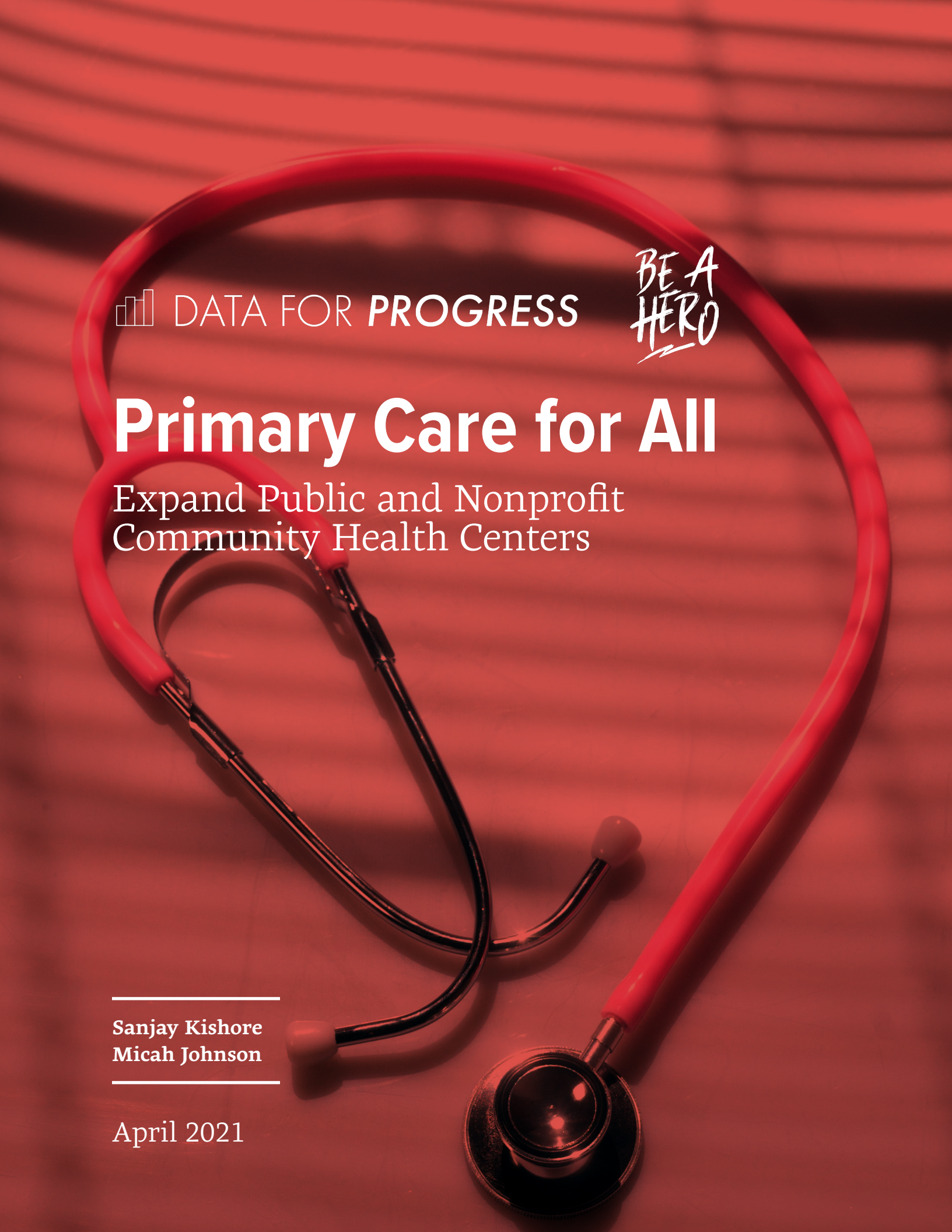


DATA FOR PROGRESS

BE A HERO

Primary Care for All

Expand Public and Nonprofit Community Health Centers

Sanjay Kishore
Micah Johnson

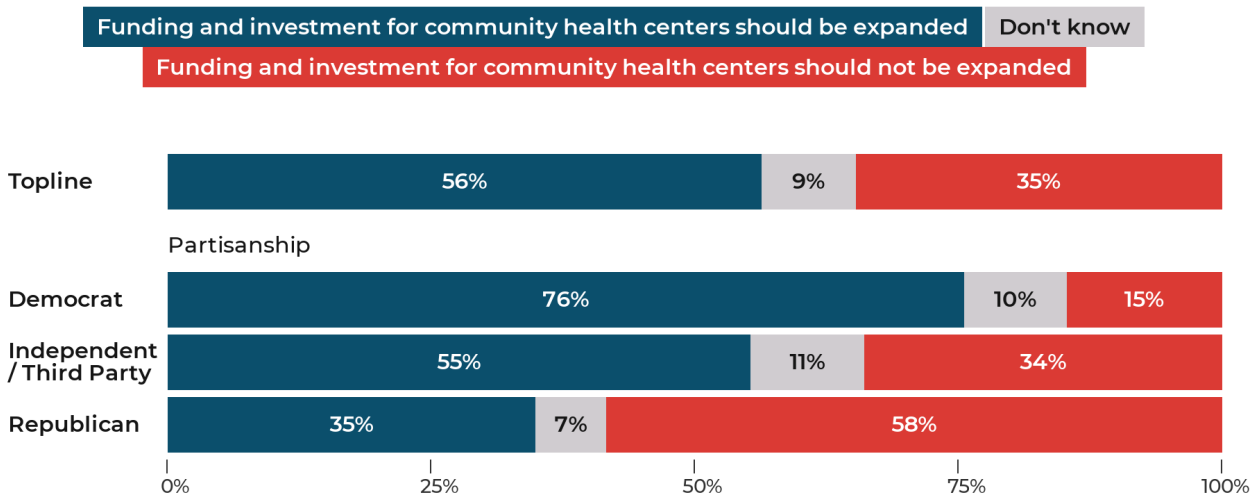
April 2021

Summary

- Access to basic medical care must be a right for all Americans, especially in the midst of the Covid-19 pandemic. To guarantee this, we need a stronger infrastructure for care: more investment in high-quality, public health care services. Federally-qualified health centers (FQHCs) are public primary care clinics that serve those in need, create jobs, have bipartisan appeal, and are consistently popular with voters.
- We propose dramatically expanding the FQHC program to build new clinics in every primary care shortage area, double federal funding for existing clinics, and support an additional 50,000 clinicians across the country who will care for 50 million Americans who currently lack reliable access to primary care.
- This expansion builds on the Biden-Harris Administration's "American Rescue Plan," which supports vaccine distribution in FQHCs and develops a public health job corps of 100,000 workers. Our proposal will require an investment of $150 billion over five years, including a $30 billion capital expenditure fund and COVID-era stabilization funds for existing clinics.
- There is strong public support for expanding FQHCs. Data for Progress conducted a poll of this proposal among 1,124 likely voters between January 29 and February 1, 2021, and found that 56% of all respondents supported this proposal compared to 35% who opposed. The proposal has majority support among both Democrats (75%) and voters who self-identify as Independents (55%).
- Rates of support were stable even when the question was asked with explicit partisan framing.

Voters Support Building New Publicly Owned Community Health Centers Even After Messaging

Voters were shown arguments for and against and then asked whether they support or oppose the proposal.



