

# Community Health Centers Poised to Weather Uncertainty from the COVID-19 Pandemic: Lessons from the Past, Reflections on Federal Program Durability

Evan V. Goldstein, MPP

College of Public Health, Ohio State University, Columbus, Ohio 43210

## Introduction

Like most sectors of the U.S. health care system, federally-funded community health centers (CHCs) face new challenges imposed by the COVID-19 pandemic. Initial reports have suggested CHCs are already experiencing declines in primary and preventative care visits due to COVID-related factors.<sup>1</sup> Of greatest concern to primary care providers employed by CHCs will be projected short-term decreases in patient visits, decreases in patient revenue, and increases in employee job loss.<sup>2</sup> Since the outset of the pandemic in the U.S., the National Association of Community Health Centers (NACHC) has called for immediate financial relief to help CHCs continue to operate on the frontlines and provide high-quality primary care services in medically-underserved communities across the U.S. In late March, the federal government included several provisions in the Coronavirus Aid, Relief, and Economic Security (CARES) Act to increase flexibility and funding to help CHCs address immediate challenges associated with COVID-19. Notable provisions included \$1.32 billion in supplemental funding for fiscal year 2020, as well as a short-term funding fix for Community Health Center Fund.<sup>3</sup> Additional federal support will surely be needed to stem the losses caused by the COVID-19 pandemic. However, important lessons from the past and recent history serve to remind us that COVID-19 will not deliver a fatal blow to the federal CHC program – and most CHCs and their clinicians will weather this new storm of uncertainty while continuing to provide invaluable services to persons who need them most.

## Lessons from the Past: Surviving Uncertainty and Improving Federal Program Durability

CHCs have long endured financial and political uncertainty, and existential threats are nothing new.<sup>4</sup> The modern CHC's roots extend back to the public health movement of the late 1800s and early 1900s, when even the earliest community clinics were written off by opponents as unnecessary and wasteful "parasitism",<sup>5(p. 182)</sup> foreshadowing a line of argument made by those opponents still decades later following the birth of the contemporary CHC program.<sup>6</sup> Perhaps not surprisingly, CHCs' financial circumstances were perhaps most dire at the time of their emergence as a federal program in the 1960s. The federal government provided only minor investments in the nascent federal CHC program, despite making large and concurrent investments in hospitals through Hill-Burton and Medicare.<sup>6</sup> As a result, the earliest CHC program budget represented just 1.5% of federal expenditures, led by bureaucrats emphasizing jobs and community wellbeing – not health care innovation.<sup>7</sup> And yet, even though CHCs were expected to perish by the 1980s,<sup>4</sup> CHCs have never fatally succumbed to financial or political uncertainty. Rather, CHCs emerged over time to become a relatively "durable" federal program.

Program durability is broadly defined as "continuing to exist" and, more specifically, as the growth and enhancement of program effectiveness over time.<sup>8(p. 17)</sup> As described by Berry, Burden, and Howell<sup>9</sup>, a federal program can become more durable if the program can *demonstrate success* to policymakers. There are several ways to define the success of an organization. One technical definition posits that an organization is successful if it can exploit its environment to acquire scarce resources and sustain its functioning.<sup>10</sup> But for philanthropic organizations – organizations that seek to make an impact on the quality of life of individuals on a daily basis – success or effectiveness is perhaps best defined by the extent to which the organization fulfills its mission.<sup>11</sup> The mission of an organization is a powerful force that defines

its purpose,<sup>12</sup> as well as its commitment to making a difference in the world in which it operates.<sup>11</sup> Primary care providers in CHCs across the U.S. strive to fulfill a similar underlying mission: To deliver high-quality, culturally-competent, and comprehensive primary health services, as well as ancillary health and social services that promote access to care and wellbeing for people of all ages, regardless of their ability to pay.

