around times for test results, the adequacy of the supply of personal protective equipment (PPE), and measures of operational capacity. These weekly snapshots have provided important insight into the challenges health centers are facing in the COVID-19 response.

The August 21st weekly update shows that 97 percent of community health centers have testing capacity, but 32 percent continued to experience average test turn-around times of four or more days, seriously reducing the value of the tests. The loss of other primary health care capacity because of the need to ramp up for COVID-19 has been striking. As of August 21st, 953 community health center sites were closed -- 1 in 14 sites nationwide. One in 20 health center staff members was unable to work, and weekly patient visits were down by 20 percent compared to before the pandemic.[24] We estimate that by August 2020, cumulative revenue losses over 21 weeks reached

Figure 12. Community Health Center Patients at High Risk of Infection and Poor Outcomes for COVID-19, 2019

Share of health center patients in 2019

Low-income	91%
Hispanic/Latino, all races	37%
Patients with hypertension	28%
Black/African American	22%
Patients with diabetes	15%
Elderly patients age 65 and older	10%
Patients with asthma	5%
Patients experiencing homelessness	5%
American Indian/Alaska Native	1%
Patients with HIV	1%

Percentages reported by HRSA. The percentages of Black/African American and American Indian/Native American patients include both Hispanic and Non-Hispanic patients. The percentage of hypertensive patients is based on estimated adult medical patients aged 18-85 and the percentage of diabetic patients is based on estimated adult medical patients aged 18-75. Source: Health Resources and Services Administration. (2020). *National Health Center Data.* https://data.hrsa.gov/tools/data-reporting/program-data/national

[21] HRSA's reported percentage of Black/African American patients includes both Hispanic and Non-Hispanic patients.

[22] HRSA. (2020). National Health Center Data. https://data.hrsa.gov/tools/data-reporting/program-data/national

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[24] Sharac, J., Hernandez, J., Velasquez, M., Shin, P., & Jacobs, F. (September 2, 2020). Key Updates from the Health Center COVID-19 Survey (Week #21): Geiger Community Health Centers Reported Improved Turn-Around Times for COVID-19 Viral Test Results as They Conducted Nearly 218,000 Tests. Geiger Gibson/RCHN Community Health Foundation Research Collaborative Data Note. http://gwhpmmatters.com/key-updates-health-center-covid-19-survey-week-21-community-health-centers-reported-improved-turn

Figure 13. National Community Health Center Estimated Weekly and Cumulative Patient Revenue Losses over 21 Weeks, April-August 2020
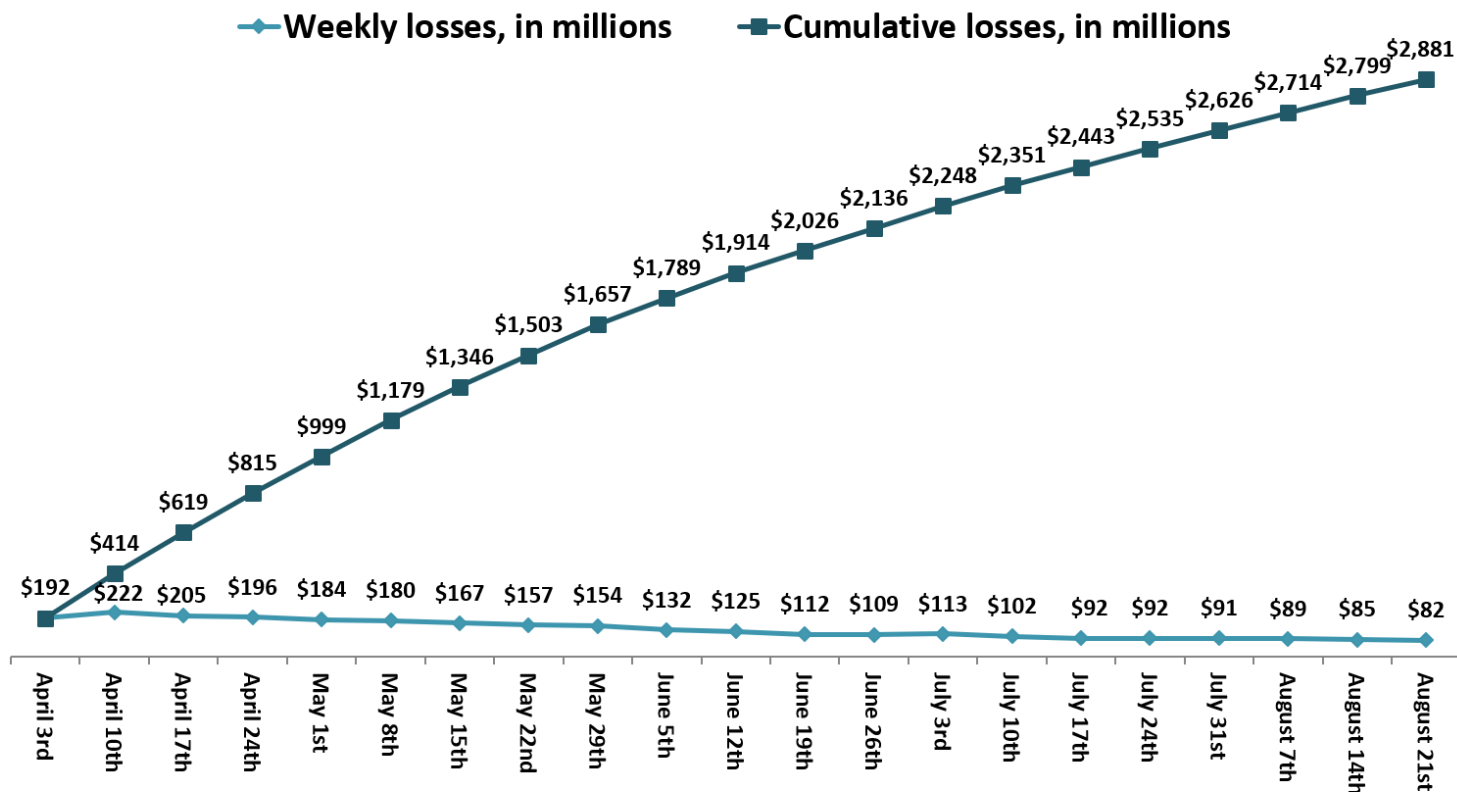
Note: Weekly patient revenue losses estimated based on the decline in weekly visits compared to pre-COVID-19 average weekly visits reported each week from the Health Center COVID-19 Survey and weekly patient revenue (total patient revenue reported for 2019 in the 2019 Uniform Data System, divided by 52). "National" includes federally-funded community health centers in the 50 states, DC, and U.S. territories/COFA states. Sources: Bureau of Primary Health Care (BPHC). (2020). Health Center COVID-19 Survey; HRSA. (2020). 2019 Uniform Data System data.

