

medicaid
and the **uninsured**

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**Community Health Centers in an Era of Health System Reform and Economic Downturn:
Prospects and Challenges**Sara Rosenbaum
Brad Finnegan
Peter Shin**Introduction**

This paper examines the role of health centers in the U.S. health care system, assessing their current and future roles in an era of both great promise and challenge. On one hand, government is poised perhaps more sharply than any time in nearly a generation to undertake a comprehensive effort at national health reform, addressing not only coverage but also access, quality, prevention, and the reinvigoration of primary health care, particularly for populations who face the highest health risks. On the other hand, the nation is facing the most severe economic recession in years, with lower income families and medically underserved communities particularly vulnerable to further loss of economic security including jobs and health care. Because of their special attributes, health centers represent a key component of the health care puzzle, not only for the patients and communities they serve, but also for the large number of people and communities who remain without a regular source of primary health care because of financial, social, cultural, and geographic barriers.

Following a background and overview of health centers, this policy brief reviews 2008 legislation reauthorizing the health centers program and examines the factors that will determine the extent to which this resilient and respected program is able to achieve its promise. This analysis uses data derived from the Uniform Data System (UDS),¹ as well as other data and research on health centers.

Background

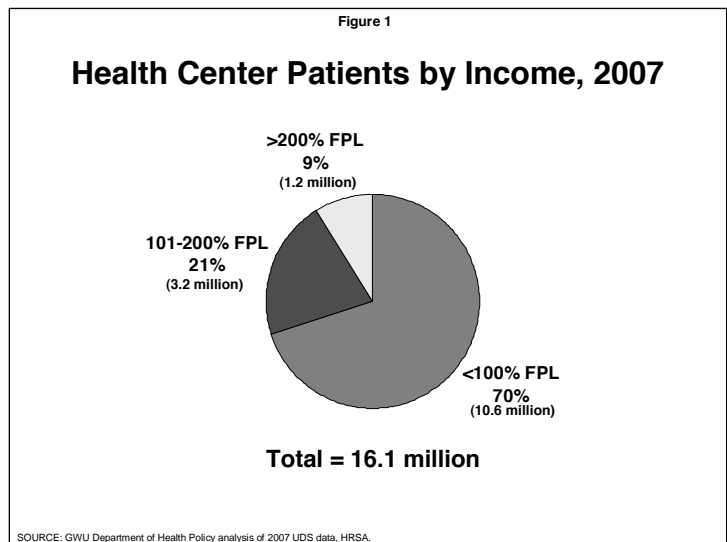
Begun as a small demonstration program,² community health centers today represent the nation's largest single system of comprehensive, primary health care. In 2007, more than 1,200 health center grantees working in nearly 7,200 delivery sites throughout the nation furnished care to more than 16 million patients. Health centers are an important source of care for uninsured, publicly insured, and under-insured low-income patients. They serve an estimated one in three low-income persons (those with family incomes less than twice the federal poverty level or \$44,100 for a family of four in 2009), one in seven rural Americans, and one in four low-income minority residents.³ They also provide care to special populations. In 2007, health centers served nearly 830,000 migrant and seasonal farmworkers and their families and nearly one million homeless persons.⁴

The term “health center” includes both clinics that receive developmental and operational grants under §330 of the Public Health Service Act,⁵ as well as entities, known as “look-alike” health centers, whose development and basic operational support comes from state and local funds but that meet all requirements applicable to federally funded health centers. Both federally funded and “look-alike” health centers are classified as “federally qualified health centers (FQHCs)” under Medicare, Medicaid and the State Children’s Health Insurance Program (CHIP). This designation entitles the qualifying centers to special payment standards to ensure that grant funding earmarked for care of underserved and uninsured populations is not needed to offset payment losses that otherwise might accrue under discounted public insurance payment rates.⁶ FQHCs are mandatory outstationed enrollment sites for Medicaid, providing assistance to pregnant women, children, and families who wish to apply for Medicaid.⁷ They are also covered by the Public Health Service Act’s §340B prescription drug program,⁸ which enables them to offer low-cost prescription drugs to uninsured patients. Federally funded health centers also receive other important forms of federal financial support.⁹

Key Characteristics of Health Centers

All health centers, whether or not they receive §330 grants, possess four bedrock characteristics required by statute that set them apart from other safety net providers. First, health centers must be located in, or targeted to serve, populations and communities that are medically underserved or that experience a shortage of primary health care professionals. Second, health centers must furnish a comprehensive array of specified primary health care services in a way that adheres to federal quality and productivity standards and they must fully participate in government insurance programs.

