# Data Note

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## *As COVID-19 Surges, Community Health Centers Face Near-Term and Long-Term Funding Instability*

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Community health centers (CHCs) are the nation's largest source of primary health care for medically underserved communities and populations. In 2018 (the most recent year of data from the Uniform Data System, the federal data repository maintained by the Bureau of Primary Care), **1,362 federally-funded CHCs cared for 28.4 million patients** in nearly 12,000 locations. Another 84 look-alike (LAL) CHCs, which meet all requirements of the Health Center Program but do not receive federal health center grant funding, cared for an additional **885,031 patients that year**. By law and mission, **CHCs operate in the nation's poorest urban and rural communities** facing elevated health risks and a shortage of primary care.

CHC patients disproportionally live in communities with concentrated poverty and elevated social risks: **68 percent have below-poverty income, and 63 percent are racial/ethnic minorities**. As a result, they are at greater risk of poor health and **are more likely to have serious and chronic health conditions** such as diabetes, cardiovascular disease, chronic obstructive pulmonary disease, and asthma, all of which are **associated with severe COVID-19 illness**.

The Health Resources and Services Administration's (HRSA's) most recently reported **survey data on health centers' response to, and impact from, the COVID-19 pandemic** show that in one week in mid-July, **CHCs tested more than 231,000 patients for the COVID-19 virus**; two-thirds of patients who tested positive were racial or ethnic minority patients. Over the 15 weeks that HRSA has been reporting CHC COVID-19 testing data,[1] CHCs have tested more than 2 million patients for COVID-19 infection and health center patients who tested positive for COVID -19 virus accounted for approximately 1 in 13 of all COVID-19 cases nationally.

The HRSA survey data also document the toll that the pandemic has taken on health centers. For the **week of July 17th**, approximately one in ten sites nationally were closed, six percent of health center staff members were unable to work, and weekly visits were 22 percent lower than before the pandemic. While these figures are much lower than the early-April peaks (when 17 percent of all sites were closed, staffing was reduced by 16 percent, and weekly visits were down 53 percent), they nonetheless indicate substantial, ongoing losses of operational capacity.

### CHCs Are Facing Critical Patient Revenue Losses

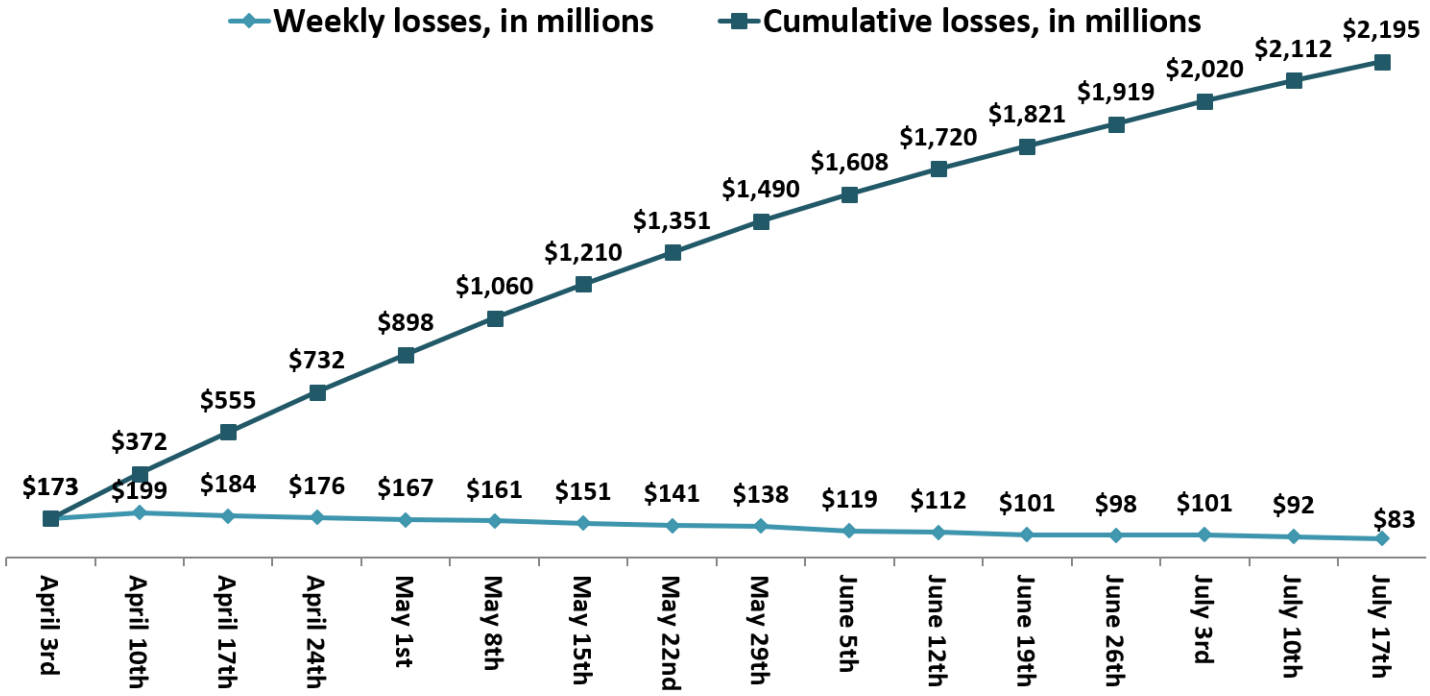
Like other primary care providers, CHCs depend heavily on health insurance to fund operations. For CHCs, which serve largely low-income patients, Medicaid is the principal source of insurance, accounting for **44 percent of CHC total revenue in 2018**. Medicaid and other patient insurance revenue is critical to maintaining basic primary care capacity for children and adults, as well to meeting the surge in need created by COVID-19.

