



Testimony

Before the Committee on Health,
Education, Labor and Pensions,
U.S. Senate

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HEALTH CENTERS

Trends in Revenue and Grants Supported by the Community Health Center Fund

Statement of Jessica Farb,
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Accessible Version

Why GAO Did This Study

Across the U.S., nearly 1,400 health centers provided care to more than 30 million people in 2021, regardless of their ability to pay. Health centers were established to increase the availability of primary and preventive health services for low-income people living in medically underserved areas.

In order to provide these services, health centers rely on revenue from a variety of public and private sources. This revenue includes grants awarded by HRSA through its Health Center Program, including funding available through the CHCF. HRSA began awarding grants funded by the CHCF in fiscal year 2011. In more recent years, health center revenue also included funding made available through COVID-19 supplemental appropriations.

This testimony describes the Health Center Program, trends in health centers' revenues from 2010 through 2017, and the purposes for which CHCF grants were awarded. This testimony is based on [GAO-19-496](#) and selected updates. For the 2019 report, GAO analyzed revenue data reported annually by health centers to HRSA from 2010 through 2017. In addition, GAO reviewed some HRSA data from 2021 to provide selected updates to the data we previously reported.

View [GAO-23-106664](#). For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

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What GAO Found

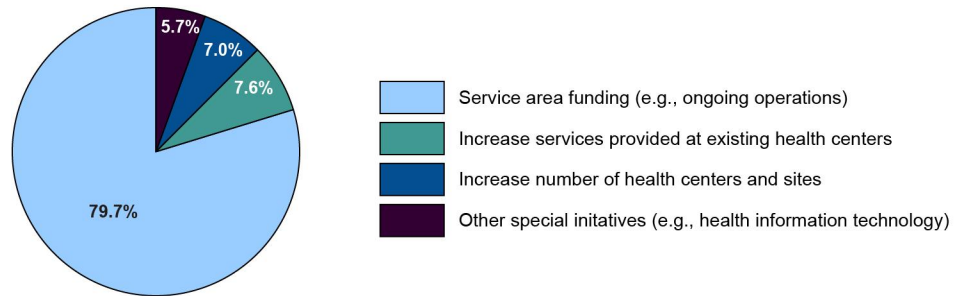
The federal Health Center Program was established in the mid-1960s in an effort to help low-income individuals gain access to health care services. It is administered by the Health Resources and Services Administration (HRSA). Through this program, HRSA makes grants to four types of health centers that primarily serve low-income populations: those that serve the general population in a certain service area, and those that serve the homeless, public housing residents, and migrant workers, respectively.

Health centers' revenue more than doubled from calendar years 2010 through 2017, from about \$12.7 billion to \$26.3 billion. Over the same time period, the number of health centers increased from 1,124 centers in 2010 to 1,373 centers in 2017. Health centers' revenue comes from a variety of sources, including reimbursements from Medicaid, Medicare, private insurance, and federal and state grants, which includes grants funded by HRSA's Community Health Center Fund (CHCF). While total health center revenue increased from 2010 through 2017, the share of revenue from each source changed in different ways. In particular, revenue from federal and state grants decreased from 38.0 percent of total revenue in 2010 to about 30.2 percent of total revenue in 2017 while reimbursements from Medicaid, Medicare, and private insurance increased.

GAO's analysis of HRSA data showed that from fiscal years 2011 through 2017, health centers received approximately \$15.8 billion in federal grants funded by CHCF. Of the federal grants funded by CHCF from 2011 through 2017, 79.7 percent—or \$12.6 billion—was awarded for the purpose of maintaining operations at existing health centers (see figure). According to HRSA officials, these CHCF grants were used to fill the gap between what it costs to operate a health center and the amount of revenue a health center received. As such, officials explained, the awards were a primary means through which health centers provided health care services that may be uncompensated, including services for uninsured patients or services not typically reimbursed by other payers, such as adult dental care. The remaining \$3.2 billion in CHCF grants were made to increase the amount of services provided at existing health centers; increase the number of health centers and sites; and support other special initiatives, such as implementing health information technology.

Total Grant Funding from the Community Health Center Fund, Fiscal Years 2011-2017

Total amount: \$15.8 billion



Source: GAO review of Health Resources and Services Administration award information. | GAO-23-106664

Data table for Total Grant Funding from the Community Health Center Fund, Fiscal Years 2011-2017

- Total amount: \$15.8 billion
- Services area funding: 79.7%
- Increase services provided at existing health centers: 7.6%
- Increase number of Health center and sites: 7.0%
- Other special initiatives: 5.7%

Source: GAO review of Health Resources and Services Administration award information. | GAO-23-106664

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee:

I appreciate the opportunity to be here today to discuss the Health Center Program. As you know, health centers were established to increase the availability of primary and preventive health care services for low-income people living in medically underserved areas. These outpatient facilities receive federal funding and serve as an important safety net provider as the majority of their patients are uninsured or enrolled in Medicaid.

