

INCREASING ACCESS TO HEALTH CARE AND REDUCING MINORITY HEALTH DISPARITIES: A BRIEF HISTORY AND THE IMPACT OF COMMUNITY HEALTH CENTERS

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Access to health care in the United States varies greatly from state to state and from community to community depending on a number of factors, including the number of poor, uninsured, and medically indigent people; the breadth, depth, and generosity of Medicaid to patients and providers; the local public health and private medical care systems; local political and economic conditions; and the extent of programs targeted specifically toward the poor, uninsured, and other vulnerable and high risk populations, such as the homeless. Among the core providers of these health care “safety nets” are public hospitals, community health centers, school-based clinics, and local health departments—which include community and teaching hospitals that provide care for significant Medicaid populations—and private physicians who provide care to Medicaid and uninsured patients, particularly in rural and inner city settings.¹ This paper will concentrate on the community health centers’ (CHCs) contributions to providing access to primary health care and reducing minority health disparities, the history of CHCs, and the challenges that they currently face.

The number of uninsured, non-elderly Americans has grown steadily since 1987 and was estimated by the Census Bureau to be 43.9 million in 1998.² An analysis by the Congressional Budget Office, noted that this figure “‘overstates the number of people who are uninsured all year,’ while significantly understating the number who

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1. AMERICA’S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 47–69 (Marion Ein Lewin & Stuart Altman eds., 2000) [hereinafter AMERICA’S HEALTH CARE SAFETY NET].

2. *Id.* at 85.

are insured for only part of the year,” estimating that between fifty-seven and fifty-nine million Americans were uninsured during some part of 1998 and between twenty-one and thirty-one million were uninsured during the entire year.³ The increase in number of uninsured individuals results from the decline in people receiving health insurance through their employers—most dramatically seen in low-income workers—as employers shift more premium costs to their employees and opt out of employment-based insurance or support individual coverage. The growth of part-time, temporary, and contract workers that do not receive health benefits, declines in Medicaid coverage since 1995 (as states try to control the program’s escalating costs), and a recent decline in companies covering their retirees are also relevant factors.⁴

Between 1990 and 2001, community health centers almost doubled the number of uninsured they serve, from 2.2 to four million.⁵ By 1999, community health centers served 8.3 million people—approximately eight percent of the nation’s forty-three million uninsured, nine percent of its thirty-two million Medicaid recipients, and nineteen percent of the forty-three million people living in federally designated areas lacking access to primary care providers.⁶

I.

A BRIEF HISTORY OF COMMUNITY HEALTH CENTERS

Since many of the contradictions of the American health system are rooted in history, an overview of the development and expansion of CHCs will preface the financial challenges they face in providing access to the uninsured and medically indigent, as well as in reducing minority health disparities.

The roots of the comprehensive community health center in the United States can be traced to the creation of outpatient dispensaries for new immigrants and the poor in Northeastern port cities in the late nineteenth and early twentieth centuries.⁷ The idea traveled to En-

3. Robert Pear, *New Study Finds 60 Million Uninsured During a Year*, N.Y. TIMES, May 13, 2003, at A22.

4. AMERICA’S HEALTH CARE SAFETY NET, *supra* note 1, at 84–93.

5. SARA ROSENBAUM & PETER SHIN, THE HENRY J. KAISER FAMILY FOUNDATION, HEALTH CENTERS AS SAFETY NET PROVIDERS: AN OVERVIEW AND ASSESSMENT OF MEDICAID’S ROLE 11 (May 2003), <http://www.kff.org/medicaid/loader.cfm?url=/Commonspot/security/getfile.cfm&PageID=14342>.

6. Bonnie Lefkowitz & Jennifer Todd, *An Overview: Health Centers at the Crossroads*, J. AMBULATORY CARE MGMT., Oct. 1999, at 1, 8.

7. ALICE SARDELL, THE U.S. EXPERIMENT IN SOCIAL MEDICINE: THE COMMUNITY HEALTH CENTER PROGRAM, 1965–1986 23 (1988).

gland in the 1920s with the Peckham Health Center,⁸ and to South Africa⁹ and Jerusalem¹⁰ in the 1940s and 1950s under the leadership of Dr. Sidney Kark. Dr. Kark's work directly influenced the co-founders of the first U.S. community health centers in Mound Bayou, Mississippi, and in the Columbia Point neighborhood in Boston in 1965.¹¹

Michael Harrington's best-seller, *The Other America: Poverty in the United States*, helped the Kennedy administration "re-discover" poverty in the United States.¹² As one consequence, the Migrant Health Act was enacted in 1962, which provided some of the first direct federal grants to community non-profit organizations for any purpose.¹³ Migrant health centers still offer a "broad array of culturally- and linguistically-competent medical and support services to migrant and seasonal farmworkers . . . and their families."¹⁴

Another arm of the War on Poverty under the U.S. Office of Economic Opportunity (OEO)—what were then called "neighborhood health centers"—sought to embody the concepts of comprehensive, continuous primary health care, social medicine, and community participation.¹⁵ The OEO also worked to provide access to high quality, preventive, and curative health care to low-income populations who lacked access to private care.¹⁶ The OEO's health care initiative was a response to high rates of undetected disease and disability among young, poor, and mostly minority applicants to its Job Corps program. Neighborhood health centers were intended not only to complement

8. See generally INNES H. PEARSE & LUCY H. CROCKER, *THE PECKHAM EXPERIMENT: A STUDY IN THE LIVING STRUCTURE OF SOCIETY* (1943) (explaining development and creation of Health Centre in South London).