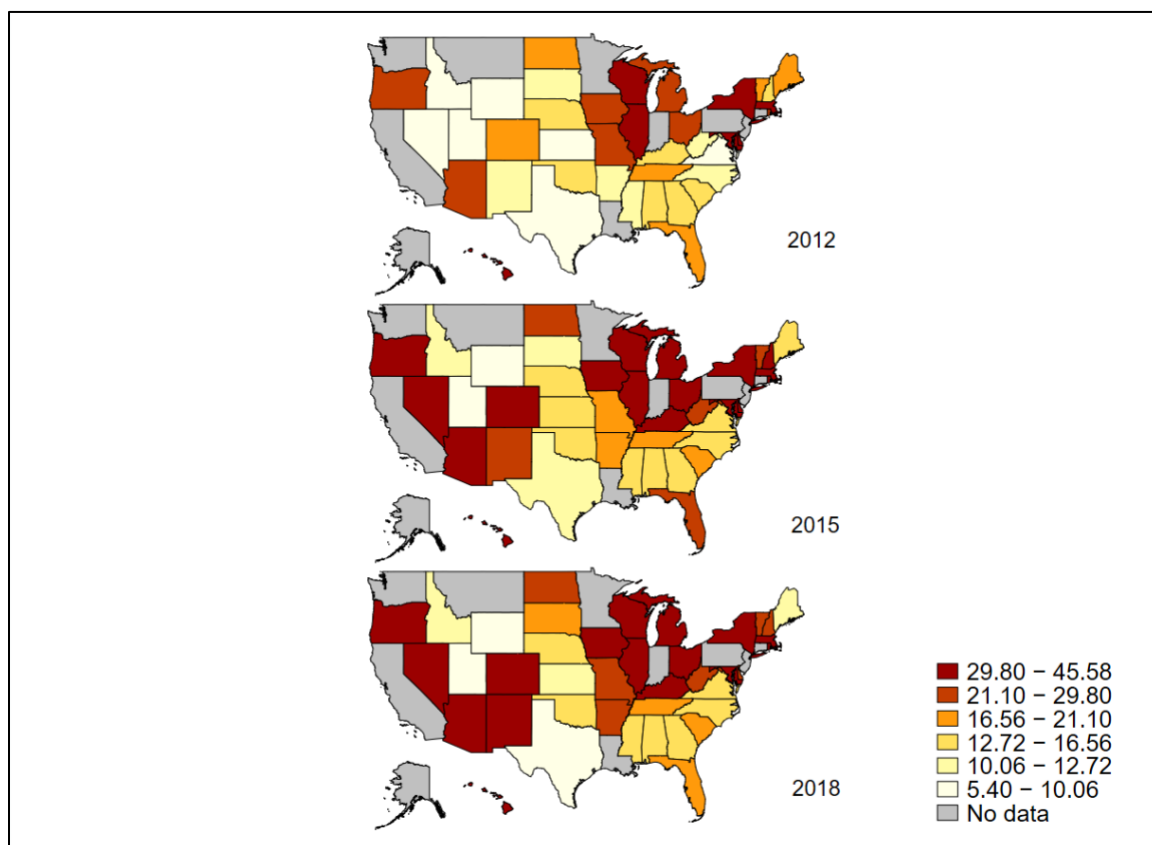
In the grander scheme of things, CHCs have grown over time and successfully pursued this mission, providing primary care and supportive services to over 28 million patients in 2018 alone.<sup>13</sup> However, to sustainably pursue this mission, modern CHC operations require sufficient and lasting sources of revenue, especially – and absent entitlement operational funding – patient Medicaid revenue. By the 1990s, all state Medicaid programs were required to cover CHC services included in each state’s Medicaid plan.<sup>14,15</sup> While federal operating grants and contracts once accounted for most CHC funding, patient Medicaid revenue eventually became the largest source of revenue for CHCs over time,<sup>14</sup> even though Medicaid revenue accounted for little initial CHC funding.<sup>5</sup> Today, Medicaid often reimburses CHCs more per encounter than any other payer,<sup>16</sup> and Medicaid eligibility expansions bring new financial opportunities for CHCs. The most recent of these opportunities came through the Affordable Care Act (ACA) Medicaid expansion, which gave states the option to expand Medicaid eligibility to individuals earning up to 138% of the FPL.