Jan 29 to Feb 1, 2021 survey of 1124 likely voters

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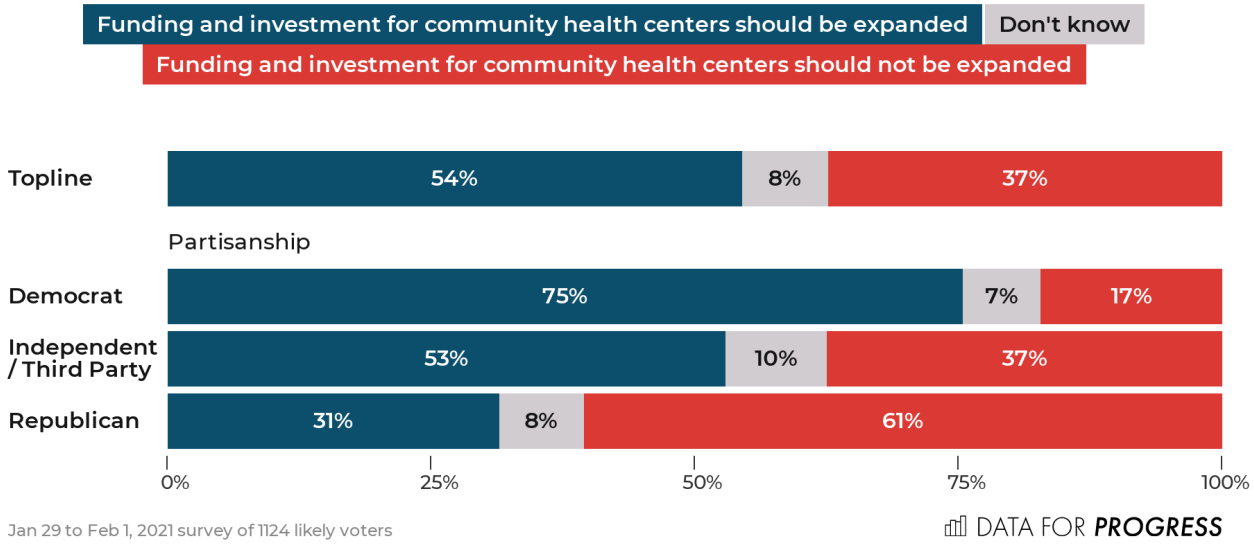

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Primary care is in crisis

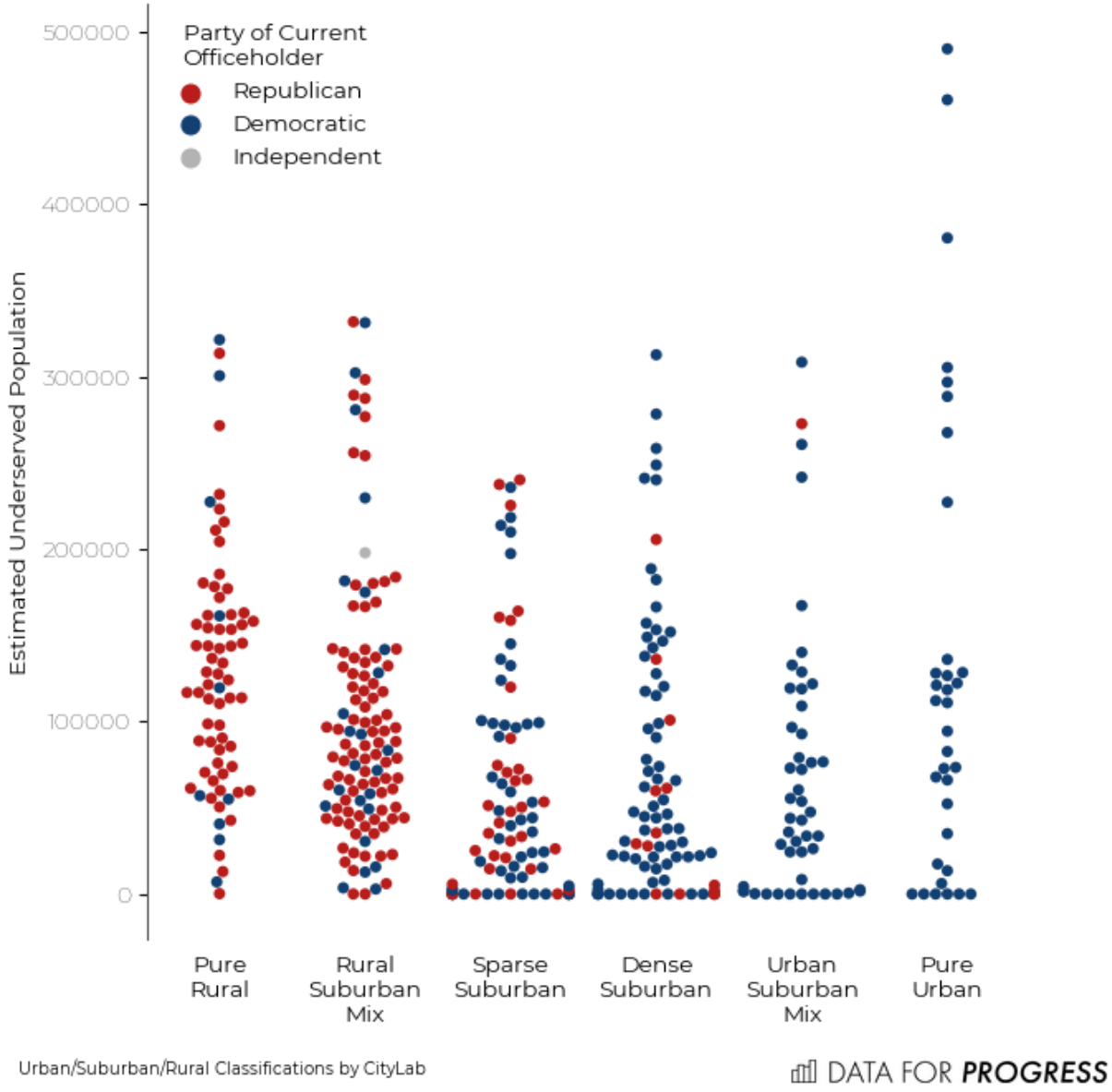
Primary care is the foundation of a functional health system, with a focus on building relationships, preventing disease, and addressing the social forces that shape health. It promotes efficient use of healthcare, lowering rates of unnecessary emergency department visits. It even decreases mortality.[1]

