INVITED COMMENTARY

A Stronger Safety Net – Community Health Centers 10 Years After the Affordable Care Act

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The Affordable Care Act made direct and indirect investments in community health centers. Ten years later, more North Carolinians benefit from a stronger primary care safety net that provides a broader scope of comprehensive services, but missed policymaking opportunities leave work to be done to achieve a healthier, more equitable state.

Introduction

Born out of the Civil Rights movement and the War on Poverty program of the 1960s, Federally Qualified Health Centers (FQHCs), commonly referred to as community health centers (CHCs), today serve over 29 million patients across the country [1] and over 631,000 North Carolinians (internal data). As federally supported public entities and private nonprofit organizations, CHCs provide comprehensive primary care and many enabling services in medically underserved communities: those that suffer from health care shortages, greater health disparities, and pervasive poverty.

Accountable to patient-majority governing boards, CHCs design their services and programs in response to their communities’ needs. North Carolina’s community health centers not only provide comprehensive primary care regardless of insurance status or ability to pay through their sliding fee discount programs, which help level the playing field for patients by providing affordable payment options based on income, but they also provide enabling services to address patients’ other barriers to care, including language and transportation. This community-based comprehensive primary care model yields improvements in quality and outcomes, as health center patients access high-value preventive services at high rates, while health centers contain costs [2]. Compared to other providers, North Carolina health centers have 29% lower total spending per Medicaid patient [2].

The Community Health Center Fund: Investing in Health Center Growth

The Affordable Care Act (ACA) not only reformed and expanded the pathways by which Americans could access health insurance coverage, but also invested in growing the country’s health care capacity. The law increased federal funding and established a commitment of $11 billion over five years to CHCs, as well as support for programs to expand the CHC workforce [3].

The total number of North Carolina CHCs grew by 56% from a base of 27 in 2010 to 42 in 2018 (internal data). CHC service sites grew even faster, increasing 71% from a base of 163 to 278 locations (internal data). Through this expansion, North Carolina health centers grew to serve an additional 182,014 patients—an increase of 44%—to a total of 591,723 in 2018 (internal data), improving access for populations who largely live in or near poverty.

The growth is felt not only in the volume of people served, but also in the expansion of comprehensive services—such as behavioral health, pharmacy, and dental care for underserved communities—producing deeper and richer relationships between FQHCs and the communities where they operate. CHCs didn’t just radiate out; they grew their depth to become even more interwoven with the fabric of their communities.

As our nation reckoned with an opioid epidemic and mental health crisis, CHCs more than tripled their mental health provider workforce (Figure 1), allowing these practices to further enhance and integrate behavioral health into the primary care medical home. During this time, the volume of mental health and substance use disorder services nearly quadrupled to over 147,000 visits in 2018 (internal data). Likewise, substance use disorder treatment services, which health centers are well-situated to deliver given their deep community ties, trusted relationships, and commitment to culturally appropriate care, grew by 422% over the same period (internal data). Also, many health centers have leveraged federal investments to combat the oral health crisis [4] by growing their dental provider workforce. Since 2010, the number of health center patient encounters for dental services has increased by over 40% (internal data).
In addition to investing in CHC growth, the ACA invested in care quality, incentivizing patient-centered, team-based models of care through its emphasis on medical homes. Given their mission and longstanding patient-centered processes for providing care, FQHCs seamlessly adapted to medical home models in which providers coordinate primary, acute, behavioral health, and whole-person needs. At the beginning of 2010, there were no certified North Carolina FQHC medical homes, but by 2018, 31 health centers with 113 sites achieved Patient-Centered Medical Home recognition from the National Committee of Quality Assurance.

These enhancements in patient access and care require sustained investment. While Congress has continually renewed its financial commitment to health centers, it has done so with significant and repeated delay, disruption, and drama. Since the end of the first five years of the Community Health Center Fund, Congress has not enacted a long-term, sustainable funding renewal. In fact, after passing a two-year extension in 2015 as part of the Medicare Access and CHIP Reauthorization Act (MACRA), Congress struggled to reach agreement on a spending package that included CHC funding and as a result let funding lapse for five months. In anticipation of that funding cliff, the majority of health centers across the nation reported planning to institute hiring freezes, spending down reserves, and canceling or delaying facility renovations or expansions, while many others were considering cutting staff hours or making layoffs, reducing operating hours, and even closing health center sites [5].

At the time of drafting this article, CHC funding is set to expire again on December 11, 2020, absent congressional action. In the midst of a deadly pandemic that has disrupted the global economy, transformed health care delivery, and disproportionately endangered the communities in which health centers serve, CHCs must brace for the possibility that 70% of their federal funding will lapse [5]. This uncertainty hinders health centers’ ability to plan and make myriad business decisions, including recruiting and retaining providers, expanding their services, and growing their footprint to respond to community needs.