Third, health centers must establish sliding fee scales based on patients’ ability to pay for care. This requirement compels health centers to discount the cost of care in advance of service rather than simply writing off bad debt and uncollectable bills, a common practice used by other nonprofit health care providers to calculate their charitable care obligations.¹⁰



Finally, and perhaps most uniquely in relation to other health care safety net providers, health centers by law must be governed by community boards, a majority of whose members are health center patients.

Patients Served by Health Centers

The policy mission of health centers has enormous implications for the characteristics of their patients. Nearly all patients are low-income.¹¹ In 2007, 70 percent of all patients had family incomes at or below 100 percent of the federal poverty level, while more than 90 percent had family incomes at or below twice the federal poverty level (Figure 1). Health center patients are

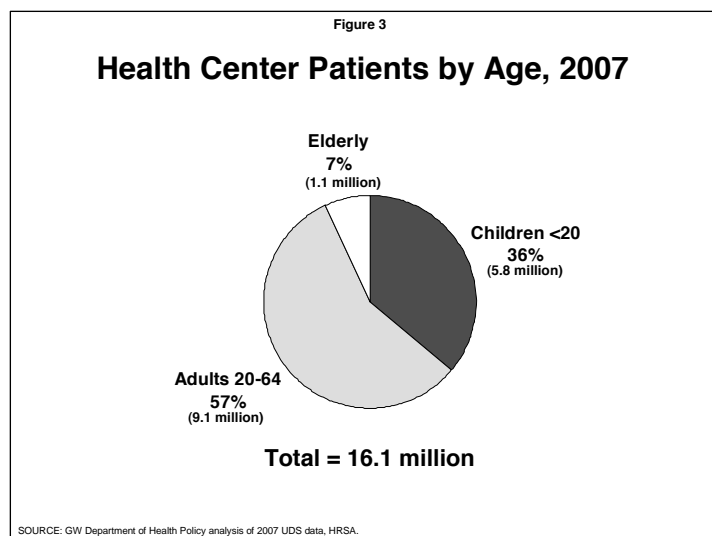
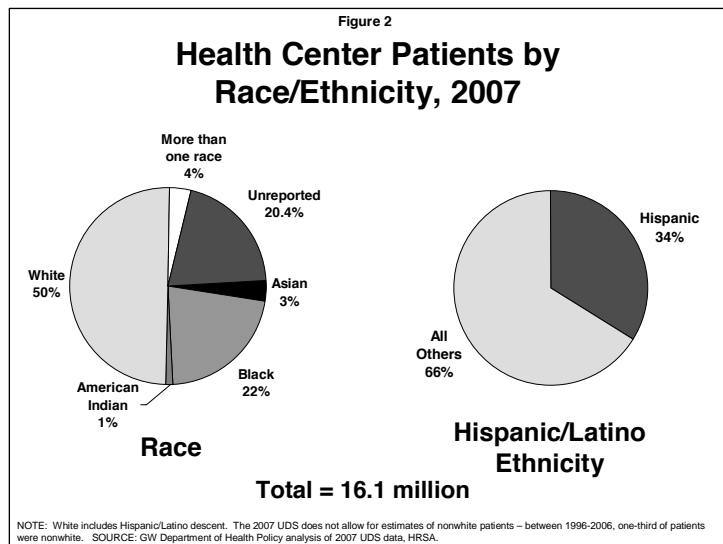
also racially and ethnically diverse; in 2007, minority patients comprised half of all health center patients, and one-third of all health center patients were of Hispanic/Latino ethnicity (Figure 2).

Health centers furnish primary care across the lifespan, caring for patients of all ages. In 2007, more than one-third of health center patients were children and adolescents, making health centers a major source of pediatric health care for low-income children (Figure 3). At the same time, nearly one in 12 patients was over age 65.

The growing number of elderly health center patients represents a trend that carries important implications for health center practice. Between 1996 and 2007, when the total U.S. elderly

population grew by 12 percent, health centers experienced a surge in the number of elderly patients served, increasing 89 percent from 597,000 to nearly 1.13 million patients. Health centers in the South are most likely to serve higher proportions of elderly patients. Nearly half of the health centers with high Medicare patient populations—defined as more than 11.6 percent of the health center patient population—are located in the South (Figure 4).