9. See generally A PRACTICE OF SOCIAL MEDICINE: A SOUTH AFRICAN TEAM'S EXPERIENCES IN DIFFERENT AFRICAN COMMUNITIES (Sidney L. Kark & Guy W. Stuart, eds., 1962) (documenting editors' experiences and studies in health work in South Africa).

10. See generally SIDNEY L. KARK, *THE PRACTICE OF COMMUNITY-ORIENTED PRIMARY HEALTH CARE* (1981) (discussing Dr. Kark's involvement with community health care in Jerusalem in 1950s).

11. H. Jack Geiger, *The Meaning of Community Oriented Primary Care in the American Context*, in *COMMUNITY ORIENTED PRIMARY CARE: NEW DIRECTIONS FOR HEALTH SERVICES DELIVERY* 60 (Eileen Connor & Fitzhugh Mullan eds., 1983).

12. See MICHAEL HARRINGTON, *THE OTHER AMERICA: POVERTY IN THE UNITED STATES* (1962).

13. United States Department of Health and Human Services Bureau of Primary Health Care, Migrant Health Program, at <http://www.bphc.hrsa.gov/migrant> (last visited Sept. 29, 2004).

14. *Id.*

15. H. Jack Geiger, *Community Health Centers: Health Care as an Instrument of Social Change*, in *REFORMING MEDICINE: LESSONS OF THE LAST QUARTER CENTURY* 16–18 (Victor W. Sidel and Ruth Sidel eds., 1984).

16. SARDELL, *supra* note 7, at 3–4.

the federal Medicare and Medicaid insurance programs,¹⁷ but also to offer a model of health care reform that ideally included community outreach and empowerment, social services, mental health services, nutrition, environmental health and sanitation, job training, legal advocacy, and other public health and community organizing initiatives.¹⁸ The OEO provided grants to medical schools, hospitals, health departments, and community-based organizations to plan and administer health centers in low-income areas, marking the first time in history that the federal government bypassed state, county, and municipal governments directly to fund experiments in health care delivery with the goal of reform.¹⁹

Dr. H. Jack Geiger, co-founder of the first two OEO health centers mentioned above, identified five central principles for the first generation of OEO-funded health centers, which continue today:

- (1) Equity in access to health care through reduction or removal of the barriers of income, insurance status, geography and transportation, language and culture, and health manpower shortages;
- (2) Services to defined communities and populations, with priority to those in greatest relative need;
- (3) Partnerships with communities through active participation by residents in health center management; the recruitment and training of residents as staff members for outreach, health education, community organization and development; and community participation in shaping and overseeing health center programs;
- (4) Multidisciplinary family health care teams expanding the medical model to include outreach, health education, social work, mental health, nutrition and environmental workers and;
- (5) Community-oriented primary care involving the application of epidemiology to primary care in the definition of major community health problems, the planning of interventions, and the evaluation of health outcomes.²⁰

The OEO supported about 100 such “model” neighborhood health centers across the country in impoverished urban and rural communities, providing primary and sometimes specialty medical care, nutrition education, dental and optometry services, mental

17. Medicare programs provide insurance for the elderly and disabled, while Medicaid provides insurance for the poor. These programs were enacted by Congress in 1964 and implemented in 1965.

18. H. Jack Geiger, *Assuring Access: Community Health Centers as a Community-Based Model of Coordinated Care*, in 2 PROCEEDINGS: THE NATIONAL PRIMARY CARE CONFERENCE 225 (Mar. 29-31, 1992).

19. SARDELL, *supra* note 7, at 3-4.

20. Geiger, *supra* note 18, at 226.

health, outreach, and home care.²¹ Community control was given to health center boards under the War on Poverty's rubric of "maximum feasible participation" to help develop indigenous leadership in these communities.²² During this period, the OEO planned to fund one thousand such centers and serve twenty-five million people.²³

CHCs outlasted the OEO and the short-lived War on Poverty. In 1975, the Department of Health, Education, and Welfare became responsible for administering community and migrant health centers as categorical grant programs under Section 330 of the Public Health Service (PHS) Act, amended over President Gerald Ford's veto of the Special Health Revenue Sharing Act of 1975.²⁴ The PHS adopted the term "community health centers," and the number of centers continued to grow from 158 in 1971 to 872 in 1982.²⁵