What Could Have Been: Investing in Health Centers by Covering (Some of) the Uninsured

The ACA has never been fully implemented and today remains a political football. For CHCs, an open wound that gets salted frequently is the absence of Medicaid expansion in North Carolina. Thanks to the ACA’s health insurance market reforms and coverage expansion provisions, nearly 480,000 fewer North Carolinians were uninsured in 2018 compared to 2010 [6]. During that time, the statewide uninsured rate fell from 17% to 11% [6], and more health center patients became insured. However, while these coverage gains are significant, they pale in comparison to those achieved by states that expanded Medicaid [7].

North Carolina health centers cared for over 591,000 patients, including 245,000 who lacked health insurance, in 2018, and nearly 70% of all patients of North Carolina CHCs have household incomes at or below the federal poverty level (FPL) (internal data). Many of those with incomes below this threshold fall into the state’s coverage gap, in which they earn too little to qualify for a subsidy but do not qualify for Medicaid. If North Carolina expanded Medicaid as called for by the ACA, experts have estimated that 389,000 uninsured adults would be eligible for Medicaid [8]. Given the massive pandemic-related job losses and associated coverage losses, those figures are certainly larger today.

Community health centers in Medicaid expansion states are “significantly more likely to report improvements in their financial stability” [9]. With increased reimbursement revenue from Medicaid, health centers in expansion states are more likely to offer robust behavioral health and substance use disorder treatment services than their counterparts in non-expansion states [9]. Medicaid expansion enables them
to stretch scarce federal resources further and invest in services, workforce, and initiatives to improve patient care.

North Carolina’s health centers have seen comparatively modest improvements in their payor mixes since 2010: 41% of health center patients in North Carolina were uninsured in 2018, down from 52% in 2010 before the ACA’s coverage expansions took place (internal data). Similarly, Medicaid beneficiaries made up 24.7% of the total patients seen within North Carolina health centers in 2018 (internal data), which is far short of what health centers see in states that expanded Medicaid. Those health centers can develop a much more sustainable financial path when they see between 40% and 50% of patients covered by Medicaid, providing the necessary revenues to sustain the cost of care for the 25% or more patients who remain uninsured. Because North Carolina failed to elect the expansion option, our equation is almost entirely reversed: health centers saw 24.7% Medicaid and 41.4% uninsured patients in 2018 (Figure 2).

Compared to states that expanded Medicaid, North Carolina’s coverage gains under the ACA came largely from increased enrollment in subsidized private health coverage on the individual insurance market. Health centers conducted extensive outreach, education, and health insurance enrollment assistance campaigns to help their community members and patients navigate the new coverage options under the ACA. These efforts provided a critical community service and contributed to reductions of uninsured people in our state.

By designating health centers as essential community providers, federal network adequacy requirements provided a somewhat enforceable incentive for qualified health plans to contract with CHCs. While this is not a flawless system, health centers have by and large been able to join health plan networks in order to continue serving as providers of choice for their patients.

**Conclusion**

Mounting evidence suggests that communities of color, lower-income households, and essential workers—all of whom are disproportionately likely to be served by community health centers—are at greater risk of contracting and/or becoming severely ill from COVID-19. Additionally, while researchers estimate that millions of Americans have lost their job-based coverage due to the pandemic, they find that greater shares of those losing coverage in non-expansion states will become uninsured entirely [10].

CHCs are rising to these challenges by conducting COVID-19 testing, providing affordable care for the newly uninsured, and conducting ongoing primary care and care management services for their patients. While the ACA’s investments strengthened health centers’ capacity to respond to an unprecedented crisis like this, one can imagine how much more resilient and responsive our state would have been were it not for the failures to expand Medicaid and to sustainably fund health centers.

Ten years later, North Carolina is reaping the benefits of the Affordable Care Act’s direct and indirect investments in community health centers, as our state’s medically underserved communities enjoy greater access to an increasingly multidisciplinary primary care safety net. To build on

**FIGURE 2.**
North Carolina Community Health Center Patients by Coverage Source

![Figure 2](image)

Source. North Carolina Community Health Center Association analysis of health center members’ Uniform Data System reports from years 2010 through 2018. For comparative analyses presented, the authors relied upon year 2018 for most recent data because Uniform Data System reports for year 2019 were not yet officially published by the federal government at the time of writing.
this progress and realize a more equitable North Carolina, lawmakers at state and national levels must provide sustainable, long-term investments in health center funding, workforce, and Medicaid expansion. NCMJ

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