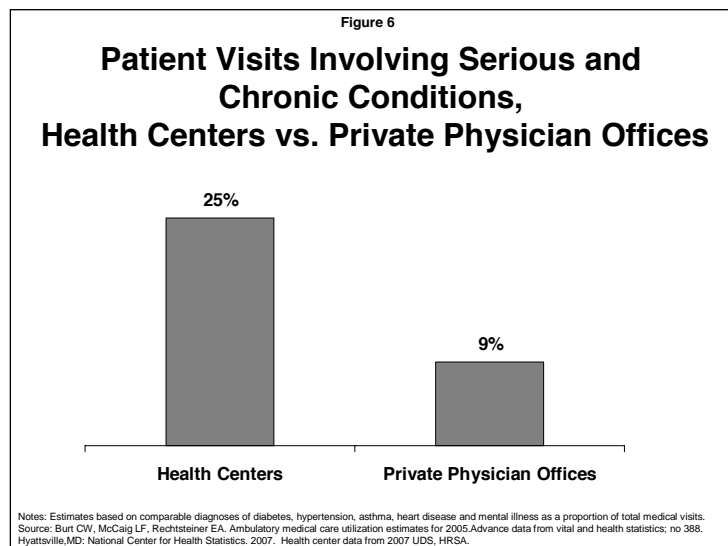
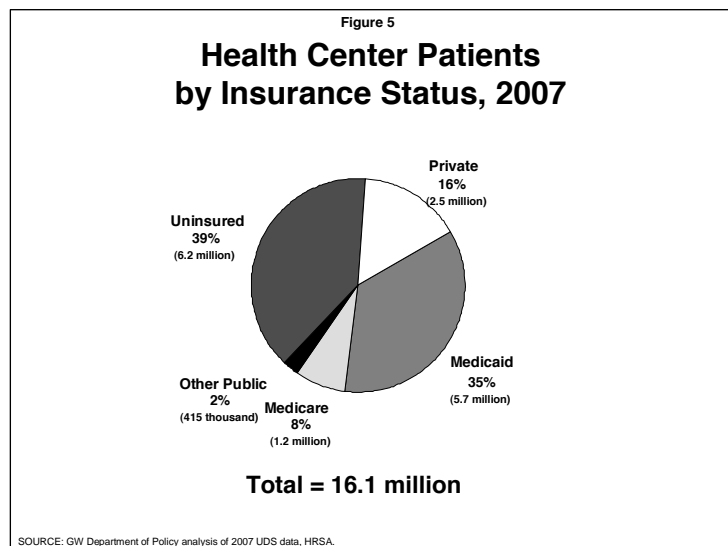
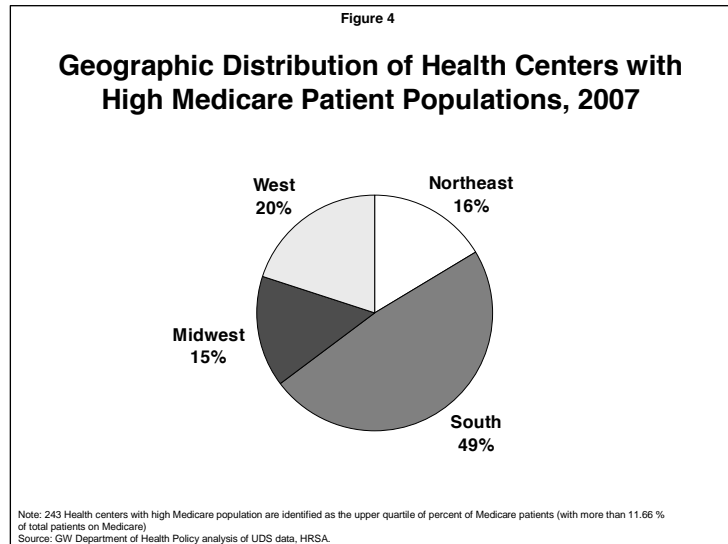
Health center patients are disproportionately uninsured. In 2007, 39 percent of all health center patients were uninsured (Figure 5). Another 35 percent of patients were covered by Medicaid. As a result of their low family incomes and sometimes unstable employment situations, health center patients can experience frequent changes in coverage status, moving from Medicaid coverage to being uninsured and back again.¹² In addition, while 16 percent of health center patients have some level of private health insurance, research examining health centers' financial experiences with private health insurance suggest that many of these patients have policies offering only limited coverage and face high deductibles and cost-sharing.¹³



The role of health centers in caring for uninsured patients has increased in recent years. Between 1990 and 2007, the proportion of the total uninsured population served by health centers more than doubled from 6 percent to nearly 14 percent. Health centers have been able to respond to this enormous growth by doubling the number of grantees and by adding staff, expanding sites, and achieving greater efficiencies linked to improved service integration and participation in integrated managed care arrangements. Between 1996 and 2006, the proportion of health centers reporting managed care participation increased from 17 percent to 60 percent.