In the first budget of the Reagan Administration, funding for the CHC categorical grant program, like many other domestic programs, was cut by twenty-five percent, eventually leading to the closure of about 200 centers nationwide by the mid-1980s.²⁶ Subsequent budgets, however, restored funding, and by 1991 approximately 550 public and voluntary organizations were supporting 1400 clinical sites, sixty percent of which were located in rural areas.²⁷ Community and migrant health centers (C/MHCs) served six million people, sixty percent of whom had incomes below the federal poverty level.²⁸ In 1998, there were 698 CHCs serving 8.7 million patients in all fifty states and territories, including the Commonwealth of Puerto Rico, the Virgin Islands, and the District of Columbia; these centers reported approximately 3,000 service sites.²⁹ By 2002, the number of community, migrant, public housing, and homeless health centers had grown to 1,000 (with 3,500 service sites) and served fourteen million people, nine million of whom were minorities.³⁰ Federal appropriations in 2002

21. Geiger, *supra* note 15, at 19–20.

22. SARDELL, *supra* note 7, at 55.

23. See Hal Strelnick & Richard Younge, *Another Kind of Bronx Cheer: Community-Oriented Primary Care at the Montefiore Family Health Center*, 22 HEALTH POL'Y ADVISORY CENTER BULL. 3, 19 (1992).

24. Alice Sardell, *Neighborhood Health Centers and Community-Based Care: Federal Policy from 1965 to 1982*, 4 J. PUB. HEALTH POL'Y 484, 490 (1983).

25. Strelnick & Younge, *supra* note 23, at 19.

26. *Id.*

27. *Id.*

28. *Id.*

29. AMERICA'S HEALTH CARE SAFETY NET, *supra* note 1, at 60.

30. NAT'L ASS'N OF CMTY. HEALTH CTRS., FACT SHEET: HEALTH CENTERS' ROLE IN REDUCING RACIAL AND ETHNIC HEALTH DISPARITIES (Sept. 2003), <http://www.nachc.com/advocacy/healthdisparities/files/disparitiesfactsheet.pdf> [hereinafter FACT SHEET].

totaled \$1.3 billion.³¹ The population that CHCs served that year was approximately one-quarter African-American and one-third Hispanic/Latino.³²

II.

MAJOR CHANGES IN COMMUNITY HEALTH CENTERS

A. *Rural and Urban Health Initiatives*

To counter attempts by the Ford administration to reduce funding for CHCs and eliminate their categorical statutory status, the PHS' Bureau of Community Health Services created the Rural Health Initiative in 1975.³³ At the time, about half of all medically underserved people lived in rural areas, but the OEO-generation of CHCs were large facilities and predominantly urban.³⁴ Eighty-five percent of CHC funding went to urban centers.³⁵ The Rural Health Initiative shifted CHC funding towards smaller, rural centers and integrated them with the National Health Service Corps (NHSC), which placed doctors, dentists, nurse practitioners, and physician assistants in C/MHCs in rural underserved communities.³⁶

In 1977, the Bureau added thirty-five small new "Urban Health Initiative" sites to its Section 330 grants, and in 1978 increased the number to sixty, again integrating NHSC personnel placement with new and existing CHCs.³⁷ Many awards were for satellite clinics administered by existing, first-generation CHCs, which were previously funded by OEO.³⁸ The Bureau placed greater emphasis on efficiency and cost-effectiveness in grant-making. Through these strategic Rural and Urban Health Initiatives, the Bureau sought to place NHSC personnel in every congressional district in the nation, and thus broaden the political support for both the NHSC and CHCs.³⁹ The Bureau ultimately succeeded in this endeavor. These initiatives have also led to the development of health center networks where federal grantees have an average of three service sites. In 1987, the Office of Rural Health Policy was also established in the Department of Health and Human Services to advise on policy affecting rural hospitals and

31. *Id.*

32. *Id.*

33. See SARDELL, *supra* note 7, at 110-12.

34. *Id.* at 112.

35. *Id.*

36. *Id.* at 112-13.

37. *Id.* at 117-18.

38. Sardell, *supra* note 24, at 493.

39. SARDELL, *supra* note 7 at 116-17.

health centers and to coordinate federal activities on rural health care.⁴⁰

B. CHCs and Block Grants to the States

Each year from 1981 to 1987, the Reagan administration proposed to reduce funding from the previous year's appropriations, and to convert the CHC program into a block grant to be administered by the states.⁴¹ The Administration succeeded only in 1981, but a "poison pill" requirement that states provide matching funds resulted in only one state—West Virginia—accepting the block grant, and only for one year.⁴² Other categorical PHS programs, including Maternal and Child Health (Title V) and Family Planning (Title X of the Social Security Act), did become state block grants.⁴³ As direct federal funding during the 1980s lagged far behind medical inflation, these programs became sources of grant revenues for those CHCs that survived the twenty-five percent budget cuts of the "Reagan revolution" budget of 1981.⁴⁴

C. Federally-Qualified Health Centers and Homeless, Public Housing, and Migrant Health Centers

In 1987, Congress enacted the Stewart B. McKinney Homeless Assistance Act (McKinney Act) to help the nation's homeless population by providing emergency food and shelter, education, and transitional and permanent housing.⁴⁵ The McKinney Act created Section 340 of the Public Health Service Act to address the health problems faced by people who are homeless. It "was modeled after a successful four-year demonstration program operated in nineteen cities by the Robert Wood Johnson Foundation and the Pew Charitable Trust."⁴⁶

40. U.S. DEP'T OF HEALTH AND HUMAN SERVS., RURAL HEALTH POLICY, at <http://www.ruralhealth.hrsa.gov> (last visited Nov. 13, 2004).