Yet, many lack access. Nearly 50 million Americans live in a primary care shortage area and are underserved.[2] Over 12% of Americans do not have a usual place they visit for medical care.[3] COVID has worsened the situation, with reports of 8% of primary care practices closing by August 2020.[4] At the same time, the pandemic has also highlighted the importance of primary care. The most affected groups, such as low-income, Black, and Brown patients, face worse health outcomes compared to patients with better access to primary care, in part due to higher rates of chronic conditions and less access to medical care.

The gaps in primary care are not divided by political party — they affect both rural and urban areas, and both historically conservative and historically liberal districts. As such, they represent an opportunity for significant and politically popular public investment from the new administration.

As we recover and rebuild, we must commit to more than increasing health insurance coverage; we must improve our public infrastructure for care. Thankfully, our nation already has a foundational program to guarantee primary care for all: federally-qualified health centers (FQHCs).

ESTIMATED UNDERSERVED POPULATION FOR PRIMARY CARE BY CONGRESSIONAL DISTRICT



Urban/Suburban/Rural Classifications by CityLab

DATA FOR **PROGRESS**

FQHCs are a model of public primary care

FQHCs are publicly-funded clinics that advance health equity and justice. FQHCs are federally-funded, community-based healthcare providers providing primary care services in medically underserved areas with predominantly low-income patients and communities of color. The first FQHC was established in 1965, the same year Medicare was written into law.

There are nearly 1,400 FQHCs operating over 10,000 service delivery sites in the U.S., serving almost 30 million Americans and spanning every U.S. state and territory, including the District of Columbia.[5] They are growing rapidly; the number of delivery sites has increased by 60% since 2009.[6] Nearly 70% of patients have incomes below the federal poverty level, and almost are members of racial or ethnic minority groups. Community health centers serve patients across all ages and who experience chronic conditions at higher rates than the general population. One in five rural residents obtains care from an FQHC, as well as one in five Americans who are uninsured.

They provide an important model for the public delivery of care. These clinics receive nearly 20% of their revenue from federal grants, 7% from Medicare, and 44% from Medicaid. Less than 10% of their revenue comes from private sources.[7] Health centers are operated by either sponsoring non-profit organizations or public agencies, such as county or municipal departments of health.[8]

FQHCs are key to the nation's COVID response. Through the first 9 months of the pandemic, FQHCs played a pivotal role in surveillance, providing COVID-19 tests to over 7 million patients in communities most at-risk. Now, they're playing a pivotal role in curbing the pandemic; in February 2021, the Biden-Harris Administration announced the launch of the FQHC Program for COVID-19 vaccination, which will direct doses to FQHCs in each state to further equity.[9] An analysis by the Kaiser Family Foundation in March demonstrated that over 50% of those who received their first vaccine dose at a health center were people of color.[10] Legislative drafts for Budget Reconciliation from the House Energy & Commerce Committee include $7.6 billion in funding for FQHCs to support COVID-19 vaccine and testing outreach as well as expansion of healthcare services.[11] Moving forward, the American Rescue Plan also calls for the development of a public health jobs corps of 100,000 workers that will partner with FQHCs to address COVID in the short term.[12] The corps will transition into community health roles to "build long-term public health capacity and improve quality of care and reduce hospitalizations for underserved and low-income communities."