Health Centers and the Quality of Patient Care

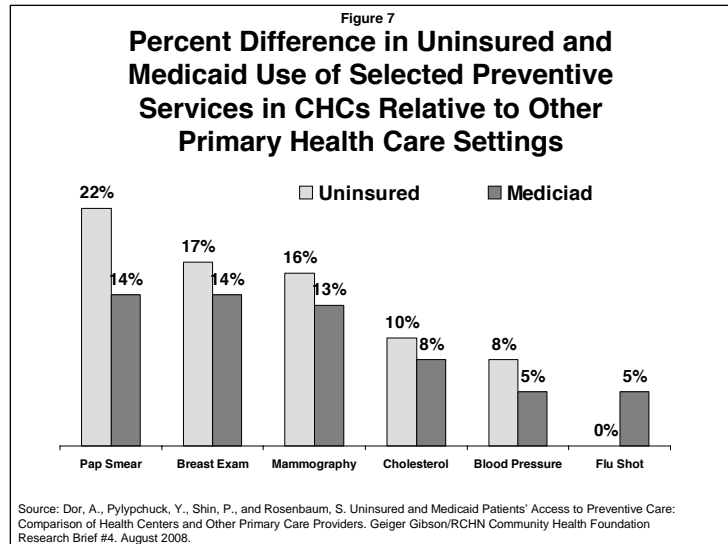
Patients served by health centers are more likely to suffer from serious and chronic conditions than low-income patients who receive care in private physicians' offices. Figure 6 shows that 25 percent of all health center visits involve patients with serious and chronic health conditions compared to 16 percent of visits to private primary care physician offices. The challenging health needs of their patients require health centers to maintain special skills in the management of low-income patients with multiple chronic conditions. Health centers have demonstrated success in furnishing care to this population.¹⁴ Patient outcome data from a comprehensive evaluation of health center performance show that on specific measures of diabetes care, the health centers participating in the evaluation exceeded the national benchmarks.¹⁵



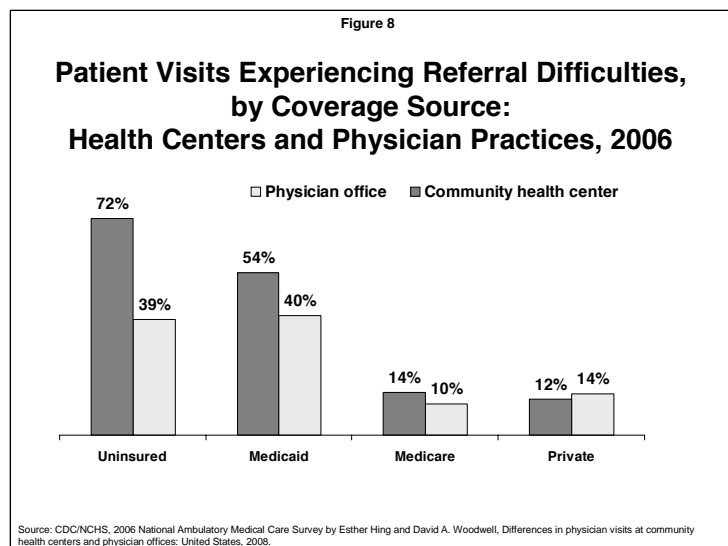
A 2008 analysis comparing preventive care performance for Medicaid and uninsured patients in health centers and other settings found that even though health center patients were more likely to be lower income, minority, and in poorer health, health centers outperformed other practice settings in the level of preventive care they provided (Figure 7).¹⁶ Specifically, health center patients were more likely to receive preventive services such as counseling on diet, smoking cessation, and alcohol consumption. However, access to specialty care for patients with more complex medical and behavioral problems is much more difficult to secure due to lack of available providers, particularly for uninsured and Medicaid patients.¹⁷