41. See SARDELL, *supra* note 7, at 193.

42. *Id.*

43. Geraldine Dallek, *Frozen in Ice: Federal Health Policy During the Reagan Years*, 18 HEALTH POL'Y ADVISORY CENTER BULL. 4 (1988).

44. See SARDELL, *supra* note 7, at 194–96.

45. Public Health Service Act, 42 U.S.C. § 201 et seq.

46. See BUREAU OF PRIMARY HEALTH CARE, U.S. DEP'T HEALTH & HUMAN SERVS., HEALTH CARE FOR THE HOMELESS INFORMATION RESOURCE CENTER: ABOUT HCH, at http://www.bphc.hrsa.gov/hchirc/about/comp_response.htm (last visited Nov. 13, 2004).

Appropriations, which currently fund 161 grantees,⁴⁷ have grown from \$35.7 million in 1990 to \$130 million in 2003.⁴⁸

In the late 1980s, Congress reacted to the fact that Medicare and Medicaid were not paying the total costs of services for program beneficiaries at CHCs by providing low reimbursement rates and limited Medicaid coverage for enabling services, such as case management, referral, and outreach.⁴⁹ As a part of the Omnibus Budget Reconciliation Act of 1989, Congress required that both Medicare and Medicaid programs reimburse health centers for their reasonable costs, establishing the criteria for Federally-Qualified Health Centers (FQHCs).⁵⁰ Congress recognized that many such clinics were supported by state and local governments, did not receive federal Section 330 grants, and were highly dependent on Medicaid revenues.⁵¹ To qualify as FQHCs and receive cost-based reimbursement, health centers must meet five requirements:

- (1) be located in a medically underserved area or serve a medically underserved population;
- (2) have nonprofit, tax exempt, or public status;
- (3) have a Board of Directors, a majority of whom must be consumers of the center's health services;
- (4) provide culturally-competent, comprehensive primary care services to all age groups; and
- (5) offer a sliding fee scale and provide services regardless of ability to pay.⁵²

In 1990, the Public Housing Primary Care Program was created under the Disadvantaged Minority Health Improvement Act to "provide accessible comprehensive primary healthcare and supportive services in order to improve the overall health and well-being of the public housing community, and to eliminate health disparities."⁵³ In 2002, some thirty-three federal grants served 70,000 public housing residents in eighteen states.⁵⁴

47. *Id.* at http://www.bphc.hrsa.gov/hchirc/about/prog_successes.htm (last visited Nov. 13, 2004).

48. *Id.* at <http://www.bphc.hrsa.gov/hchirc/about/appropriations.htm> (last visited Nov. 13, 2004).

49. U.S. GEN. ACCOUNTING OFF., COMMUNITY HEALTH CENTERS: CHALLENGES IN TRANSITIONING TO PREPAID MANAGED CARE 5 (May 1995), <http://www.gao.gov/archive/1995/he95138.pdf>.

50. *Id.*

51. *Id.*

52. AMERICA'S HEALTH CARE SAFETY NET, *supra* note 1, at 60 (footnote omitted).

53. HEALTH RES. & SERVS. ADMIN., DEP'T OF HEALTH AND HUMAN SERVS., PUBLIC HOUSING PRIMARY CARE PROGRAM: FACT SHEET, at http://www.bphc.hrsa.gov/phpc/phpc_program/fact_sheet.htm (last visited Nov. 13, 2004).

54. *Id.*

Also in 1990, the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act was passed by Congress as the first federally-funded service program for HIV/AIDS, and was later incorporated as Title IV of the Social Security Act.⁵⁵ Many CHCs have applied for and received supplementary federal funds to provide more comprehensive and intensive services for their patients.⁵⁶

In 1996, the Health Centers Consolidated Care Act was passed, which incorporated the Public Health Service's Migrant, Community, Homeless, and Public Housing programs all under Section 330 and as Federally-Qualified Health Centers.⁵⁷ Homelessness programs were not required to have boards of directors with consumer majorities.⁵⁸

In 1997, Congress passed the State Children's Health Insurance Program (SCHIP), which became Title XXI of the Social Security Act.⁵⁹ SCHIP authorized \$40 billion to be spent over ten years, expanding health insurance to children under nineteen years of age from families whose incomes were both (a) above what would qualify for Medicaid, and (b) up to 200 percent of the federal poverty level.⁶⁰ SCHIP, based on successful programs already operating in Florida and New York, became the greatest investment in children's health since the enactment of Medicaid. States were permitted to expand their Medicaid programs, purchase existing insurance, or create new subsidized health insurance programs, all to be approved by the Secretary of Health and Human Services.⁶¹ In accordance with this legislation, states contribute a defined share to obtain federal matching funds to cover uninsured children, and some have extended coverage to low-income parents.⁶² Most states have employed managed care organizations to insure these children and families. Before becoming eligible for separate programs, potential recipients must demonstrate that they are not Medicaid-eligible.⁶³

55. AMERICA'S HEALTH CARE SAFETY NET, *supra* note 1, at 62.

56. *Id.*

57. See U.S. DEP'T OF HEALTH AND HUMAN SERVS., PUBLIC HOUSING PRIMARY CARE PROGRAM, at http://www.bphc.hrsa.gov/phpc/phpc_program/fact_sheet.htm (last visited Nov. 22, 2004).