Health centers are comprehensive, high-quality, and accountable. By statute, FQHCs must provide comprehensive services, including primary care, mental health, dental care, and vision. Many also provide urgent care services. They also must accept all patients, regardless of immigration or insurance status, and at least 51% of their Board of Directors must consist of patients from the communities the center serves. Community members on the board must be representative of the center's patient population across demographic factors such as race, ethnicity, and gender. In 2017, the Congressional Research Service found that FQHCs provide services with quality that rivals or is superior to care provided at private clinics.[13]

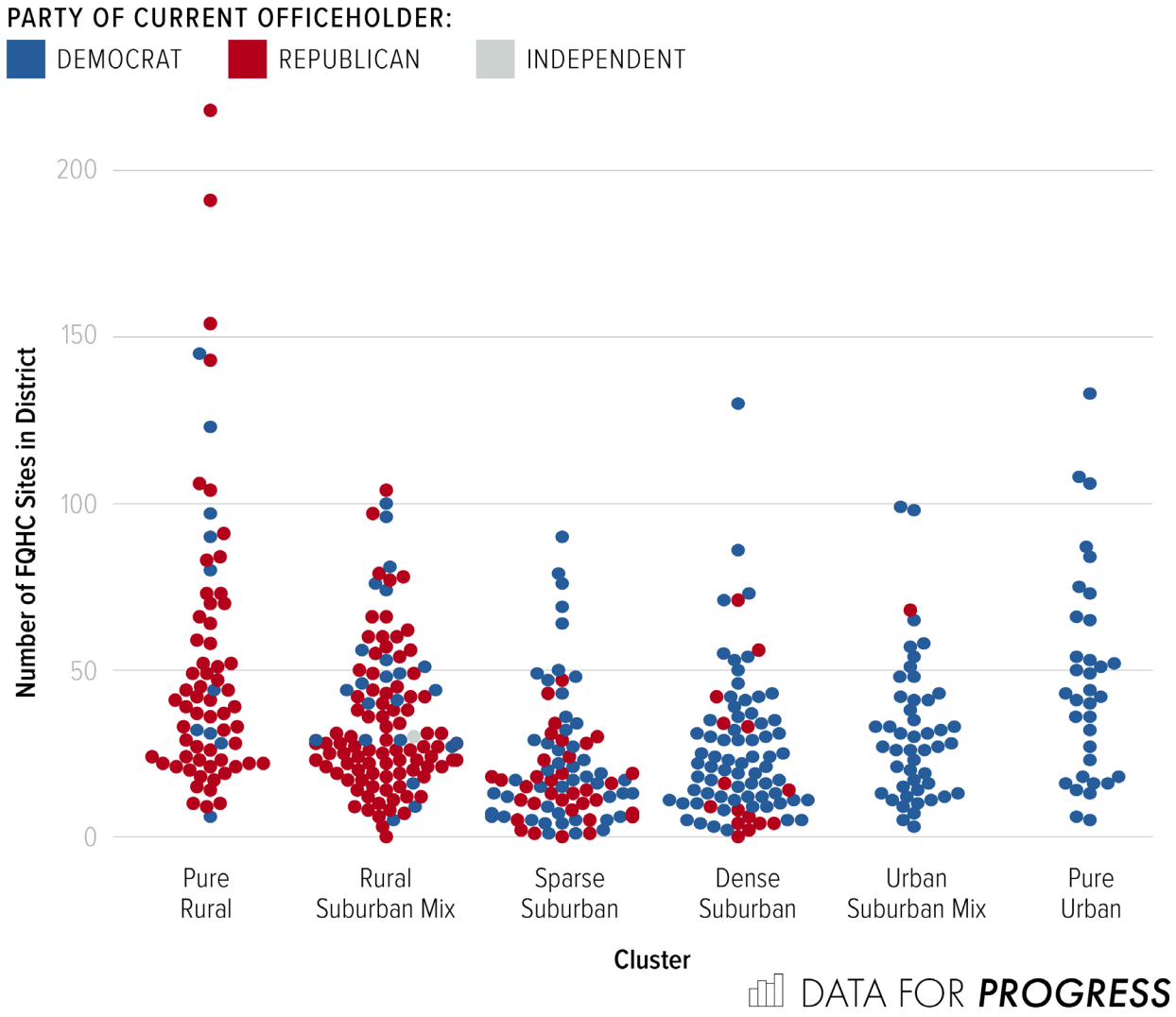
FQHCs are on the frontlines of the substance use disorder crisis. FQHCs have experienced a five-fold increase in patients seeking care for substance use disorder in the past decade, and they have responded. Nearly 5,000 providers at FQHCs are authorized to prescribe medication-based treatment for opioid use disorder, and they served almost 100,000 patients in 2018. These numbers will likely increase with the removal of restrictions (such as the Drug Enforcement Administration-mandated X-waiver to administer, dispense, and prescribe buprenorphine). Visits for management of tobacco and alcohol use have also dramatically increased, all while health centers have tripled their behavioral health staffing over the past ten years.[14]