Health centers play a particularly important role for low-income women of childbearing age, infants, and children. In 2007, nearly 250,000 infants were born to health center patients, making health centers a source of care for approximately one in eight low-income babies.¹⁸ Pediatric care is one of health centers' most important activities. In 2007, 5.8 million children under 19, representing one in every five low-income children in the U.S., received care at health centers.¹⁹

Extensive research into the impact of health centers on pediatric health shows that health center services have led to reductions in community infant mortality rates, an increase in the number of children with a regular source of primary care, and increased use of preventive pediatric care.²⁰

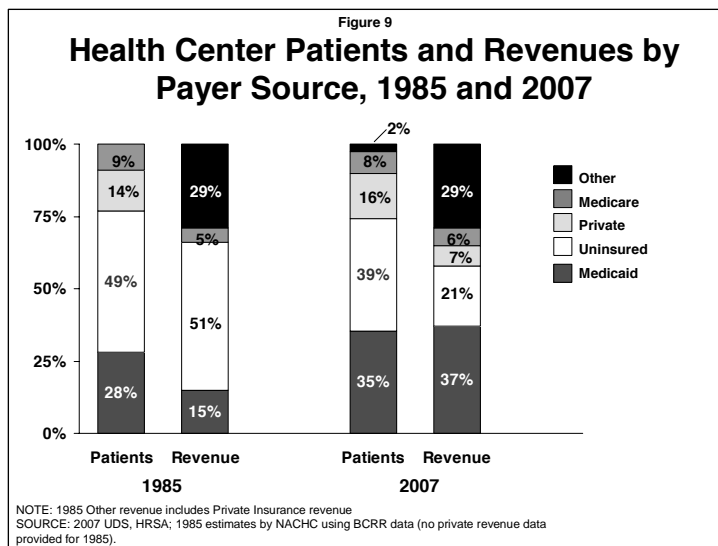


Despite their achievements, health centers face serious challenges in securing the full range of health care that their patients need. Compared to physicians in private practices, health centers are more likely to experience referral barriers for both their uninsured and Medicaid patients (Figure 8). While the causes of this greater difficulty are not known, one possible explanation lies in the far greater numbers of uninsured and Medicaid patients served by health centers, which perhaps inevitably increases the potential for health center clinical staff to encounter referral problems.

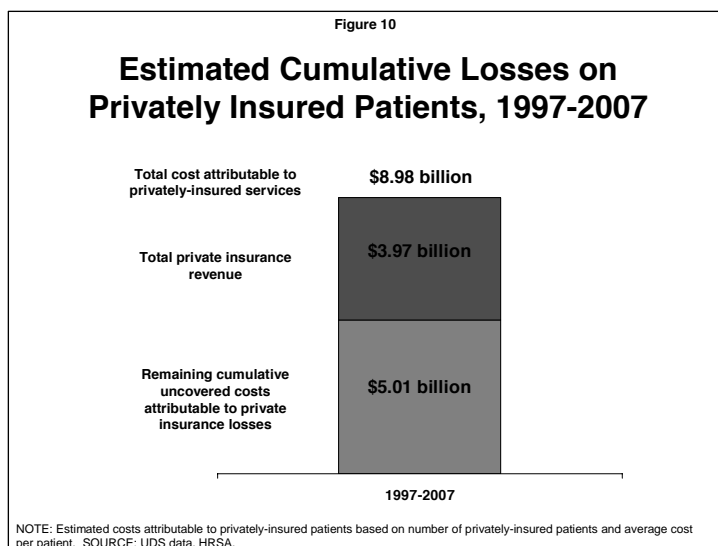


Health Center Revenues

Health centers depend on a combination of Medicaid payments, grant revenues, and other sources of funding to support their operations. While Medicaid and grant funds are most significant to health centers, the relative importance of these two funding streams has changed over the years. At the same time that grant funding failed to keep up with inflation, growth in Medicaid revenues has fueled health center expansions. Medicaid policy changes, including eligibility expansions (particularly for low-income children and families), the addition of FQHC services as required services, and rules ensuring that payments to health centers reflect the reasonable cost of care, led to the increased payments. In 1985, Medicaid patients reflected 28 percent of all health center patients but only 15 percent of revenues. By 2007, Medicaid patients and revenues stood in parallel; grants for the care of uninsured patients had declined to only 21 percent of operations from their earlier 51 percent level (Figure 9). The increase in Medicaid financing over time is the principal explanation for health centers' ability to grow to meet the ongoing needs of their low-income patients.