CHCs are experiencing serious patient revenue losses. **Figure 1** shows that cumulatively, **between April 3 and July 17, 2020 (16 weeks), CHCs nationally experienced an estimated $2.195 billion in patient revenue losses**. **Table 1** presents state-by-state estimates of cumulative CHC revenue losses, ranging from $2.4 million in Wyoming to $446.6 million in California. The average weekly national CHC revenue loss over this time period stands at over $137 million. Revenue losses have declined as patient visits have begun to pick up and as states and **Medicaid managed**

[1] HRSA began reporting Health Center COVID-19 Survey data as of April 3rd, 2020, but began reporting patient testing data on April 10th, 2020.

care plans, whose primary care provider networks depend heavily on CHCs, appear to be moving toward advance payments such as monthly capitation in order to keep their networks afloat. Despite this, we estimate a **continuing, major patient revenue decline for the most recent week of $83 million** (**Figure 1**).

## Figure 1. National Community Health Center Estimated Weekly and Cumulative Patient Revenue Losses over 16 Weeks, April-July 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 2018 in the 2018 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; BPHC. (2019). 2018 Uniform Data System Data. HRSA.

### Other Sources of Funding Are Essential to Offsetting Steep Patient Revenue Losses, But They Are Inadequate and Their Future is Uncertain

Under Congressional COVID-19 relief funding legislation, CHCs have five principal sources of revenue to turn to in order to stem the effects of revenue losses:

- **The Paycheck Protection Program (PPP)**, which provided time-limited operational funding for employers, including nonprofit health care providers. The **National Association of Community Health Centers (NACHC) reports** that as of June 15th, 87 percent of CHCs received a total of $2.5 billion in PPP loans, with an average loan of $2 million per health center ($1.6 million for rural CHCs on average, and $2.3 million for urban CHCs on average). In 2018, health centers reported **total accrued costs of $28.1 billion**; with an average yearly cost of $20.6 million per health center. **This average PPP loan of $2 million will allow the typical CHC to operate just over one month**. **NACHC also reports** that 94 of the nation's largest CHCs were disqualified. While this is a relatively small number, these very large, multi-state CHCs care for **approximately three in ten CHC patients nationally**. Larger health centers may be eligible for the CARES Act's Main Street Lending Program since **the program's eligibility was recently expanded to include non-profit organizations**. However, **unlike PPP loans, these loans are not forgivable**.
- **The HHS Provider Relief Fund** was initially funded at $175 billion and was **recently expanded by another $4**

billion, but only for targeted hospital funding. The provider-specific data available for this Fund are incomplete, and it is therefore not possible to reliably know how much funding is flowing to CHCs. There is reason to believe, however, that CHCs are able to draw only limited support from the Fund. First, the entire special Fund for highly dependent Medicaid providers is **capped at $15 billion**. Second, providers that qualify for funding through the General Distribution Fund (those serving Medicare beneficiaries, which includes CHCs) are disqualified from obtaining additional funds through the targeted Medicaid fund, no matter how limited their General Fund draw. Indeed, CHCs are excluded **from the Medicaid Fund** even if they are simply eligible for General Fund revenue. Nearly all CHCs serve Medicare beneficiaries, thereby disqualifying them from the Medicaid fund. Third, although the Provider Fund data are incomplete, it is possible to see how some CHCs are faring under the General Fund recipient list, and the amounts are shockingly low. For example, Camuy Health Services in Puerto Rico, which served 15,350 patients in one of the Commonwealth's poorest communities, has received **$283 in General Fund assistance**. Wesley Community Health Center in Phoenix, Arizona, and El Centro de Corazon in Houston, Texas – both located in COVID-19 epicenters – have **received $1,405 and $1,497 in General Fund Assistance**, respectively.

