



Puerto Rico Community Health Centers and Lessons for U.S. System Resilience



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Puerto Rico's 21 community health centers (CHCs), operating across nearly 150 delivery sites, serve approximately 1 in 7 island residents. Amid recurring natural disasters, fragile infrastructure (particularly its electrical grid), capped Medicaid funding support, and persistent clinician shortages, these CHCs have become vital providers of primary care and behavioral, urgent, and emergency services. This brief describes their recent evolution within such constraints and offers lessons applicable to vulnerable mainland communities confronting severe weather, workforce, and challenges with reliable access to health care.

Historical Background

The earliest health centers in Puerto Rico were established during the [1970s](#) as part of the national effort to expand access to primary care to [migrant and agricultural workers](#). Over time, this effort expanded to broader communities at high risk of poor health. However, from the outset, Puerto Rico CHCs have operated under distinct limitations stemming from the island's [territorial status](#).

Although Puerto Rico residents are U.S. citizens, the island's exclusion from many federal programs, such as full Medicaid match funding and entitlement-based health financing, has shaped a divergent system. Unlike the states, Puerto Rico's Medicaid financing is capped through a federal block grant, regardless of population need or medical inflation. Such structural limitations have shaped a chronically underfunded health system, reliant on short-term waivers or supplemental funding to maintain coverage and avoid care disruptions.

Puerto Rico's community-based health care model has its roots in a regionalization framework developed in the late 1950s, which envisioned publicly operated Diagnostic and Treatment Centers as the foundation of a coordinated primary care system. However, subsequent health system reforms shifted primary care delivery toward private physician practices operating under capitated managed care arrangements. This model introduced centralized oversight while delivery became more decentralized, resulting in new financial responsibilities for local governments in supporting broader health coverage. These changes contributed to challenges in service coordination and placed strain on the infrastructure that once supported the public health system.

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First CHCs opened in 1972

In 1972, CHCs were introduced and grew steadily on the island, reinstating the model of community-oriented, team-based, coordinated primary care delivery. Over time, these CHCs developed into robust, team-based care delivery organizations that now serve nearly half a million residents. In many ways, their growth represents a course correction toward community-centered, integrated primary care.

This divergence has been deepened by Puerto Rico's prolonged fiscal crisis, including its [2017 bankruptcy](#), which intensified uncertainty in health financing systems. The Puerto Health Insurance Administration (ASES), which oversees the Medicaid program (known as Vital), has faced chronic budget shortfalls, payment delays to providers, and a reliance on short-term federal relief packages. Unlike the states, Puerto Rico's federal Medicaid allotment is [capped](#), regardless of need. Temporary increases to the Federal Medical Assistance Percentage (FMAP), such as during COVID-19, have offered brief stability, but these are not permanent solutions.

Despite this volatile [landscape](#), over time, these CHCs have become essential to the island's health infrastructure. Their comprehensive primary care service models, emergency response capabilities, and deep community presence positioned them as both care providers and continuity anchors during repeated crises.

Health Conditions and Service Demands

In 2023, [40%](#) of Puerto Rico's population lived below the Federal Poverty Level (FPL), more than triple the U.S. average of 12.5%. This widespread poverty, combined with limited private insurance options, drives a heavy reliance on Medicaid. Compounding this, Puerto Rico's Medicaid eligibility thresholds are more restrictive. Unlike the mainland, where eligibility is based on the FPL, Puerto Rico uses a locally defined standard that is substantially lower. For example, a family of three in the U.S. mainland must have an annual household income of no more than [\\$26,650](#) compared to [\\$9,000](#) in Puerto Rico.

Chronic conditions are widespread. Puerto Rico's population experiences high rates of [chronic conditions](#), particularly diabetes, hypertension, and cardiovascular disease, that are closely linked to poverty, housing instability, and limited access to nutritious food and preventive care. According to [federal data](#), Puerto Rico persistently has higher rates of chronic conditions than the 50 states and DC.