The majority of health centers serve the general population within a designated area, while other types of health centers provide care to more specific populations, including the homeless, residents of public housing, and migrant and seasonal farmworkers. Regardless of type, health centers are required to provide health care to individuals who are members of the health center's target population or to all individuals located in the health center's service area, regardless of their ability to pay. In some communities, these centers may be the only primary care providers available to certain vulnerable populations. In 2021 nearly 1,400 health centers operated more than 11,000 sites that provided care to more than 30 million people in the United States, including one in five rural residents and one in three living in poverty.

Health centers rely on revenue from a variety of public and private sources, including federal, state, and local governments; and payments for services from Medicaid, Medicare, private insurance, and patients. This revenue includes grants awarded by the Health Resources and Services Administration (HRSA) through its Health Center Program. In 2010, the Patient Protection and Affordable Care Act (PPACA) established an additional source of funding for the Health Center

Program’s grants: the Community Health Center Fund (CHCF).¹ The CHCF supports a variety of grants to health centers for health care services for low-income populations.

My statement today describes the Health Center Program, trends in health centers’ revenues from 2010 through 2017, and the purposes for which CHCF grants were awarded during our period of analysis. This statement is based on our most recent report on the Health Center Program, which was issued in May 2019, and selected updates.²

For our May 2019 report, we analyzed HRSA data collected from health centers and compiled in its Uniform Data System to identify the sources and amounts of revenue health centers received from calendar years 2010 through 2017, the most recent data at the time of our analysis.³ We also reviewed HRSA grant documentation for grants funded by the CHCF for fiscal years 2011-2017—the most recent data at the time of our analysis—including information on the award amount and purpose of the grant, and reviewed some published studies that described the purposes for which CHCF grants have been made. Additionally, we interviewed HRSA officials, authors of the published studies, and an association representing health centers. Our May 2019 report includes a full description of our scope and methodology. In addition, we reviewed some HRSA data from 2021 to provide selected updates to the data we

¹Pub. L. No. 111-148, § 10503, 124 Stat. 119, 1004 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 2303, 124 Stat. 1029, 1083 (2010); Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 221, 129 Stat. 87, 154 (2015); Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 50901, 132 Stat. 64, 282 (2018); Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Pub. L. No. 116-59, § 1101, 133 Stat. 1093, 1102; Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Pub. L. No. 116-69, § 1101, 133 Stat. 1134, 1136; Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Div. N, Title I, § 401, 133 Stat. 2534, 3113; CARES Act, Pub. L. No. 116-136, § 3831, 134 Stat. 281, 433; Continuing Appropriations Act, 2021 and Other Extensions Act, Pub. L. No. 116-159, § 2101, 134 Stat. 709, 728; Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, § 1201, 134 Stat. 1041, 1044; Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 301, 134 Stat. 1182, 2922) (codified at 42 U.S.C. § 254b-2).

²GAO, *Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund*, [GAO-19-496](#) (Washington, D.C.: May 30, 2019).

³These data include data reported annually by health centers on their patient-related revenue, such as payments from Medicaid and Medicare, as well as other revenue provided from HRSA grants, other federal grants, and non-federal grants or contracts.

previously reported, such as amount of revenue health centers received and the number of health centers serving patients.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Health Center Program

The federal Health Center Program was established in the mid-1960s in an effort to help low-income individuals gain access to health care services. The Health Center Program, authorized in Section 330 of the Public Health Service Act, is administered by HRSA's Bureau of Primary Health Care and makes grants—known as Section 330 grants—to four types of health centers that primarily serve low-income populations:

1. *Community health centers.* These health centers serve the general population with limited access to health care. They are required to provide primary health services to all residents who reside in the center's service area. More than three-quarters of health centers are community health centers.
2. *Health centers for the homeless.* These health centers provide primary care services to individuals who lack permanent housing or live in temporary facilities or transitional housing. These centers are required to provide substance abuse services and supportive services targeted to the homeless population.
3. *Health centers for residents of public housing.* These health centers provide primary health care services to residents of public housing and individuals living in areas immediately accessible to public housing.
4. *Migrant health centers.* These health centers provide primary care to migratory agricultural workers (individuals whose principal employment is in agriculture and who establish temporary residences for work purposes) and seasonal agricultural workers (individuals whose principal employment is in agriculture on a seasonal basis but do not migrate for the work).