nearly $2.9 billion **(Figure 13)**, or nine percent of total revenue reported in 2019, up from an earlier estimate of $2.2 billion in losses based on 16 weeks of survey data and 2018 UDS data.[25]

Congress has appropriated approximately $2 billion in dedicated funding for COVID-19 testing and for maintaining health center staffing and operations,[26] and health centers also have been able to benefit from the Paycheck Protection Program.[27] They also have received limited help from the Provider Relief Fund and the Uninsured Claims Fund established by the Trump administration with the $175 billion appropriated under the CARES Act. But all community health centers depend for basic operations on the Community Health Center Fund, which accounts for over 70 percent of total Section 330 grant funding.[28] Without further action, the CHC Fund will expire at the end of November 2020, triggering a catastrophic revenue loss if not renewed.

Near-term and long-term challenges

Lawmakers have recommended that the next COVID-19 relief bill include $77.3 billion in funding for community health centers, including at least $7.6 billion in emergency supplemental funding and a five-year extension of the Community Health Center Fund, sufficient to maintain existing programs and services while addressing the extraordinary financial demands of the COVID-19 pandemic.[29] These financial demands include acquisition of PPE, modification of service delivery sites to ensure patient and staff protection, and other reforms aimed at adapting health centers to the needs of patients for both diagnostic testing and treatment. Ultimately these costs also include routine testing that increasingly may be required for essential workers, who are disproportionately low-income.

Beyond the services and costs attributable to the direct pandemic response lies the challenge of being

able to adapt health care practices designed for the poorest Americans to a world in which the traditional high-touch, high-contact way of doing things may no longer be possible. It also means being able to bring back urgently needed forms of health care that demand physical contact such as dental care, laboratory testing, medical procedures, and other health interventions for which virtual visits are a weak substitute at best. Also essential is upgrading virtual visit capacity in order to be able to maintain participating provider status for insurance billing and payment purposes.[30] In the early weeks of the pandemic, special restrictions on virtual visits were waived in order to allow patient services that do not meet normal HIPAA privacy and security rules. As health centers transition to a more permanent virtual service capability, these early procedures will need to be upgraded. Most challenging of all may be how to make the virtual visit model work for patients who overwhelmingly lack the technology to be able to take maximum advantage of virtual visits and other technology advances such as in-home patient monitoring as a substitute for frequent office visits.

All of this is playing out against a backdrop of historic community-wide unemployment, skyrocketing social risks, and elevated threats from poverty and its consequences, along with signs of insurance erosion.[31] These trends are in evidence in ACA Medicaid expansion states and non-expansion states alike. The deeper question becomes, how do health centers maintain the community resilience for which they are so well known?

[25] Shin, P., Sharac, J., Morris, R., Rosenbaum, S., & Jacobs, F. (August 3, 2020). As COVID-19 Surges, Community Health Centers Face Near-Term and Long-Term Funding Instability. Geiger Gibson/RCHN Community Health Foundation Research Collaborative Data Note. https://www.rchnfoundation.org/?p=9075

[26] https://bphc.hrsa.gov/program-opportunities/coronavirus-disease-2019; https://bphc.hrsa.gov/program-opportunities/cares-supplemental-funding: https://bphc.hrsa.gov/program-opportunities/expanding-capacity-coronavirus-testing-supplemental-funding

[27] https://www.nachc.org/wp-content/uploads/2020/07/Health-Centers-and-PPP-Loans-Final.pdf

[28] http://www.nachc.org/focus-areas/policy-matters/health-center-funding/federal-grant-funding/

[29] https://www.warren.senate.gov/imo/media/doc/CHC%20letter.pdf

[30] Morris, R., Hernandez, J., Rosenbaum, S., Jacobs, F., Shin, P., & Sharac, J. (2020). What Can We Learn from Telehealth Experience of Community Health Centers During the COVID-19 Pandemic? GW Health Policy & Management Matters Data Note. http://gwhpmmatters.com/what-can-we-learn-telehealth-experience-community-health-centers-during-covid-19-pandemic

[31] National Center for Health Statistics and the U.S. Census Bureau. (2020). Health Insurance Coverage: Household Pulse Survey. https://www.cdc.gov/nchs/covid19/pulse/health-insurance-coverage.htm; Dorn, S. (2020). The COVID-19 pandemic and resulting economic crash have caused the greatest health insurance losses in American history. Families USA. https://familiesusa.org/resources/the-covid-19-pandemic-and-resulting-economic-crash-have-caused-the-greatest-health-insurance-losses-in-american-history/