Behavioral health needs on the island are also acute, fueled by [decades](#) of economic instability, repeated natural disasters, and pandemic-related trauma. These have contributed to increasing rates of suicide, anxiety, depression, and substance use. However, behavioral health professionals are in [short supply](#). Most Puerto Rico CHCs have turned to [integrated behavioral health](#) models with embedded clinicians, supported by federal grant programs and 340B reinvestments, to provide care where specialty services are unavailable.

PERCENT OF ADULTS WITH CHRONIC CONDITIONS, 2021

	Puerto Rico	50 States and DC
Cardiovascular disease (coronary disease or myocardial infraction)	9.2%	5.9%
Hypertension	41.2%	32.4%
High Cholesterol	37.6%	35.7%
Diabetes	16.8%	10.9%
Obesity	35.8%	33.9%

Source: Puerto Rico Behavioral Risk Surveillance System, Trends Report 2011-2021. CDC, BRFSS Prevalence and Trends Data.

Social vulnerability compounds these health challenges. The [U.S. Census](#) noted that 43% of Puerto Rico’s residents exhibited high social vulnerability – more than double the mainland rate. Given that [86% of CHC](#) patients are below the Federal Poverty Level (FPL), CHCs are likely to identify food insecurity, housing instability, and transportation barriers. CHCs screen for such issues, recognizing the reality that health care delivery on the island cannot be separated from a broader system of social support and work to align care delivery with population needs.

Health Care Amid Structural Limitations

Puerto Rico CHCs serve nearly [500,000](#) individuals, approximately two-thirds of whom are enrolled in Medicaid. CHCs serve roughly 1 in 5 people insured through Medicaid on the island and rely heavily on Medicaid to sustain their role as primary care safety-net providers. In 2024, Medicaid accounted for 61% of CHC revenue.

A central structural challenge is Puerto Rico’s capped Medicaid financing. Unlike states, which receive open-ended federal contributions based on income and enrollment, Puerto Rico operates under a capped [block grant](#). Puerto Rico’s Federal Medicaid Assistance Percentage (FMAP) was originally set at 50% in 1968, capped at \$20 million. The FMAP was raised to 55% in 2011 and temporarily increased to 100% in 2019 as emergency relief, before being reset at [76%](#) in 2020. However, this enhanced FMAP is set to expire in 2027, when it will revert to 55%, which is far below what the island would receive under the same formula applied to states (from [50% to 83%, depending on per capita income](#)).

In addition to Medicaid, CHCs received federal health center funding to cover uncompensated care costs, especially for uninsured or underinsured populations. In 2024, federal CHC grants accounted for 17% of total revenue. However, this funding remains uncertain beyond authorization cycles, adding to the fiscal instability CHCs must navigate.

With looming federal Medicaid reductions and no long-term guarantee of federal CHC surrounding funding, Puerto Rico CHCs face renewed existential threats. The loss of even partial support would have significant consequences for access to care for nearly half a million medically vulnerable residents.

Strategic Use of Limited Resources

Although financial pressures limit investments in staffing, technology, and infrastructure, CHCs continue to deliver comprehensive services, often stepping into roles typically filled by public hospitals or emergency services. Indeed, some CHCs also operate emergency care rooms. In many communities, they are also the only source of [behavioral health, oral health, vision care, and pharmacy services](#).

Federal 340B drug pricing program: While CHCs rely heavily on Medicaid and federal health center funding, they must bridge funding gaps through other mechanisms. One such program is the [340B Drug Pricing Program](#), which allows participating providers to purchase outpatient medications at reduced prices and reinvest the resulting savings into care delivery. In Puerto Rico, 340B revenue-savings supports behavioral health integration, mobile medical units, outreach, and other critical supports at CHCs. These resources are especially essential during disaster events when physical access to care sites is limited.

Private philanthropy: Philanthropic partners also play a critical role. [Direct Relief](#), [Hispanic Federation](#) and [Americares](#), for example, have supported the installation of solar energy systems and FDA-compliant pharmaceutical and laboratory refrigerators and freezers. They also supplied critical medical equipment and operational support during emergency responses.