While Medicaid payments have been key to health centers' success, private insurance revenues are strikingly low in relation to the proportion of health center patients who are covered by private health insurance. In 2007, the proportion of patients with private health insurance stood at 16 percent of all health center patients; however, payments from private health insurance represented only 6 percent of health center operating revenues. This discrepancy in revenues may reflect numerous factors, including more limited coverage, higher cost-sharing, and lower payments that lack the special features of the FQHC payment system.²¹ These key differences have had a considerable financial impact on health centers; the estimated cumulative losses experienced by health centers over the 1997-2007 time period as a result of the revenue gap between private insurance and health center costs surpasses \$5 billion (Figure 10). If compensated for these losses, health



centers would be able to provide comprehensive primary care services to an additional one million uninsured patients.

The losses experienced by health centers under private health insurance are intensified by the stagnation of grant-related revenues. In real dollar terms, federal discretionary funding for health centers grew only 12 percent from 1980 to 2007, despite a 22 percent growth in the total number of health centers (Figure 11) and a more than three-fold increase in the number of patients served.²²

Just as the health status characteristics of health center patient visits are substantially different from those who receive care in physicians' offices, important

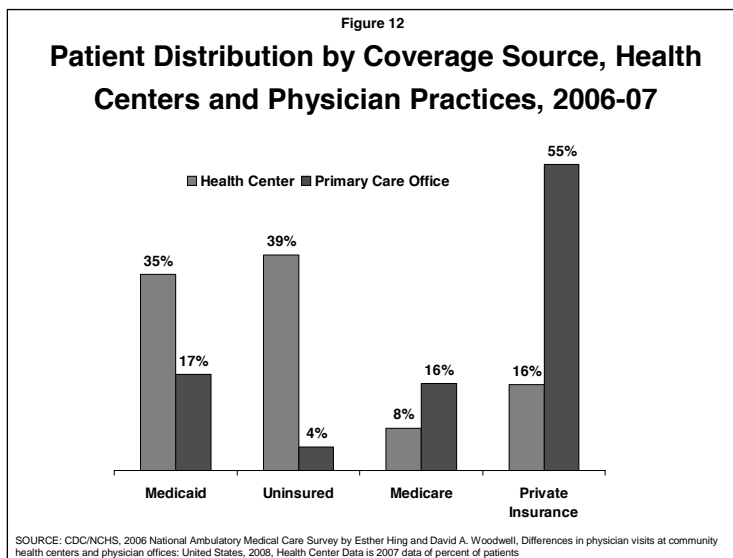
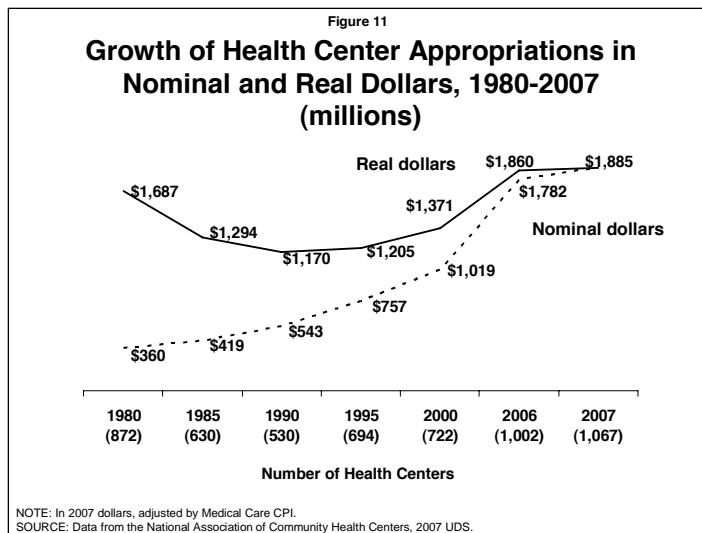
considerations also distinguish health centers and physicians where operating revenues are concerned. In an office-based primary care physician practice, 55 percent of patients are covered by private health insurance, compared to 16 percent in the case of health centers. By contrast, Medicaid and uninsured patients comprise 35 percent and 39 percent, respectively, of all health center patients, while these two groups make up only 17 percent and 4 percent, respectively, of patients served (Figure 12).