FQHCs are local and national economic engines. In 2019, these health centers employed over 252,000 Americans full-time as health center providers and staff.[15] The presence of public infrastructure for care in communities is essential for adapting to changing needs and growth. Workers in the area have access to more affordable healthcare providers, centers purchase supplies from national manufacturers, and FQHC employees receive income to support local businesses. One analysis demonstrated that FQHCs generated over $50 billion in economic activity; for every $1 invested via federal grants, health centers produced over $5 for their local communities, including employees using their paychecks to buy goods in their neighborhoods and other indirect economic impacts.[16]

FQHCs have a history of broad political appeal. FQHCs have been supported by bipartisan Congressional Community Health Center Caucuses in both the House and Senate.[17]

As discussed above, President Biden has already signaled his intent to invest in FQHCs as a key component of COVID response and vaccines administration. His campaign platform called for a doubling of investment in community health centers, which would entail a total federal investment of more than $50 billion over five years (given that grants in FY2019 were $5.6 billion).[18]

Federally Qualified Health Center Sites by Congressional District



Expand FQHCs to guarantee primary care to all Americans

While the FQHC program has grown steadily in the past decade, far too many Americans remain without basic medical care. In the wake of COVID-19, it is crucial that we repair and revitalize our public capacity to deliver high-quality care. For too long, we have delayed the provision of basic health services to our fellow citizens. It's time to guarantee not just coverage but care.

DRAMATICALLY EXPAND FQHCS

We call for the establishment of a new FQHC in every primary care shortage area. We propose to accomplish this by investing $150 billion in FQHCs over 5 years, including a $30 billion capital expenditures fund and a $8 billion emergency COVID relief fund as requested by the National Association of Community Health Centers.[19] This investment will support an additional 50,000 primary care providers in community health centers across the country who will care for 50 million Americans who currently lack reliable access to primary care.

There are currently 7,000 primary care health professional shortage areas as designated by the U.S. Health Resources and Services Administration (HRSA) with an estimated population of nearly **50 million Americans** who do not have reliable access to primary care providers (PCPs).[20] While HRSA and other groups define reliable access at a ratio of 1 provider per 3,500 patients, such large panel sizes are often not sustainable for long-term practice. Instead, ratios of 1 provider to 1,000 patients could help retain providers at these health centers and increase quality of care. With this in mind, we would need **50,000 additional providers** (Physicians, Doctors of Osteopathic Medicine, Nurse Practitioners, Physician Assistants and more) to address shortage gaps.

This would require significant investment in both capital expenditure and maintenance funds. While size of clinics will vary depending on population and geography, HRSA affiliated partners recommend an estimated 1,500 square feet for each full-time provider and team members.[21] The median cost of health center capital expenses was $358 per square foot in 2013.[22] With these assumptions, we would require capital investment of **roughly $30 billion** to build space for the 50,000 new primary care providers needed to fill the shortage gap.

