



# The Section 330 Financial Model: Current Environment & Strategic Risk Considerations

Section 330 grants provide federal operating support to community health centers, helping them serve all patients regardless of ability to pay. This funding exists within a financial landscape shaped by rising costs, reliance on Medicaid and savings generated from the 340B Drug Pricing Program, and other factors that create potential risks to stability and sustainability.

## Section 330 Model: Foundation but Not Full Funding

Section 330 grants provide federal funding to support the provision of services provided by health centers so they can serve all patients, regardless of their ability to pay. It also provides some important protections and benefits to include:

- Malpractice coverage through the Federal Tort Claims Act (FTCA)
- Fixed payment rates under a prospective payment system (PPS) under Medicaid and Medicare
- Eligibility for 340B drug discounts

*However:*

- Section 330 grants make up only about 11% of total health center revenue for health centers overall
- Almost three quarters of money comes from patient payments
- Medicaid alone is 45% of total revenue

*Health center grant funding subsidizes part of the costs to provide services to patients, but they are predominantly funded by Medicaid, Medicare, Commercial Insurance, and other patient payments.*

## National Financial Snapshot (2024)

In 2024, health centers across the country faced tight margins, rising costs, and limited cash reserves, making financial vigilance more important than ever.

- Total national health center revenue in 2024: \$49.6 billion
- Costs grew faster than revenue
- Average health center had a slightly negative margin (~-2%)
- Approximately half of centers had fewer than 90 days cash on hand
- Roughly one quarter operated with margins below -4%

*Because margins are tight, delays in payments, changes in Medicaid coverage, or shifts in 340B savings can quickly create cash shortages, affecting clinic hours, staffing, and the services that can be offered.*

## Where the Money Comes From

Unlike a typical doctor's office, a health center relies on a mix of funding sources. If one source changes, it can affect the center's entire budget and operations:

- **Medicaid (48%):** 1 in 2 patients are on Medicaid.
- **Federal Section 330 Grant (11%):** This pays for care for the uninsured, but it is fixed, it does not increase when more uninsured patients walk through the door.
- **Medicare (15%):** Medicare payments under the PPS are steady but subject to complex federal billing rules and many health centers have to perform additional work to receive wrap around

payments when working with Medicare Advantage plans.

- **340B Drug Discount Savings:** Savings generated by purchasing drugs at a discount. Many health centers have relied on these savings to fund non-revenue generating services like transportation or nutrition and due to changes in federal policy and manufacturer-imposed restrictions, the support provided by this program has been eroding which is challenging for health centers that already have minimal operating margins.

## Medicare and Medicaid: PPS & “The Wrap”

Health centers are paid under a PPS for services covered by Medicare and Medicaid. This is a flat, bundled rate per visit, intended to reflect reasonable per-visit costs rather than a fee-for-service “menu.”

For Medicare, the geographically unadjusted payment rates for a health center in 2026 are \$207.72 (lower payment limit for established patient visits) or \$278.78 (upper payment limit for limited new patients, annual wellness visits, and initial preventive physical exams). Medicaid PPS rates vary by state.

There are times when a health center is not paid PPS rates as required by law: for example, when health center’s patients are enrolled in Medicare Advantage (MA) plans or when states are utilizing Managed Care Organizations (MCOs) to administer Medicaid programs. In these cases, the health center must request wrap payments to cover shortfall between the payment from the MA plan or MCO and PPS payment owed to health center, ensuring the Health Center can be made whole.

A health center’s financial stability can hinge on timely wrap payments. A health center may appear financially stable on paper, but if wrap payments are delayed, it may not have enough cash on hand to cover payroll, vendors, or other expenses while waiting for payments it is owed.

## The Current Risk Profile (2026 Landscape)

The “safety net” is currently being stretched by a number of specific forces:

### 1) The “Uninsured Spike”

Following the 2024-2025 Medicaid redeterminations (where states re-checked eligibility), millions lost coverage.

- The Result: Health centers saw a 25% increase in uninsured patients.
- The Impact: Costs go up, but the Section 330 grant stays flat. This is the primary driver of the current -2.1% national deficit.
- The operational risks: Increased front-end eligibility workload, higher no-show rates tied to coverage uncertainty, increased bad debt exposure, greater reliance on section 330 funds

### 2) The Telehealth Policy Uncertainty

- Telehealth accounts for 13% of all visits.
- Medicare Telehealth Policy: Current flexibilities allow health centers to be paid for these visits through December 31, 2027.
- The Risk: After December 31, 2027, strict “in-person” requirements return for mental health.

### 3) 340B Concentration Risk

The 340B program allows health centers to buy drugs at a discount and use the savings to support services. Drug manufacturers are increasingly restricting where 340B discounts apply (the “Contract Pharmacy” battle).

- In 2024, health centers bought \$4.7B in 340B drugs
- Profits depend on reimbursement, contracts, and manufacturer rules

- Compliance is strict, audits and record-keeping matter
- The Risk: If a health center relies heavily on 340B revenue, policy changes or compliance problems can affect cash and services.

#### 4) Workforce Costs and Inflation

In 2024, health centers employed over 313,000 full-time staff nationally. Workforce challenges and rising costs create pressure on operations, including:

- Ongoing staff shortages across the sector
- Rising wages combined with unfilled positions
- Fewer available appointment slots, limiting patient access
- Higher spending on contract labor to fill gaps
- Productivity pressures that can affect quality and compliance
- Delayed investments in security, analytics, and revenue cycle systems

#### The 330 model works, but it is margin sensitive.

- A Medicaid-heavy payer mix with thin margins means small disruptions create real operational consequences.
- Cash timing is as important as payment rates.
- Wrap payments, telehealth billing, and 340B cash flow all affect liquidity.
- Liquidity must be monitored closely.
- Days cash on hand, payment lags, pharmacy concentration risk, and payer mix trends should be standing board agenda items.

#### Health Centers should emphasize:

- Active liquidity monitoring
- Payer mix and wrap lag tracking
- 340B concentration analysis
- Telehealth policy surveillance
- Workforce cost discipline

#### Helpful Links and References

1. <https://www.kff.org/medicaid/community-health-center-patients-financing-and-services/>
2. <https://www.medicaid.gov/federal-policy-guidance/downloads/sho10004.pdf>
3. <https://nachc.org/wp-content/uploads/2023/03/b9784c7326bea6f2202ef78a41872e03.pdf>
4. <https://www.hrsa.gov/opa/updates/2024-340b-covered-entity-purchases>
5. <https://www.nachc.org/2024-uds-early-takeaways-community-health-center-growth-under-pressure/>
6. <https://www.nachc.org/community-health-centers-grew-in-2024-but-patient-access-faces-a-tipping-point/>
7. <https://www.congress.gov/crs-product/R48696>
8. <https://www.hrsa.gov/opa/implementation-contract>
9. [https://issuu.com/nachc.com/docs/medicare\\_reimbursement\\_resources\\_for\\_fqhcs?fr=xKAE9\\_zU1NQ](https://issuu.com/nachc.com/docs/medicare_reimbursement_resources_for_fqhcs?fr=xKAE9_zU1NQ)

**Disclaimer:** This is intended as a high-level overview of the Section 330 financial model and current risk environment, not a detailed reimbursement or audit analysis. The figures referenced rely heavily on UDS data, which should be interpreted cautiously since accounting methodology, categorization, and reporting conventions vary across tables. As a result, trends and directional insights are more reliable than precise cross-table comparisons or margin calculations. Individual health center performance will vary based on state policy, payer mix, operational efficiency, and pharmacy model design.