58. AMERICA'S HEALTH CARE SAFETY NET, *supra* note 1, at 60 n.6.

59. See *Implementation Principles and Strategies for the State Children's Health Insurance Program*, 107 PEDIATRICS 1214, 1214 (2001) (policy statement from the American Academy of Pediatrics, Committee on Child Health Financing).

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

III.

CHANGES AFFECTING COMMUNITY HEALTH CENTERS IN
THE HEALTH CARE MARKETPLACEA. *Medicaid Managed Care and CHCs*

Following the apparent success of commercial managed care plans in slowing the growth of health care costs for large employers, states began to change their Medicaid reimbursement systems from traditional fee-for-service for providers to a range of risk-based and primary care case management models of managed care.⁶⁴ States have reformed their Medicaid programs to control costs, expand coverage to the uninsured, and promote accountability among providers and plans to improve performance and quality.⁶⁵ When Medicaid expenditures grew at alarming rates between 1988 and 1992 because of an economic recession and new federal eligibility mandates, they became the fastest growing component of most states' budgets.⁶⁶ Experiments with voluntary Medicaid managed care plans that began in the 1980s accelerated towards mandatory enrollment in the 1990s, as states tried to control costs.⁶⁷ By 1998, more than half of Medicaid beneficiaries were enrolled in managed care. By 2000, forty-eight states' Medicaid programs had some managed care initiatives, with ten states enrolling more than three-fourths of their beneficiaries in managed care.⁶⁸

The enabling legislation for state-level experimentation with Medicaid managed care was incorporated in the Omnibus Budget Reconciliation Act (OBRA) of 1981, which paved the way for Arizona's Health Care Cost Containment System, the nation's first statewide Medicaid managed care program, in October of 1982.⁶⁹ Until then, Arizona had been the only state that did not participate in Medicaid.⁷⁰

B. *Section 1115 and 1915(b) Waivers*

Originally introduced as part of the 1962 Public Welfare Amendments to the Social Security Act, Section 1115 waivers allow states to set aside almost any Medicaid regulatory requirement from eligibility rules to reimbursement formulas, subject to approval by the Center for

64. AMERICA'S HEALTH CARE SAFETY NET, *supra* note 1, at 29.

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.* The only two states without managed care initiatives were Alaska and Wyoming.

69. *Id.* at 30.

70. *Id.*

Medicare and Medicaid Services (formerly the Health Care Financing Administration) and the Secretary of Health and Human Services.⁷¹ As long as total program costs were budget neutral, Medicaid program savings could be used to expand coverage to other low-income groups.⁷² Medicaid covers only half of Americans living below the poverty level, and only about one-third of all beneficiaries remain on Medicaid for more than a year, most of whom lose their eligibility and become uninsured.⁷³ The waivers shifted direct payments from providers to managed care plans, permitting CHCs either to contract with these plans or the state Medicaid agency, or to establish their own managed care plans.⁷⁴ Revisions of Section 1115 waivers eliminated the federal requirement for cost-based reimbursements to federally-qualified CHCs, enacted in the 1989 OBRA.⁷⁵ CHCs had increased their dependence on Medicaid revenues which had accounted for only twenty-one percent of their income in 1990 but nearly twice that amount—thirty-five percent—by 1997.⁷⁶

Section 1915(b) waivers have been adopted by forty states.⁷⁷ While these waivers are more limited, they exempt states from federal rules concerning comparability and availability of services statewide, and permit states to implement mandatory managed care in one county, part of the state, or for just certain categories of individuals.⁷⁸ These waivers also give states the right to allow plans to offer FQHC services without having to contract with FQHCs to provide them. In most states, implementation of the waiver programs improved potential provider reimbursement and increased the willingness of some insurers and providers that had previously avoided Medicaid patients to participate in state-level managed care, resulting in increased competition by providers for Medicaid patients.⁷⁹

C. Medicaid Managed Care Models

States employ two major models of Medicaid managed care: risk-based plans and fee-for-service primary care case management.

71. *Id.* at 31.

72. John Holahan et al., *Insuring the Poor Through Section 1115 Medicaid Waivers*, HEALTH AFF., Spring 1995, at 200.

73. See Olveen Carrasquillo et al., *Can Medicaid Managed Care Provide Continuity of Care to New Medicaid Enrollees? An Analysis of Tenure on Medicaid*, 88 AM. J. PUB. HEALTH 464, 465 (1998).