HRSA’s Section 330 grants are funded by a combination of discretionary appropriations provided through the annual appropriations process and mandatory appropriations provided from the CHCF.⁴ From fiscal years 2010 through 2021, funding appropriated for Section 330 grants—which includes funding from discretionary appropriations and the CHCF—increased from about \$2.1 billion to \$5.6 billion. In addition, some COVID-19 relief acts appropriated supplemental funding for Section 330 grants.⁵

Health centers are required to provide comprehensive primary health services, including preventive, diagnostic, treatment, and emergency health services. (See table 1.) All services that health centers provide must be available to patients at the center regardless of patient payment source or ability to pay and must be available (either directly or under a referral arrangement) to patients at all health center service sites. Services are provided by clinical staff—including physicians, nurses, dentists, and mental health and substance abuse professionals—or through contracts or cooperative arrangements with other providers.

Table 1: Selected Primary Health and Supplemental Services Provided at Health Centers

Category	Examples of services provided
Primary health services	Primary health services include basic health services including those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology.
Preventive health services	Required preventive services include <ul style="list-style-type: none"> • Well-child care • Prenatal and perinatal care • Immunizations • Voluntary family planning • Preventive dental care
Emergency medical services	Required services that are provided through defined arrangements with outside providers for medical emergencies during and after centers’ regularly scheduled hours.

⁴Discretionary appropriations are generally made through the annual appropriations process. Mandatory appropriations are generally created and funded in the same law in a multiyear or permanent basis and not through the annual appropriations process. Although created in 2010 under PPACA, the first year of CHCF funding was fiscal year 2011.

⁵For example, the American Rescue Plan Act of 2021 appropriated an additional \$7.6 billion for Section 330 grants. Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43.

Category	Examples of services provided
Enabling services	Required services include, but are not limited to <ul style="list-style-type: none"> • Translation services • Health education • Transportation for individuals residing in a center’s service area who have difficulty accessing the center
Supplemental services	Additional services that are not primary health services but are appropriate to meet the health needs of the service population, such as behavioral health and environmental health services. ^a Health centers are not required to provide these services.

Source: Public Health Services Act. | GAO-23-106664

^aBehavioral health services include the services of psychiatrists, psychologists, and other appropriate mental health professionals. Environmental services can include the detection and alleviation of unhealthful conditions associated with water supply and lead exposure, among other things.

In addition to the services they provide, health centers are also required to document the unmet health needs of the residents in their service area and to periodically review their service areas to determine whether the services provided are available and accessible to area residents promptly and as appropriate. Health centers also must have a sliding fee scale based on a patient’s ability to pay and generally must be governed by a community board of which at least 51 percent of the members are patients of the health center. HRSA determines whether health center grantees meet these and other health center program requirements when making award determinations.⁶

Trends in Health Centers’ Revenue

Our analysis of HRSA data showed that health centers’ revenue more than doubled from calendar years 2010 through 2017, from about \$12.7 billion to \$26.3 billion.⁷ HRSA data also showed over the same time period, the number of health centers increased from 1,124 centers in 2010 to 1,373 centers in 2017. In addition, the number of patients served over the same time period increased by 7.7 million patients, from 19.5

⁶In 2017 HRSA issued the Health Center Program Compliance Manual, which outlines 18 program requirements. The Health Center Program Compliance Manual is the consolidated resource to assist in understanding and demonstrating compliance with the Health Center Program requirements found in the Health Center Program’s authorizing legislation and implementing regulations, as well as certain applicable grants regulations. For information on the Health Center Program Compliance Manual see <https://bphc.hrsa.gov/compliance/compliance-manual>.

