Increase Funding for Community Health Centers (CHCs)

Description of the policy and how it works in practice

Encourage increased and sustained governmental and philanthropic investment in community health centers (CHCs)—public and nonprofit entities that provide care to patients in medically underserved areas regardless of the patient's ability to pay.

For further background, the vast majority of CHCs participate in the Health Resources & Services Administration (HRSA) Health Center Program or are "look-alikes" (meaning they meet all the requirements of the Health Center Program but do not currently receive funding from it). Many CHCs additionally register with the Centers for Medicare & Medicaid Services (CMS), allowing them to receive Medicare and Medicaid reimbursement as Federally Qualified Health Centers (FQHCs). Health centers may also be school based or run by charitable or other social services organizations that provide additional social services or limited medical care.

In 2023, there were about 1,400 HRSA-funded health centers, operating more than 15,000 service sites, which served over 31 million people.[1] Over 43% of CHC revenue came from Medicaid reimbursement, while another 15% came from other federal grants through a combination of HRSA funding and COVID relief payments.[1] Another 25% of CHC funding came from potentially more stable sources, including direct patient payments, Medicare, and private insurance.[2] The remaining 16% of CHC funding came from other grants or forms of revenue (including other federal grants, state and local grants, philanthropic funding, contracts, fundraising, interest, and other miscellaneous sources).[2]

Health Impact

There is strong evidence, including systematic review, that increased funding for CHCs results in improved access to care, which can be complemented by ensuring and increasing health insurance coverage such as through Medicaid expansion.[3]

Feasibility

Because Medicaid provides such a large portion of funding for CHCs, the primary policy mechanism to improve their funding is federal advocacy focused on Medicaid (increased funding and increased reimbursement rates). However, to the extent Medicaid funding is threatened by federal policy changes under the Trump administration in 2025 and 2026, CHCs can benefit from sustained and increased state, local, and philanthropic investments, or other changes like increases in other types of federal funding (such as 340B) or value-based payment models.[1]

Overview of the policy's impact on Black health and racial equity

Numerous studies have shown that CHCs address disparities for BIPOC, low-income, and rural communities, particularly because they provide care regardless of ability to pay, and a patient's ability to pay is affected by the various forms of structural discrimination they face.[3] Nationwide, CHCs served almost 5.5 million Black patients in 2023, making up about 21% of the total CHC patient population.[4] Due to the way race and ethnicity are reported, this is at least a slight undercount. In total, CHCs served over 18 million patients from "racial and/or ethnic minority," backgrounds, making up about 63% of all their patients, some of whom may also count as part of the Black population.[4] In addition, health center look-alikes served almost 200,000 Black patients in 2023, making up almost 20% of their total patient population.[5]

Summary information from policy assessment

- **Policy status**

  MODERATE — While evidence of the health and equity impacts of funding for CHCs is strong, potential policy advocacy in this space is rated as moderate, given (1) the high resource requirements (below) and (2) limitations on using the primary federal policy levers in the policy landscape as of November 2025.

- **Jurisdiction authority (federal, state, county, municipality, other)**
  Federal, state, county, municipality, and other funding can be implemented through any level or organization of government, as well as through private organizations like philanthropies.

- **Resource requirements (high, moderate, low)**
  HIGH — CHCs have long been underfunded and need substantial, sustained investment.[1]

- **Return on investment (no, yes-social, yes-environmental, yes-economic)**
  YES-ECONOMIC — There is strong evidence that funding for community health centers results in cost savings by providing more preventive care and reducing the need for costlier health services like emergency care.[6] At least one analysis has also looked at the economic impact of CHCs through job creation or support, economic output, and labor income.[6]

- **Legal considerations**
  There are little to no legal considerations that act as a barrier to policy implementation. Barriers are primarily political and budgetary.

- **Strength of evidence (strong, moderate, weak)**
  STRONG — There is strong evidence that increased funding for CHCs results in improved access to care, especially for BIPOC, low-income, and rural communities.[6]

- **Equity (yes, unclear/sometimes, no)**
  YES — CHCs are present throughout the nation and disproportionately serve Black and other BIPOC patients, increasing equity in access to care.

- **Operational approach to equity (structural, procedural, distributional)**
  STRUCTURAL, PROCEDURAL, AND DISTRIBUTIONAL — Investment in CHCs contributes to structural change in the health care system through their emphasis on, and availability of, services regardless of ability to pay, and efforts they engage in to address upstream, nonmedical determinants of care.[7] CHCs contribute to increased procedural equity through requirements that recipients of services serve on boards — exercising power over how these dollars are spent and services are implemented. Finally, CHCs contribute to distributional equity by further ensuring availability of health care services in underserved communities.

Examples of the successful implementation of the policy in Black communities

Others working in this space include KFF, the National Association of Community Health Centers (NACHC), and the Commonwealth Fund. As NACHC has documented, CHCs were originally developed by Black leaders in the 1960s and 1970s as part of the Civil Rights Movement.[8] Examples of successful implementation include:

- Funding and technical assistance for CHCs has been a priority of the New York State Black, Puerto Rican, Hispanic, and Asian Legislative Caucus through their Empower Black New York Agenda.[9] In the past three fiscal years, the New York state legislature has approved appropriations of $450,000 to the Primary Care Development Corporation (PCDC), to provide funding and technical assistance to primary care providers—especially CHCs in underserved communities.[10] PCDC has noted that historical redlining and modern disinvestment in predominantly Black neighborhoods in New York contributes to disparities in access to care and recommends targeted investment in these areas.[11]
- NACHC has conducted assessments of state funding for CHCs in partnership with state Primary Care Associations (PCAs). As of the last published policy assessment in 2024, at least 13 states provided direct funding to CHCs in FY 23, although the report does not identify which specific states provided funding.[12] NACHC's latest, more comprehensive report from FY 2016 indicates that 22 states provided funding to CHC's, either from the state's general budget or from the state's tobacco tax.[13] States with the largest Black populations, or largest proportions of Black population, that provided CHC funding according to this report include: Florida, Georgia, Illinois, Maryland, Mississippi, New York, South Carolina, and Virginia.
- As an example of successful philanthropic funding, the Episcopal Health Foundation (EHF) in Texas has provided sustained funding to at least seven CHCs through its Community Centered Health Homes Initiative since 2017, based on models and funding developed by Prevention Institute and Kresge Foundation.[14] EHF's current strategic framework prioritizes grants related to food and nutrition security, maternal health, and diabetes prevention, in part out of recognition for how these issues disproportionately affect Black communities.[15]