74. AMERICA'S HEALTH CARE SAFETY NET, *supra* note 1, at 31.

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

Under risk-based plans, the managed care organization assumes financial risk for a defined set of health care services in exchange for a fixed payment per enrollee per month, often adjusted for age.⁸⁰ Managed care organizations can assume full risk for health care delivery for a defined comprehensive range of services or partial risk by contracting for just a limited range of services (e.g., ambulatory care).⁸¹ Primary care case management assigns responsibility for health care to a specific primary care provider who receives payments on a fee-for-service basis and typically receives an additional monthly capitation fee for case management services. As market competition and cost control efforts have strengthened, states have moved away from primary care case management towards risk-based plans, doubling their number between 1993 and 1998.⁸²

Almost ninety percent of Medicaid enrollees in risk-based managed care plans are women of child-bearing age and children, who represent about three-quarters of all beneficiaries; however, these groups account for only about one-quarter (twenty-seven percent) of Medicaid spending.⁸³ Medicaid managed care can only offer major savings to states if the more costly low-income elderly and disabled populations (with their greater needs—and expenditures—for health care) can be successfully enrolled and cared for.⁸⁴

D. Balanced Budget Act of 1997 and Balanced Budget Refinement Act of 1999

The 1997 Balanced Budget Act (BBA) also significantly revised and expanded state options within federal Medicaid regulations, granting states the authority to mandate managed care enrollment for those elderly and disabled patients who are eligible for both Medicare and Medicaid. Most important to federally-qualified CHCs was the phase-out of cost-based reimbursement for FQHCs over five years. Although the BBA Refinement Act of 1999 extended the year of final repeal of cost-based reimbursement from 2003 to 2005, the National Association of Community Health Centers estimated that these provisions of the BBA of 1997 would cost CHCs approximately \$1.1 billion, with the BBA Refinement Act cutting these losses roughly by half.⁸⁵ During the transition, FQHCs are not to receive less for treat-

80. *Id.*

81. *Id.* at 32.

82. *Id.*

83. *Id.*

84. *Id.*

85. *See id.*

ing Medicaid beneficiaries in managed care than for those under fee-for-service plans. States may continue cost-based reimbursements to CHCs, as some twenty-seven states have done,⁸⁶ however uncertain and fragile such support may be.

The BBA of 1997 also permits states, without federal approval, to limit Medicaid beneficiaries' choice in urban areas to two managed care options and to one option in rural areas, and for providers to sponsor Medicaid-only managed care plans, independent of insurance companies that many CHCs have joined or co-sponsored.⁸⁷ If these provider-sponsored plans meet both federal certifications for Medicare and consumer protection regulations, then they may participate in both Medicare and Medicaid without the large financial reserves required by most states for insurance companies.⁸⁸ In summary, the BBA of 1997 included both coverage of uninsured children under SCHIP and potential reductions in Medicaid reimbursements to CHCs and other safety net providers, and facilitated CHC participation in Medicaid managed care. The BBA Refinement Act of 1999 eased some of the Medicaid cuts to CHCs by lengthening the time of their transition from cost-based reimbursements to competing in an increasingly competitive Medicaid marketplace.

E. The Community Access Program

The Health Care Safety Net Act of 2000 created the Community Access Program (CAP) and was amended in 2002.⁸⁹ CAP grants are designed to "increase access to health care" for the uninsured and underinsured "by eliminating fragmented service delivery, improving efficiencies among safety net providers, and by encouraging greater private sector involvement." CAP grants support the development and implementation of chronic disease and case management protocols, the linkage of hospital and clinic services through improved management information systems, and community health workers' health promotion, outreach, insurance enrollment, and case management efforts.⁹⁰ Since 2000, CAP grants have been awarded to a total of 158 urban and rural communities.⁹¹

86. *Id.*

87. *Id.* at 37.

88. *Id.*

89. See BUREAU OF PRIMARY HEALTH CARE, U.S. DEP'T. OF HEALTH & HUMAN SERVS., THE COMMUNITY ACCESS PROGRAM (CAP), at <http://www.bphc.hrsa.gov/cap> (last visited Nov. 22, 2004).

90. *Id.*

91. *Id.*

IV.

COMMUNITY HEALTH CENTERS RESPOND TO THE NEW
HEALTH CARE MARKETPLACE

In response to the changing Medicaid and SCHIP marketplace, CHCs have pursued both vertical and horizontal integration strategies to maintain their missions and fiscal viability.⁹² Vertical integration consists of CHCs joining or developing strategic alliances with hospitals, hospital systems, or major health plans to maintain their Medicaid patients and gain access to Medicare and commercial enrollees. Horizontal integration for CHCs involves joining together with other primary care providers and CHCs to gain bargaining leverage in negotiations with managed care plans and hospitals or actually forming managed care plans of their own.⁹³

During the 1990s, with only a twenty-eight percent increase in the number of federal C/MHC grantees, the number of people that they served doubled.⁹⁴ During this same period the rate of growth in the number of uninsured attending CHCs grew at more than two and one-half times the national rate.⁹⁵ There is also evidence that a significant proportion of CHCs' new uninsured patients had previously used other providers that were now demanding payments they could not make.⁹⁶ The number of uninsured patients attending CHCs grew from 2.2 million (thirty-eight percent of all users) in 1990 to 3.6 million (forty-one percent of users) in 1998. Federal Section 330 grant revenues fell from forty-one percent of CHC revenue in 1990 to twenty-four percent in 1998, with Medicaid increasing from twenty-one percent to thirty-four percent during the same period.⁹⁷ However, CHCs with greater involvement in managed care have been found to serve a significantly smaller proportion of uninsured patients, but a higher proportion of Medicaid patients.⁹⁸ CHCs that pursued managed care strategies had more diversified sources of revenue and were less dependent upon grant funding, but also had greater financial vulnerabil-

92. See Debra J. Lipson & Naomi Naierman, *Effects of Health System Changes on Safety-Net Providers*, HEALTH AFF., Summer 1996, at 41–42.