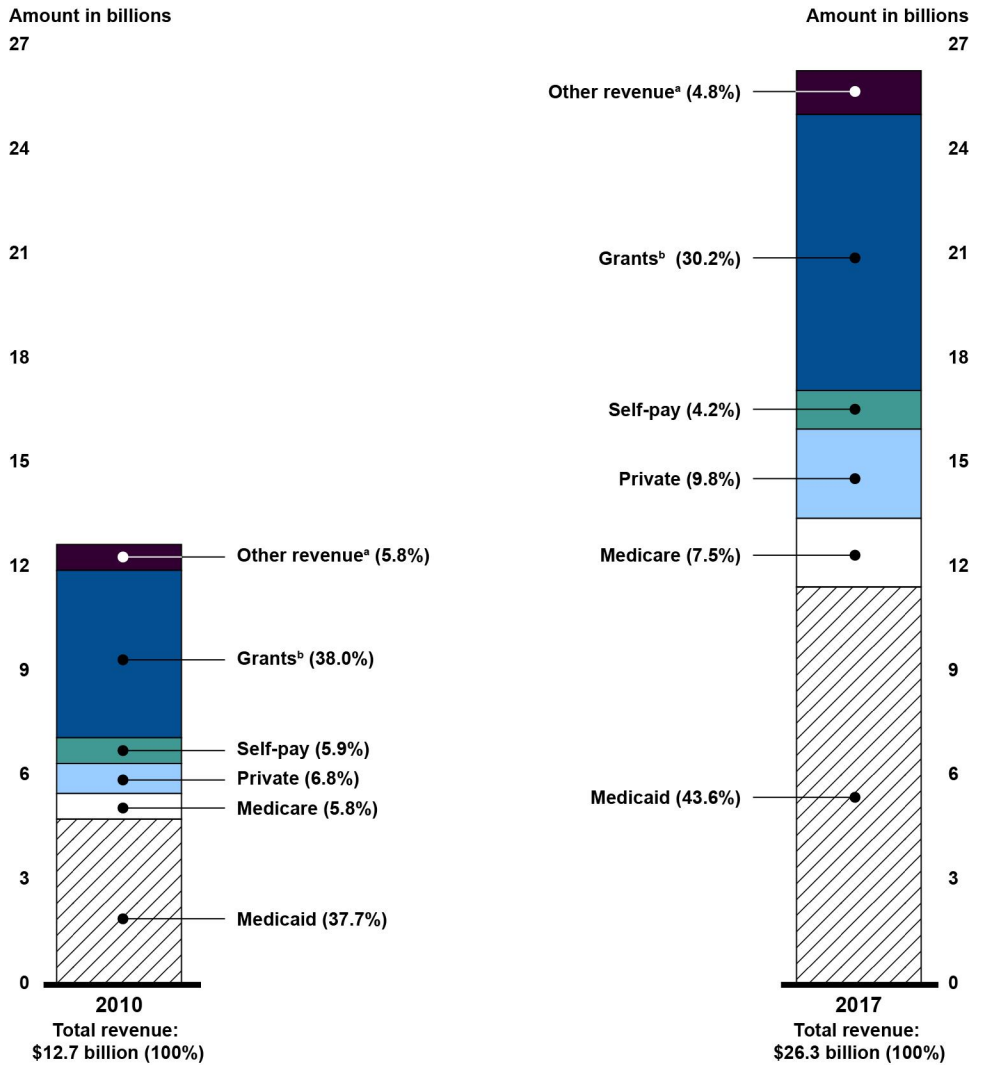
⁷In real terms, the growth in revenue is less. Specifically, the inflation-adjusted increase was about 85 percent instead of 107 percent.

million to 27.2 million. In 2021, there were nearly 1,400 health centers serving more than 30 million patients.

Health centers' revenue comes from a variety of sources, including reimbursements from Medicaid, Medicare, private insurance, and federal and state grants. While total health center revenue increased from 2010 through 2017, the share of revenue from each source changed in different ways. In particular, revenue from federal and state grants decreased from 38.0 percent of total revenue in 2010 to about 30.2 percent of total revenue in 2017 while reimbursements from Medicaid, Medicare, and private insurance increased (see fig. 1).⁸

⁸In 2021, revenue from federal and state grants represented about 31.2 percent of total revenue. Reimbursements from Medicaid, Medicare, and private insurance represented about 60.4 percent of total revenue. The remaining 8.4 percent includes revenue from self-pay, other public insurance, and non-patient related revenue not reported elsewhere, such as rent from tenants.

Figure 1: Health Center Revenue 2010 and 2017



Source: GAO analysis of Health Resources and Services Administration (HRSA) Uniform Data System data. | GAO-23-106664

Data table for Figure 1: Health Center Revenue 2010 and 2017

	Year 2010	Year 2017
Medicaid	37.7%	43.6%
Medicare	5.8%	7.5%
Private	6.8%	9.8%
Self pay	5.9%	4.2%
Grants /b/	38.0%	30.2%

	Year 2010	Year 2017
Other Revenue /a/	5.8%	4.8%

Source: GAO analysis of Health Resources and Services Administration (HRSA) Uniform Data System Data. | GAO-23-106664

Notes: Revenue in the Uniform Data System is defined as the gross receipts on a cash basis for each year collected by health centers, regardless of the period in which the paid for services were rendered. Dollars are nominal. Percentages may not add to 100 due to rounding.