### **ACA Medicaid Expansion: A Case Study on Improving CHC Durability**

Twenty-four states chose to expand their Medicaid programs through the ACA at first opportunity in 2014.<sup>17</sup> Several early studies demonstrated that expansion-state CHCs experienced increases in Medicaid-covered visits,<sup>18,19</sup> increases in the share of patients covered by Medicaid,<sup>20</sup> and improvements in selected screening rates and process to care measures

immediately following the ACA Medicaid expansion.<sup>21</sup> Beyond these initial policy effects, in an analysis presented by the author elsewhere,<sup>22</sup> Figures 1 and 2 suggest there were also longer-term policy effects of the ACA Medicaid expansion on Medicaid coverage and uninsurance among CHC patients. Using Uniform Data System (UDS) Health Center Program Grantee data for all CHCs in the initial Medicaid expansion states from 2012 through 2018, Figure 1 illustrates the increase in the percentage of adult CHC patients with Medicaid coverage by state and over time.

**Figure 1. Percentage of Adult Health Center Patients with Medicaid, by State: 2012-2018**



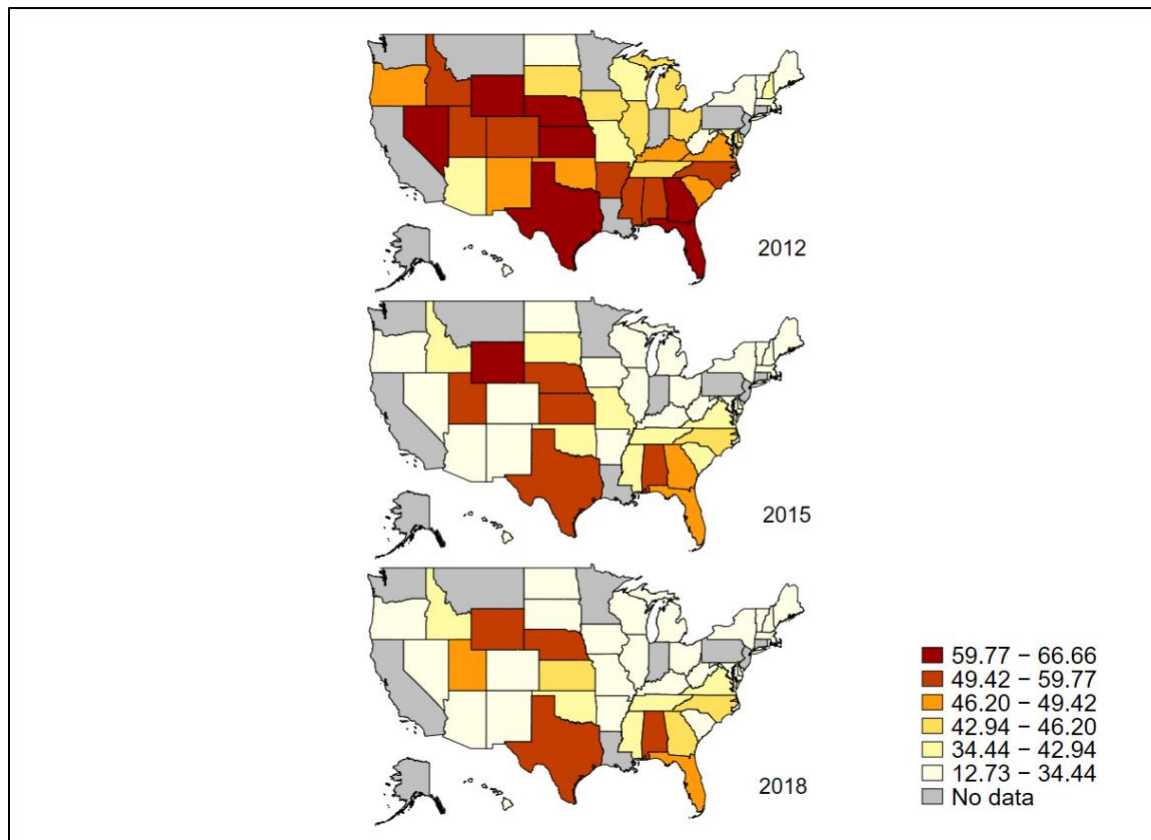
Notes: Percentage of adult CHC patients with Medicaid coverage by state and time. 2012 is baseline. Author calculation using UDS data from 2012-2018.