93. *Id.*

94. See BUREAU OF PRIMARY HEALTH CARE, DEP'T OF HEALTH & HUMAN SERVS., EXPERTS WITH EXPERIENCE: COMMUNITY & MIGRANT HEALTH CENTERS—HIGHLIGHTING A DECADE OF SERVICE (1990–2000) 8 (n.d.), <http://www.bphc.hrsa.gov/chc> (last visited Nov. 22, 2004).

95. *Id.*

96. See Lefkowitz & Todd, *supra* note 6, at 8.

97. AMERICA'S HEALTH CARE SAFETY NET, *supra* note 1, at 120, 121 tbl. 3.5.

98. See Leiyu Shi et al., *The Impact of Managed Care on the Mix of Vulnerable Populations Served by Community Health Centers*, 24 J. AMBULATORY CARE MGMT. 51, 52 (2001).

ity due to higher costs and net revenue deficits.⁹⁹ CHCs have sought other federal, state, local, and private grants for specific needs, including maternal and child health, family planning, substance abuse treatment for pregnant women and children, infant mortality, and primary care for people with HIV or AIDS.¹⁰⁰ This “patchwork” of diverse grants exacts a high administrative and managerial toll while also diversifying risk.

The Institute of Medicine has summarized the CHCs’ dilemma as follows:

The ability of CHCs to succeed in future years is directly related to their ability to respond to the increasing number of uninsured patients that they serve in a more competitive, demanding environment. The number of uninsured patients served by FQHCs has grown at nearly double the rate of the number of uninsured persons in the general population since 1990. . . . The rising number of uninsured patients in the absence of revenue streams to support such care could threaten the fiscal viability of CHCs.¹⁰¹

V.

EFFECTIVENESS OF COMMUNITY HEALTH CENTERS ON ACCESS, HEALTH, AND HEALTH DISPARITIES

Since the late 1960s, research has been conducted on the performance, health status impact, and cost-effectiveness of CHCs’ provision of health care for poor and minority patients. From the beginning, CHCs have enabled greater access to and increased use of primary care and preventives services by high-risk, low-income populations, including children and the elderly.¹⁰² Early studies demonstrated striking effectiveness in lowering perinatal and infant mortality rates,¹⁰³ preventing rheumatic fever,¹⁰⁴ and lowering cardiovascular

99. Leiyu Shi et al., *Managed Care and Community Health Centers*, 23 J. AMBULATORY CARE MGMT. 1, 11 (2000).

100. AMERICA’S HEALTH CARE SAFETY NET, *supra* note 1, at 62.

101. *Id.* at 123.

102. *See, e.g.*, Louise M. Okada & Thomas T. H. Wan, *The Impact of Community Health Centers and Medicaid on the Use of Health Services*, 95 PUB. HEALTH REP. 520, 524–27 (1980); Ronald A. Reynolds, *Improving Access to Health Care Among the Poor—The Neighborhood Health Center Experience*, 54 MILBANK MEMORIAL FUND Q.: HEALTH & SOCIETY 47, 54–66 (1976).

103. *See* Andre Chabot, *Improved Infant Mortality Rates in a Population Served by a Comprehensive Neighborhood Health Program*, 47 PEDIATRICS 989, 992–93 (1971).

104. *See* Leon Gordis, *Effectiveness of Comprehensive-Care Programs in Preventing Rheumatic Fever*, 289 NEW ENG. J. MED. 331, 334 (1973).

mortality.¹⁰⁵ CHCs have also been found to achieve reductions in hospitalization rates¹⁰⁶ and pediatric emergency room visits¹⁰⁷ for population of their targeted communities. As a consequence of these achievements (among others), the cost of health care for the populations using health centers has been found to be significantly lower than for similar populations that use private physicians, hospital outpatient departments, and emergency departments as their primary source of care.¹⁰⁸ In summary, the available evidence suggests that CHCs successfully reach low-income communities, serve as an effective entry point to the health care system, and promote on-going and continuous high quality care at relatively lower costs while improving health status.