Health Centers as Medical Homes Offering Medical, Dental, and Mental Health Treatment

By virtue of their mission and their funding requirements, health centers display the attributes of "medical homes," a concept that emphasizes coordination and comprehensiveness of care, the ability to manage patients with multiple health care needs, and key practice characteristics such as the use of appropriate health information technology and the provision of information about health care quality.^{23,24} With the promise of

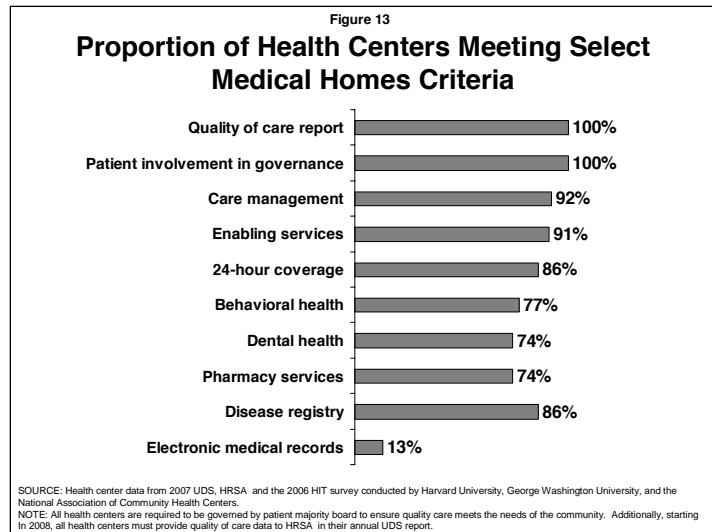
higher quality and lower health care costs, states and payers are increasingly moving towards understanding and recognizing such enhanced care delivery models.²⁵

Even though their patient population includes some of the most vulnerable populations, including migrant and homeless families, health centers effectively serve as medical homes, bringing high quality, affordable health care to communities that would otherwise lack it.²⁶

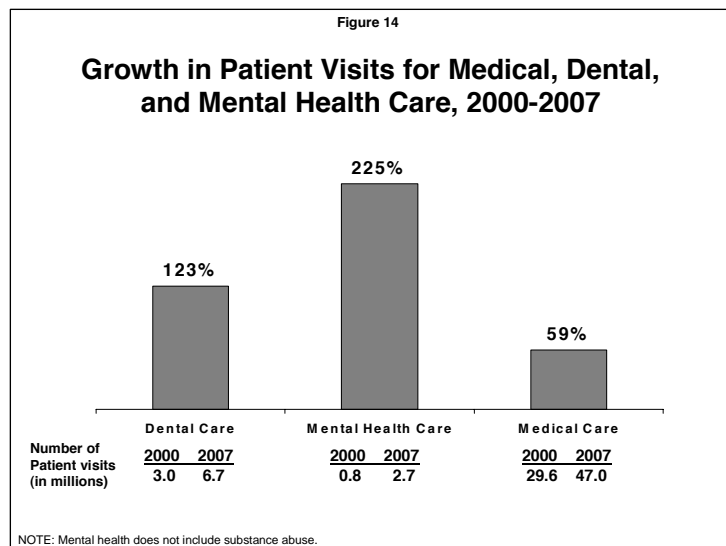


Because of the mission and location, health centers serve large volumes of patients with serious chronic diseases, including diabetes, HIV, cardiovascular disease, emphysema and behavioral and substance use illnesses. As medical homes, health centers either provide or arrange for a broad array of health care (Figure 13).

As part of the commitment to the medical home model, health centers are increasingly providing services, such as dental and mental health care, that are needed by patients. While 75 percent of all patient visits were for medical care, treatment linked to dental and behavioral health care comprised 11 percent and 6 percent of all visits, respectively. The growth in mental health and dental care at health centers has been especially pronounced, a response to increasing patient need as other sources of primary health care for publicly insured and uninsured patients shrink.²⁷ Between 2000 and 2007, the number of patient visits for dental care increased by 123 percent and those for mental health care grew by 225 percent. By contrast, over this same time period the number of patient visits for medical care grew by a more modest 59 percent (Figure 14).