SAMHSA (the Substance Abuse and Mental Health Services Administration) has provided funding to CHCs, through the Puerto Rico health department, for mental health and substance use programs, filling service gaps left by an under-resourced public sector.

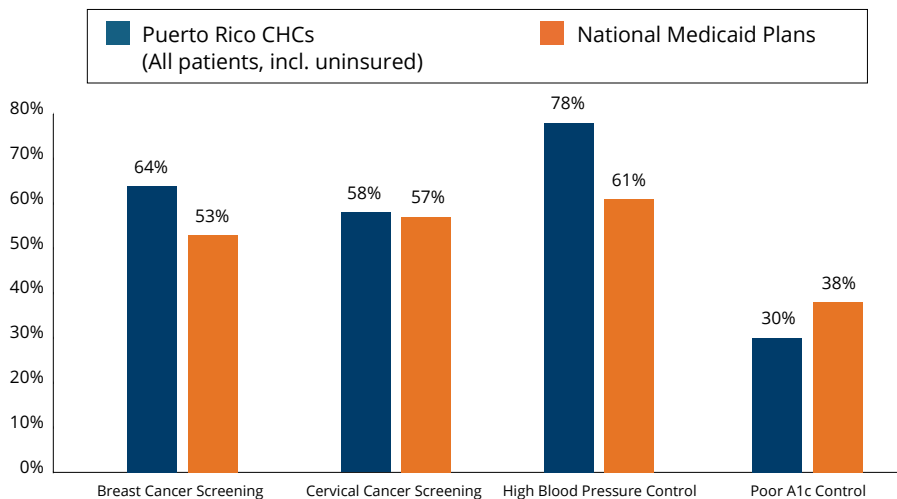
“ CHCs serve roughly 1 in 5 people in Puerto Rico insured through Medicaid. ”

Puerto Rico CHCs deliver positive health outcomes and savings to the health system

Despite these financial constraints, CHCs consistently deliver high-value care. Nationally, CHCs serve Medicaid patients at approximately [24%](#) lower cost than other providers, demonstrating that cost [efficiency](#) can be achieved without compromising quality. These savings are achieved despite serving a sicker, poorer population.

Puerto Rico CHCs generally perform above national Medicaid benchmarks, despite structural disadvantages. Their reported quality outcomes reflect the entire patient population, including those without insurance, while national benchmarks are limited Medicaid beneficiaries who generally have more consistent access to care. This makes the performance of Puerto Rico CHCs especially notable.

KEY QUALITY MEASURES



Source: 2024 Uniform Data System, HRSA. HEDIS 2024, medians.

Today, many CHCs collaborate closely with local governments on care coordination, emergency response, and population initiatives. Still, the absence of a coordinated policy framework limits the full realization of CHCs to function as integrated patient-centered medical homes with seamless connections to hospitals and specialists.

Integrated Emergency Operations

Following [Hurricane Maria](#) (2017), many CHCs found themselves the only available medical sites in their communities but lacked full [functionality](#). In response, many began redesigning operations with [emergency readiness](#) as a core feature. Today, some Puerto Rico's CHCs include [solar](#) energy systems with battery storage and water pumps, interoperable [long-range radios](#), [satellite communications](#), mobile health vans, and backup fuel and power for extended periods of time. These upgrades have enabled CHCs to maintain operations through power outages and other crises, including the 2020 earthquakes and Hurricane Fiona in 2022.

CHC Spotlights

From the southern coast of Ponce to the mountainous west and up to the coastal northwestern part of Rincon, Puerto Rico's CHCs embodies redesigned primary care. The following CHCs represent three complementary models of what care can look like when grounded in mission, resilience, and ingenuity.

MEDX (Medical Experience), rebranded in 2024, operates a 42,000 sq. ft. facility with team-based suite care (and no waiting room) and VR-integrated behavioral health.