Given that most clinics serve underinsured or uninsured patients, many FQHCs continue to struggle financially even with federal support. Over 40% had negative operating margins in 2018, before the toll of the COVID-19 pandemic.[23] FQHCs currently receive roughly 18% of their annual revenue from federal grants as part of the Community Health Center Fund, which was roughly $5.68 billion for FY21. At baseline, this funding should be doubled to allow existing clinics to stabilize from the impact of COVID-19 and to better serve their current patients. It should then be increased three-fold to match the expansion of total population served by FQHCs under our proposal. As new clinics open, funding will increase from current levels to **$30 billion annually.**

INCREASE THE NUMBER OF PUBLICLY-OWNED AND OPERATED CLINICS

Many FQHCs are run by third party non-profit organizations, which can limit their reach in areas where few entities are available to sponsor a health center. Indeed, analyses have shown that new expansions in FQHCs after the Affordable Care Act were less likely to occur in rural or high-poverty areas.[24] Currently, Section 330 of the U.S. Public Health Act caps the amount of federal grants to public FQHCs at 5%. We should eliminate this cap and instead encourage public agencies in high-need areas to operate health centers. These clinics have the advantage of synergizing key domains of clinical care and public health.

STABILIZE FINANCING MECHANISMS

The primary source of federal grants to FQHCs is the Community Health Center Fund (CHCF), established under the Affordable Care Act. This discretionary fund has been the victim of political gridlock since its establishment; for instance, Congress failed to renew the fund in 2017, leading to a months-long lapse in support to financially vulnerable clinics and a compromise in clinical care. The omnibus spending package passed in December 2020 did reauthorize the CHCF, but only for three years. FQHCs need a more reliable and comprehensive source of financing. The federal government should either create a permanent fund to support FQHCs or establish funding cycles of at least five years.

INVEST IN PRIMARY CARE JOBS

We will not be able to meaningfully address inequities in primary care without investing in doctors, nurses, pharmacists, medical assistants, social workers, community health workers, and other essential healthcare staff. Investing in brick and mortar buildings can only go so far. A forthcoming memo will outline a full suite of policies to strengthen the healthcare workforce and create good, meaningful jobs. Several of these policies work hand-in-hand with the expansion of community health centers:

- Create a national service program to fund tuition or forgive student loans for healthcare professionals who commit to working 5 years in a community health center, including physicians, nurse practitioners, physicians assistants, registered nurses, psychologists, pharmacists, psychiatrists, and social workers. This can be accomplished by expanding existing federal programs including the National Health Service Corps.
- Eliminate the cap on graduate medical education slots
- Expand public medical education by providing grants to public universities and historically black colleges and universities (HBCUs) to establish or expand medical schools, nurse practitioner programs, and physician assistant programs
- Support partnerships between FQHCs and community colleges to provide workforce training and placement, and partnerships with local public high schools to provide paid internships
- Expand the Teaching Health Centers program that allows medical school graduates to complete their residency training in FQHCs

Support primary care innovation

Reimbursement in existing FQHCs is typically centered around fee-for-service models (via the Prospective Payment System, or PPS) that prioritize volume of patients. These models often do not allow providers to invest the time necessary to properly serve patients, especially when accompanying those with limited health literacy or who do not speak English as a first language. This is one of many factors contributing to increased rates of burnout among providers in FQHCs.[25]

Some states, such as Oregon, Wisconsin, and Minnesota, have experimented with alternative payment models to focus time and resources based on complexity of patients.[26] In the long term, public clinics could build on models of innovation in the private sector and limit providers to assignments of ~500-1000 patients (as opposed to > 2,000 often in practice), normalize appointments of ~45 minutes (in contrast to the regular 15 minute intervals employed currently), allow for investments addressing social determinants, and organize primary care relationships around broader teams including health coaches and community health workers.

Questions

From January 29 to February 1, 2021, Data for Progress conducted a survey of 1124 likely voters nationally using web panel respondents. The sample was weighted to be representative of likely voters by age, gender, education, race, and voting history. The survey was conducted in English. The margin of error is ±2.9 percentage points.

POLICY FRAMING

Some lawmakers in Congress are proposing investing $30 billion to build new publicly owned community health centers, as well as increasing the budget of existing community health centers by an additional $30 billion per year. Community health centers are required to provide primary care, dental care, and mental health services in areas where private services are lacking. Supporters say that and that expanding them would address critical healthcare shortages and make the U.S. better prepared in the event of another pandemic. Opponents oppose the proposal, they say that it would lead to a government takeover of healthcare that would cost taxpayers too much money and cause fraud and waste. Which comes closer to your view?

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