- **The HRSA Uninsured Claims Fund**, separate from the Provider Relief Fund, offers potentially a third source of funding. The HRSA Uninsured Claims Fund operates with a $2 billion allocation for the entire nation. Data available from the Uninsured Claims Fund are also incomplete, and it is not possible to know reliably how much support is flowing to CHCs for their uninsured patients. As with the Provider Relief Fund, the payments that do show up on the list are shockingly low. For example, El Centro De Corazon in Houston, operating in a state in which approximately 1 in 5 residents is uninsured and whose patients were overwhelmingly uninsured (57 percent in 2018), reports paid claims from the Uninsured Claims Fund of **$2,057**. Refuah Health Center, which serves a medically underserved, low-income religious minority community of more than 68,000 patients just outside of New York City in Rockland County, New York, has received **$50**. Despite serving more than 100,000 patients, Unity Health Care in Washington, D.C. has received only **$1,086** in uninsured claims payments.
- **Supplemental COVID-19 grants**. In addition to general grant funding, Congress has appropriated a total of $1.999 billion in additional targeted COVID-19 grants for federally-funded CHCs over three separate emergency measures (COVID-19 (H8C) grants, CARES (H8D) grants, and ECT (H8E) grants) to support health centers' response to the COVID-19 pandemic. HRSA also recently awarded $17 million to LAL health centers to expand their testing capacity. Grants can be used to support COVID-19 testing and treatment and maintain overall capacity. **However, the total COVID-19 appropriation of $1.999 billion translates into an average $1.47 million in supplemental funding per federally-funded CHC grantee, less than would be required to keep an average CHC running for a month**.
- **Federal CHC general operating grant**. As noted, federally-funded CHCs receive general operating grants through Section 330 of the Public Health Service Act. Section 330 funds consist of the Community Health Center Fund (CHCF), originally authorized under the Affordable Care Act, and annual discretionary appropriations. CHC Section 330 grant funds account for about 17 percent of total revenue; for FY2019, Section 330 grant funding totaled $5.6 billion, with over 70 percent ($4 billion) from the CHCF and $1.6 billion from annual appropriations. This Fund is set to expire at the end of November 2020.

## Meeting the Needs of the Nation's Hardest-Hit Communities

As patient revenue continues to lag, and as the added costs of mounting an effective COVID-19 response in the nation's poorest communities continue to soar, additional short-term and long-term revenue emerge as critical to sustaining both core and expanded CHC operations. Chief among these needs are:

- Ensuring that the Paycheck Protection Program, when extended, is open to all CHCs.
- An additional infusion of targeted supplemental funding to support the CHC COVID-19 response and to enable CHCs to make critically important operational changes such as adding service sites, mobile services, patient

support and outreach staff, purchasing needed equipment, and providing additional support services to patients who are isolated and in quarantine.

- Revision of the HHS Provider Relief Fund to enhance help to providers with substantial Medicaid patient populations.
- Additional CHC funding under the HRSA Provider Claims Fund in order to defray the cost of caring for uninsured COVID-19 patients, including costs directly related to COVID-19 as well as for underlying conditions likely to complicate COVID-19 treatment and recovery.
- Long-term extension of the CHC Fund to eliminate the uncertainty surrounding the continued CHC basic appropriation and an increase in the size of the Fund during the period of public health emergency declaration to enable CHCs to sustain and expand both COVID-19 care and routine and ongoing primary health care services.

## Table 1: Cumulative losses of patient revenue at federally-funded community health centers due to weekly visit declines over 16 weeks, nationally and by state

| State | Estimated loss in patient revenue over 16 weeks | State | Estimated loss in patient revenue over 16 weeks |
|---|---|---|---|
| National | -$2,194,977,145 | MT | -$9,221,579 |
| AK | -$18,223,700 | NC | -$33,837,653 |
| AL | -$10,913,127 | ND | -$3,515,108 |
| AR | -$12,390,750 | NE | -$6,235,780 |
| AZ | -$35,465,593 | NH | -$5,285,208 |
| CA | -$446,595,676 | NJ | -$24,271,591 |
| CO | -$41,416,213 | NM | -$18,401,658 |
| CT | -$25,421,263 | NV | -$4,136,068 |
| DC | -$20,793,522 | NY | -$212,335,573 |
| DE | -$2,667,014 | OH | -$43,687,685 |
| FL | -$93,941,369 | OK | -$14,520,924 |
| GA | -$24,150,257 | OR | -$47,532,391 |
| HI | -$18,788,569 | PA | -$56,063,685 |
| IA | -$17,337,542 | PR | -$21,832,415 |
| ID | -$17,819,317 | RI | -$13,922,697 |
| IL | -$76,400,130 | SC | -$35,591,955 |
| IN | -$36,070,598 | SD | -$3,858,765 |
| KS | -$11,900,505 | TN | -$19,000,562 |
| KY | -$43,030,919 | TX | -$88,413,912 |
| LA | -$27,871,762 | UT | -$8,363,032 |
| MA | -$58,013,303 | VA | -$18,275,915 |
| MD | -$35,252,925 | VT | -$14,821,839 |
| ME | -$18,685,997 | WA | -$124,696,500 |
| MI | -$53,345,580 | WI | -$28,943,093 |
| MN | -$15,751,257 | WV | -$35,897,939 |
| MO | -$46,727,644 | WY | -$2,412,589 |
| MS | -$13,732,384 | | |

Note: Weekly patient revenue losses estimated based on the decline in weekly visits compared to pre-COVID-19 average weekly visits reported each week in the Health Center COVID-19 Survey and weekly patient revenue (total patient revenue reported for 2018 in the 2018 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 (BHPC). (2020). **Health Center COVID-19 Survey**; BHPC. (2019). **2018 Uniform Data System Data**. HRSA.