^aOther revenue includes two categories in the Uniform Data System: (1) other public insurance and (2) non-patient related revenue not reported elsewhere, such as revenue from fund-raising, rent from tenants, medical record fees, and vending machines.

^bGrants in HRSA's Uniform Data System include three categories of revenue: (1) Section 330 grants, such as Health Center Program grants; (2) other federal grants, such as Medicare and Medicaid Electronic Health Record Incentive grants; and (3) non-federal grants or contracts, such as amounts from contracts that are not tied to the delivery of services and amounts received from state and local indigent care programs.

In response to earlier increases in program funding, GAO was previously asked to examine HRSA's oversight of the Community Health Center Program. In our May 2012 report, we made six recommendations for improving oversight such as strengthening HRSA's ability to consistently identify and cite grantee noncompliance and periodically assessing whether HRSA's new process for addressing grantee noncompliance was working as intended.⁹ HRSA implemented all six of our recommendations.

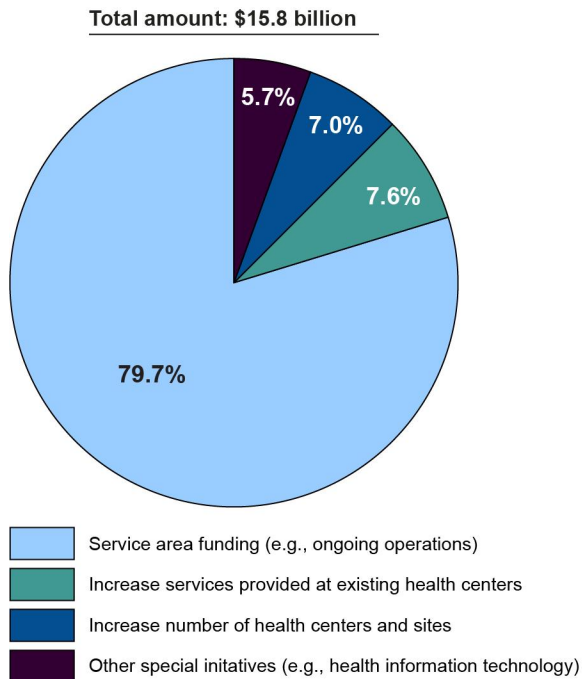
Purposes of Community Health Center Fund Grants

GAO's analysis of HRSA data showed that from fiscal years 2011 through 2017, health centers received approximately \$15.8 billion in Section 330 grants funded by the CHCF. Of this total amount, 79.7 percent—or \$12.6 billion—was awarded for the purpose of maintaining operations at existing health centers (see fig. 2). According to HRSA officials, these CHCF grants were used to fill the gap between what it cost to operate a health center and the amount of revenue a health center received. As such, officials explained, the awards were a primary means through which health centers provided health care services that may be uncompensated, including services for uninsured patients or services not typically reimbursed by other payers, such as adult dental care. The remaining \$3.2 billion in CHCF grants were made to increase the amount of services provided at existing health centers; increase the number of

⁹GAO, *Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements*, [GAO-12-546](#) (Washington, D.C.: May 29, 2012).

health centers and sites; and support other special initiatives, such as implementing health information technology.

Figure 2: Total Health Resources and Services Administration (HRSA) Section 330 Grants Funded by the Community Health Center Fund (CHCF), Fiscal Years 2011–2017



Source: GAO review of Health Resources and Services Administration award information. | GAO-23-106664

Data table for Figure 2: Total Health Resources and Services Administration (HRSA) Section 330 Grants Funded by the Community Health Center Fund (CHCF), Fiscal Years 2011–2017

- Total amount: \$15.8 billion
- Services area funding: 79.7%
- Increase services provided at existing health centers: 7.6%
- Increase number of Health center and sites: 7.0%
- Other special initiatives: 5.7%

Source: GAO review of Health Resources and Services Administration award information. | GAO-23-106664

Notes: Section 330 grants funded by the CHCF are a subset of all Section 330 grants. Percentages may not add to 100 due to rounding. Dollars across fiscal years are nominal.

In the coming months, we will be starting an examination of trends in health center funding since our last review, including an assessment of

how additional funding provided in response to the COVID-19 pandemic has been used. In addition, we anticipate analyzing the characteristics of the patients health centers serve, among other issues.

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Jessica Farb at (202) 512-7114 or farbj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. In addition to the contact named above, key contributors to this statement were Kristi Peterson (Assistant Director), Amy Leone, Michelle Rosenberg, Cathleen Whitmore, and Jennifer Whitworth.

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