MED Centro has several mobile health units and an Elite Clinical Response Team that can be rapidly deployed to disaster-affected areas across the island.

Costa Salud Community Health Center combines integrated care with mobile outreach, ensuring access even in the most remote corners of Rincon and surrounding areas.

All three leverage available resources to fortify their clinics with solar power and hurricane resistant design and invest in home-based outreach, chronic health care coordination, and pharmacy access. These CHCs are not outliers. They are premier primary care providers shaped by need. ■

The Puerto Rico Primary Care Association has been a central partner to develop a culture of emergency preparedness in Puerto Rico CHCs.

In Puerto Rico, cultivating a resilient health care system demands more than infrastructure, it calls for a deeply rooted culture of preparedness. The Puerto Rico Primary Care Association, a non-profit, private organization that serves all CHC 's in the island and provide supports and technical assistance, has been instrumental in developing this culture across the island's CHCs, acting as a driving force behind emergency readiness initiatives, as the establishment of *redundant radio communication systems* that ensure clinics stay connected during crises, even when traditional communications systems fail. These systems safeguard continuous coordination between CHCs, emergency responders, and government agencies.

Additionally, the Association has pioneered *centralized data systems for emergency preparedness*, enabling real-time access to clinics information, resource availability, and operational tracking. These platforms streamline decision-making in emergencies, allowing health centers to respond faster and more efficiently to unfolding situations.

Critically, the Association has forged strong alliances with *philanthropic partners* who share the vision of resilient care. These collaborations have unlocked vital funding for equipment, training, and technology that might otherwise be out of reach. Thanks to these partnerships, CHCs across the island have been equipped with generator systems, mobile medical units, and specialized emergency protocols tailored to local needs.

More broadly, the island's Health Center Controlled Network (HCCN), under the Puerto Rico Primary Care Association, has worked to standardize data systems, coordinate care delivery, promote innovation in technology use and advocate for sustainable infrastructure investment.

Key Lessons for U.S. Mainland Vulnerable Communities

Puerto Rico's CHCs are not just safety-net providers. They are institutional models of resilience, adaptation, and integrated community health. The operational realities faced by Puerto Rico CHCs mirror emerging challenges in vulnerable mainland communities, from hurricane-impacted [states](#) to fire-prone [regions](#) and rural areas experiencing hospital [closures](#). Puerto Rico CHCs' approaches offer tested strategies.

These CHCs also demonstrate how partnerships with philanthropic and federal agencies can mitigate financing limitations, even if temporarily. However, these supports cannot substitute for foundational reforms. Sustained capital investment in CHCs and stable Medicaid payment policies are essential to stabilize clinical teams, ensure quality care, and strengthen physical, electrical, and digital infrastructure.

Hurricane Maria

When Hurricane Maria struck Puerto Rico in September 2017, 95% of the island lost power, and nearly half the population was without access to clean water and phone service within days. In the months that followed months, researchers found between 2,975 and 4,645 excess deaths. These deaths were largely due to indirect causes complications of chronic illnesses exacerbated by system failure.

Key contributors included:

- The loss of refrigeration for insulin and other temperature-sensitive medications.
- Disruptions in treatments and monitoring of cardiovascular and respiratory conditions.
- Damaged infrastructure that cut off access to care, including flooded roads, clinic closures, and health care facility operations constrained by limited generator fuel.

This experience revealed the importance of cold storage, mobile medical teams, and the integration of clinical continuity in emergency plans. It also emphasized the need for durable power systems that protect care access for patients with chronic conditions during extended outages. ■

Despite persistent constraints and repeated disruption, Puerto Rico CHCs continue to deliver consistent, comprehensive and high value care. Their evolution reflects innovation and necessity as they adapt to funding shortfalls, infrastructure challenges, and rising demand. Their experience offers valuable lessons for CHCs nationwide, especially in areas where severe weather threats, economic hardships, and provider shortages converge. Puerto Rico CHCs are models of how health systems can reorient toward resilience, integration, and flexibility in the face of compounding shocks.