VIEWPOINT

HEALTH POLICY

Federally Qualified Health Centers and Related Primary Care Workforce Issues

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Since the Affordable Care Act (ACA) was enacted in 2010, provisions that increase access to insurance coverage have generated widespread policy attention and contentious public debate. By contrast, other important provisions of the ACA, such as the expansion of the National Health Service Corps and federally qualified health centers (hereafter referred to as health centers), generated almost no conflict. Federally qualified health centers are community-based health care organizations that, with federal funding, provide primary care in underserved areas. Through these programs, ACA funding increased the number of primary care locations, services, and clinicians available to medically underserved rural and urban communities. This expansion was particularly important given research linking primary care to improved health outcomes and increased health equity.[1]

Federally Qualified Health Centers: Background

While significant funding increases are a recent phenomenon, health centers have a long history of federal support dating back to the first $51 million appropriation from Congress in 1967. In 1990, federal legislation augmented health center reimbursement from Medicare and Medicaid. Following a $2 billion investment in health centers through the American Recovery and Reinvestment Act of 2009 (ARRA), the ACA infused an additional $11 billion over 5 years (2011-2015).

By 2020, 1400 federally qualified health centers were operating 14 500 health care sites, with locations in every state, US territory, and the District of Columbia,[2] with an enacted federal appropriation of approximately $5.6 billion. Today, approximately 16% of health center revenue comes from competitive federal grants awarded by the Health Resources and Services Administration (HRSA). This funding largely benefits individuals insured through Medicaid and Medicaid expansion, as well as individuals who are uninsured. An additional 43% of health center revenue is derived from Medicaid reimbursement and 8% from Medicare.[3] Foundation and state funds, as well as private insurance, supply most of the other revenue.

Prior to enactment of ARRA and the ACA, federally qualified health centers were providing care for an estimated 18.8 million patients. By 2020, an estimated 30 million people received primary care services in these centers, including 9 million children.[2] Overall, health centers have more than tripled the number of patients served since 2000. At federally qualified health centers, primary care is defined broadly. An array of services, often available onsite, includes behavioral health and medical and dental care. Transportation to and from the health center is often available, reducing missed appointments. Some centers also include food banks, employment resources, and connection to other social services like the Special Supplemental Nutrition Program for Women, Infants, and Children. Efforts that align health care and social services are important given the relationship between poor health status and social needs.

This nationwide primary care infrastructure largely reflects a shared mission between local and federal entities. In exchange for federal support, health centers are required to serve areas and populations designated by the HRSA as medically underserved. These centers are required to provide care for any individual or family, regardless of ability to pay, with a sliding fee scale applied for low-income patients. According to data from 2020, 91% of patients are low income, 81% are publicly insured or uninsured, and 63% are members of racial and ethnic minority groups.[2] While the overall US primary care system is challenged in its ability to meet the needs of certain populations, including people of color, those with low incomes, and rural residents,[1] health centers focus on these populations. Furthermore, federal law authorizing health centers specifically includes migrant farm workers and people who are homeless as part of the population served. Individuals and families served by health centers are among the most economically vulnerable in the nation and often have complex health and social challenges.

Addressing Contemporary Challenges

The health center–HRSA partnership is dynamic and reflects a responsive, flexible infrastructure that adapts to meet emerging health care needs. Health centers assess their local communities' unique health-related challenges and respond to them, while the HRSA identifies and prioritizes national health needs through targeted grant funding and technical assistance. With this additional federally prioritized support, health centers can institute more comprehensive efforts to address certain challenges facing local communities. Recent examples include federal support for treatment of opioid use disorder and the current National Hypertension Control Initiative. Given the populations health centers serve, efforts to address the COVID-19 pandemic are an exceedingly high priority. The social inequities experienced by health center populations increase their risk for SARS-CoV-2 infection as well as mortality and morbidity.[4]

In strengthening COVID-19 efforts, as with other priorities, health centers bring the added value of established ties to the communities they serve. This relationship is often strengthened by segments of their workforce, such as community health workers, that draw from local populations. These bonds with the community create a foundation for trust on which to base critical initiatives

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like increasing vaccine uptake. More broadly, health center flexibility coupled with federal resources can support currently overstretched sectors such as public health.

Despite the importance of health centers in providing care to underserved populations, the work of health centers can be made more difficult as a result of increased frequency in delays by Congress to make funding decisions. This can lead to delays in local health center decision-making, potentially affecting operational activities, such as hiring a pharmacist or purchasing medical equipment. While the amount and timing of Congressional funding decisions are too often uncertain, needs of the populations served by health centers are not.

Expanding the Primary Care Workforce

Delivery of quality health care to medically underserved populations requires an adequate supply of a culturally sensitive and diverse primary care workforce. Increasing the number of primary care clinicians, especially in underserved areas,[1] is urgent. In 2019, more than 7200 geographic areas, facilities, and populations across the US were deemed to have insufficient numbers of primary care practitioners,[5] and health centers have had difficulty in increasing their primary care workforce commensurate with program growth.[6]

The challenge of ensuring an adequate primary care workforce supply is coupled with increasing recognition of the need for health care team members who understand the relationship among social determinants of health, health disparities, and health outcomes.[7,8] To help address these concerns, more academic institutions should partner with health centers to develop needed experiential learning, so that health professions trainees could acquire deeper understanding of the health and lived experiences of health center patients and of associated interventions to support them and their families. These educational opportunities could extend beyond clinical experience and include trainee participation in home-based services and community engagement, thus providing richer learning about circumstances contributing both to broad health inequities and to specific health problems. Learning in safety net settings also affords nursing, medical, and other students the important opportunity to consider their own attitudes and assumptions about underserved populations.[8] Taken together, these perspectives could enhance their future patient care and build on content increasingly discussed in health professions classrooms and health system board rooms.

These experiences also could help to shape future practice choices. For example, the HRSA-funded Teaching Health Centers medical residency training program is associated with significantly increasing the likelihood that residents will choose primary care practice in underserved settings.[9] Complementing this training support, albeit with considerably less funding, is the HRSA's Advanced Nurse Education Workforce Program that prioritizes nurse practitioner residency training in health centers.

At another level, working in tandem with academic institutions, health centers are uniquely positioned to engage both their own employees and the communities they serve in creating health career education pathways. Such efforts could help to address the identified need for increased numbers of health professions students, administrators, and health care leaders from historically marginalized and excluded populations.[10]

To increase stability in workforce programs that contribute to diversity and supply of primary care clinicians to underserved populations, and in health center continuity of services, Congress should consider moving away from the vagaries of annual appropriations to permanent biennial funding cycles. The resulting stability afforded to training and service delivery should be met with actionable information including standardized data collection inclusive of measures aimed at disparities, quality including care coordination, and objective measures informing funding adequacy. In addition, consistent with recently advanced recommendations, federal funding should support a task force established to delineate goals and strategies aimed at increasing workforce diversity and increasing supply and retention of primary care clinicians in medically underserved areas.[1] Over time, primary care training in safety net settings like health centers might become as ubiquitous as Veterans Administration–based training is for physician education. Given the essential role of federally qualified health centers, the relationship of primary care to health status, and the glaring need to address health inequities, sharpening the collective focus on targeted efforts like these could not be more timely.

ARTICLE INFORMATION

Conflict of Interest Disclosures: Dr Wakefield reported serving as a member of the Commonwealth Fund's Task Force on Payment and Delivery System Reform. In the Viewpoint, she cites and supports pursuit of one of the recommendations of the task force.

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