The number of states in which at least 29.8% of adult CHC patients had Medicaid coverage (6 states, including DE, HI, IL, MA, NY, WI) more than doubled (16 states, including AZ, CO, HI, IA, IL, KY, MA, MD, MI, NM, NV, NY, OH, OR, RI, WI) from 2012 to 2018. All but one of

those 16 states adopted the ACA Medicaid expansion at first opportunity in 2014 or previously.<sup>23</sup>

Figure 2 shows a commensurate decline in the percentage of uninsured adult CHC patients across the U.S. over the same period.

**Figure 2. Percentage of Uninsured Adult Health Center Patients, by State: 2012-2018**



Notes: Percentage of uninsured adult CHC patients by state and time. 2012 is baseline. Author calculation using UDS data from 2012-2018

These (and other multivariate analyses not yet published) suggest expansion-state CHCs were able to successfully navigate new policy environments, take advantage of new resources, decrease uninsurance among adult CHC patients, and increase the share of adult CHC patients covered by Medicaid. Moreover, CHCs seem to have largely retained most expansion-covered individuals as patients over time.<sup>22</sup> Expanding and *retaining* Medicaid coverage among CHC

patients provides critical protections to low-income patients and improves access to care within medically-underserved communities. Expanding Medicaid coverage among CHC patients also provides CHCs with the operational financial support needed for clinicians to provide high-quality services and to demonstrate success in pursuing their mission in communities across the U.S.

## **Conclusion**

Despite recent respite provided by the CARES Act, financial uncertainty induced by the ongoing COVID-19 pandemic will continue to vex CHC clinicians and other stakeholders. Aside from known federal and local funding challenges, new unknowns and macroeconomic and political concerns will undoubtedly continue to emerge. For example, how will the COVID-19 pandemic continue to affect CHCs over the months ahead? Or how will the looming federal court decision on the constitutionality of the ACA affect state Medicaid expansion decisions and CHCs' patient Medicaid revenue in the years to come? These and other questions will be answered in time. However, one thing is certain: Over 1,300 CHCs now comprise a “durable” federal program – one that is unlikely to either die outright or significantly change,<sup>9</sup> especially since their clinicians continue to *demonstrate success* by providing high-quality primary care services to persons who need them most. Lessons from the past remind us that CHCs know how to survive uncertainty, and more recent evidence from the post-ACA era suggests CHCs are well prepared to take advantage of new Medicaid eligibility expansions and expand their services in medically-underserved communities across the US, even if only incrementally. Today, despite the difficulties caused by the ongoing pandemic, CHCs are poised to navigate the uncertainty, to take advantage of changing policy environments, and to successfully pursue their mission.