Access to a regular and usual source of care can mitigate health status disparities. CHCs have reduced racial, ethnic, income, and insurance status disparities in access to primary care, and provide important preventive screening procedures—such as mammograms, clinical breast examinations, and Pap smears—at rates that meet or exceed national averages.¹⁰⁹ After controlling for socio-demographic factors, disparities in health status do not exist among health center users; in fact, there are no significant differences between white and African-American health center patients,¹¹⁰ while non-white Hispanic health center patients are the healthiest group of the three.¹¹¹ Evidence suggests that health centers are successful in reducing and eliminating

105. See Mark B. Dignan et al., *Effect of Increased Access to Health Care on Mortality from Cardiovascular Disease in Rural Tennessee*, 94 PUB. HEALTH REP. 186, 191 (1979).

106. See Seymour S. Bellin et al., *Impact of Ambulatory-Health-Care Services on the Demand for Hospital Beds: A Study of the Tufts Neighborhood Health Center at Columbia Point in Boston*, 280 NEW ENG. J. MED. 808, 809 (1969).

107. See Louis I. Hochheiser et al., *Effect of the Neighborhood Health Center on the Use of Pediatric Emergency Departments in Rochester, New York*, 285 NEW ENG. J. MED. 148, 150 (1971).

108. See Fred Goldman & Michael Grossman, *The Production and Cost of Ambulatory Medical Care in Community Health Centers*, 4 ADVANCES IN HEALTH ECON. & HEALTH SERVS. RES. 1, 46–50 (1983); but see Stuart H. Altman & Elinor Sochoritzsky, *The Cost of Ambulatory Care in Alternative Settings: A Review of Major Research Findings* 2 ANN. REV. PUB. HEALTH 117, 132, 139 (1981) (explaining that results of studies on ambulatory care costs do not lend themselves to generalizations).

109. NAT'L ASS'N OF CMTY HEALTH CTRS, SPECIAL TOPICS ISSUE BRIEF #2: THE ROLE OF HEALTH CENTERS IN REDUCING HEALTH DISPARITIES 12–13 (July 2003) [hereinafter SPECIAL TOPICS ISSUE BRIEF].

110. NAT'L ASS'N OF CMTY HEALTH CTRS, FACT SHEET: HEALTH CENTERS' ROLE IN REDUCING HEALTH DISPARITIES AMONG AFRICAN AMERICANS (Aug. 2003), <http://www.nachc.com/advocacy/HealthDisparities/files/AfAmDisparitiesFactSheet.pdf>.

111. NAT'L ASS'N OF CMTY HEALTH CTRS, FACT SHEET: HEALTH CENTERS' ROLE IN REDUCING HEALTH DISPARITIES AMONG HISPANICS & LATINOS (Sept. 2003), <http://www.nachc.com/advocacy/HealthDisparities/files/HispanicDisparitiesFactSheet.pdf>.

minority health disparities by establishing themselves as their patients' usual and regular source of care, and by providing culturally sensitive practices with community involvement.¹¹²

A national analysis of state-level minority health disparities has shown that greater levels of health center penetration—namely, the proportion of low-income individuals served by CHCs—were associated with significant and positive reductions in minority health disparities, particularly in minimizing the disparities between blacks and whites in the areas of prenatal care, infant mortality, and total death rates. Regarding disparities between Hispanics and whites, CHC penetration was significantly associated with reductions in the gaps in prenatal care and tuberculosis rates.¹¹³

VI.

CURRENT CIRCUMSTANCES

During the 2000 presidential campaign, the major health initiative proposed by then-candidate George W. Bush was expansion of the CHC program. Once in office, President Bush proposed a five-year initiative to increase federal funding for the CHC program by \$2.2 billion through 2006.¹¹⁴ The President's initiative received strong congressional support, as 2001, 2002 and 2003 saw the three largest annual funding increases over the program's entire history; health centers were able to serve more than two million additional people as a result.¹¹⁵ The President's five-year proposal, if fully funded, would serve 6.1 million additional patients.¹¹⁶ In addition, a bipartisan congressional initiative (the Resolution to Expand Access to Community Health, or REACH) has sought to extend care to an additional ten million patients.¹¹⁷

112. See Robert M. Politzer et al., *Inequality in America: The Contributions of Health Centers in Reducing and Eliminating Disparities in Access to Care*, 12 MED. CARE RES. REV. 234, 236 (2001).

113. PETER SHIN ET AL., GEORGE WASHINGTON UNIV. CTR. FOR HEALTH SERVS. RES. & POL'Y, REDUCING RACIAL AND ETHNIC HEALTH DISPARITIES: ESTIMATING THE IMPACT OF HIGH HEALTH CENTER PENETRATION IN LOW-INCOME COMMUNITIES 11–15 (Sept. 2003).

114. SPECIAL TOPICS ISSUE BRIEF, *supra* note 117, at 14.

115. *Id.*

116. *Id.*

117. *Id.*

VII.

CONCLUSION

Community health centers have demonstrated their effectiveness in addressing health care access for poor, low income, at risk, and minority populations over almost four decades. CHCs have adapted to a changing and increasingly competitive Medicaid marketplace by diversifying their income, reducing their dependence on federal Section 330 grants, and joining in both vertical and horizontal integration strategies, as bipartisan initiatives to expand their number and impact have grown. CHCs still reach only a modest fraction of low-income and underserved populations, but hold the promise of effectively addressing access to primary care and reducing minority health disparities for all those they serve.