## References

1. National Association of Community Health Centers. Community Health Centers Fight for Survival in COVID-19 Pandemic. <http://www.nachc.org/community-health-centers-fight-for-survival-in-covid-19-pandemic/>. Published 2020.
2. National Association of Community Health Centers. *Health Centers on the Front Lines of COVID-19: \$7.6 Billion in Lost Revenue and Devastating Impact on Patients and Staff.*; 2020. <https://www.nachc.org/wp-content/uploads/2020/04/Financial-Loss-Fact-Sheet.pdf>.
3. National Association of Community Health Centers. *Summary of Key CHC Provisions in the CARES Act.*; 2020. file:///C:/Users/golds/Downloads/CARES-Act-Summary-for-Health-Centers-4-1-20.pdf.
4. Sardell A. *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1986*. Pittsburgh, PA: University of Pittsburgh Press; 1989.
5. Starr P. *The Social Transformation of American Medicine*. New York, NY: Basic Books; 1982.
6. Hoffman BR. *Health Care for Some : Rights and Rationing in the United States since 1930*. Chicago, IL: The University of Chicago Press; 2012.
7. Lefkowitz B. *Community Health Centers : A Movement and the People Who Made It Happen*. Piscataway, NY: Rutgers University Press; 2007.
8. Thompson FJ. *Medicaid Politics : Federalism, Policy Durability, and Health Reform*. Washington, D.C.: Georgetown University Press; 2012.
9. Berry CR, Burden BC, Howell WG. After enactment: The lives and deaths of federal programs. In: *American Journal of Political Science*. Vol 54. ; 2010:1-17. doi:10.1111/j.1540-5907.2009.00414.x
10. Yuchtman E, Seashore S. Factorial analysis of organizational performance. *Adm Sci Q*. 1967;12(3):377-395.
11. Sheehan RM. Mission accomplishment as philanthropic organization effectiveness: Key findings from the excellence in philanthropy project. *Nonprofit Volunt Sect Q*. 1996;25(1):110-123. doi:10.1177/0899764096251008
12. Wright BE, Pandey SK. Public Organizations and Mission Valence: When Does Mission Matter? *Adm Soc*. 2011;43(1):22-44. doi:10.1177/0095399710386303
13. HRSA. 2018 National Health Center Data. <https://bphc.hrsa.gov/uds/datacenter.aspx>. Published 2019.
14. MACPAC. Federal Legislative Milestones in Medicaid and CHIP. <https://www.macpac.gov/federal-legislative-milestones-in-medicaid-and-chip/>. Published December 2018.
15. U.S. Congress. *H.R.3299 - Omnibus Budget Reconciliation Act of 1989*. Congress.Gov; 1989. <https://www.congress.gov/bill/101st-congress/house-bill/3299>.

16. CHRT. Federally Qualified Health Centers: An Overview. <https://chrt.org/publication/federally-qualified-health-centers-overview/>. Published 2013.
17. Foundation KF. 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/>. Published 2019.
18. Hoopes MJ, Angier H, Gold R, et al. Utilization of community health centers in medicaid expansion and Nonexpansion States, 2013-2014. *J Ambul Care Manage*. 2016;39(4):290-298. doi:10.1097/JAC.0000000000000123
19. Angier H, Hoopes M, Gold R, et al. An early look at rates of uninsured safety net clinic visits after the affordable care act. *Ann Fam Med*. 2015;13(1):10-16. doi:10.1370/afm.1741
20. Han X, Luo Q, Ku L. Medicaid expansion and grant funding increases helped improve community health center capacity. *Health Aff*. 2017;36(1):49-56. doi:10.1377/hlthaff.2016.0929
21. Cole MB, Galárraga O, Wilson IB, Wright B, Trivedi AN. At federally funded health centers, medicaid expansion was associated with improved quality of care. *Health Aff*. 2017;36(1):40-48. doi:10.1377/hlthaff.2016.0804
22. Goldstein E V., Seiber EE. Have Community Health Centers Become the Preferred Home of Medicaid Expansion Enrollees? In: *AcademyHealth 2020 Annual Research Meeting*. In-person meeting canceled due to COVID-19.; 2020.
23. Foundation KF. States Getting a Jump Start on Health Reform's Medicaid Expansion. <https://www.kff.org/health-reform/issue-brief/states-getting-a-jump-start-on-health/>. Published April 2012.