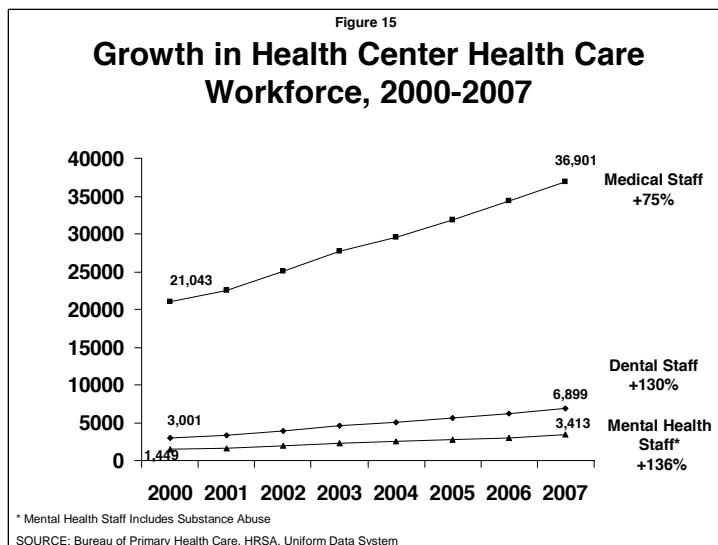
Despite their ability to provide a wide range of treatment and services in keeping with patient needs, health centers face numerous obstacles to being recognized as qualified medical homes. Their financial constraints make it difficult to attract and retain clinical staff or to adopt expensive electronic medical record systems. As noted earlier, few providers are available in underserved areas to coordinate with, particularly for uninsured care. Health centers are also heavily reliant on Medicaid and the varying payment rules and major changes in coverage and benefits present unique challenges for sustaining continuous care management.²⁸ Beyond workforce and financing challenges, the major obstacle for medical home recognition lies with the ability to adopt and use health information technology. While HIT can encompass various types of information systems, including patient registry data which are available in most health centers, only 13 percent would meet the electronic medical record criteria.²⁹ As of 2008, all health centers must report on certain key performance measures as a condition of federal funding, but few are able to do so on an electronic basis.³⁰ At the same time, health centers provide services that exceed the



medical home criteria, including direct input of patients on practices via the patient majority board and responsiveness to and impact on community need.

Health Centers as Creators of Jobs and a Local Economy Stimulus

As health centers have grown, so has their workforce. Between 2000 and 2007 the number of medical staff employed by health centers grew by 75 percent to nearly 37,000 clinicians, while dental staff and mental health staff grew by 130 percent and 136 percent, respectively (Figure 15). In 2007, health centers accounted for slightly more than 49,000 jobs in some of the nation's most economically depressed inner city and rural communities. A 2008 estimate of health centers' impact on local economies concluded that each \$1 million invested in health centers can be expected to yield a \$6 million rate of return while providing comprehensive health care to an additional 8,400 patients.³¹



Challenges and Opportunities

The past year has seen major changes in federal health center policy, leading to both enormous opportunities and challenges for health centers. Several key legislative initiatives were enacted in 2008 and 2009. These new laws and their impact on health centers are described below.

The Health Care Safety Net Act of 2008. The Health Care Safety Net Act of 2008³² was enacted in October 2008. It reauthorizes the health centers program for four years (through FY 2012) and anticipates program growth of 50 percent over this time period through funds to develop new health centers and expand the reach of existing grantees. If met, this growth trajectory is expected to increase the total number of patients served by health centers to more than 25 million by the end of FY 2012. The Act also envisions an expansion of quality improvement efforts, an increasing emphasis on integration strategies between health centers and larger health care delivery systems, and significant growth in the National Health Service Corps, whose members are extensively deployed at health centers. This commitment of resources to health centers and the National Health Service Corps recognizes the essential need to build primary care capacity in poorer communities. Whether these federal goals are reached over time will depend on several factors, including Medicaid, and to a lesser extent Medicare, coverage and payment policies; the ability of health centers to secure access to the capital necessary to develop new sites and expand existing ones; and the extent to which the National Health Service Corps expansion yields the primary care workforce whose availability is crucial to health center growth. Another consideration is whether possible future health insurance reforms reach lower income uninsured patients and how any new coverage is provided to this population.

The Children's Health Insurance Program Reauthorization Act of 2008 (CHIPRA).³³

CHIPRA, signed into law on February 4, 2009, extends and expands CHIP. The reauthorization of CHIP is important to health centers in several respects.

Enrollment and retention reforms. CHIPRA's emphasis on enrollment and retention includes both steps to bring greater efficiencies to enrollment, as well as financial incentives to states to undertake administrative innovations that spur enrollment.³⁴ As a result, experts project CHIPRA will predominantly benefit children already eligible for coverage but unenrolled (3.4 million of the 4.1 million children added by CHIPRA)³⁵ Health centers can be partners in finding and enrolling uninsured children. In 2007, they served 1.4 million uninsured children or nearly one-quarter of all uninsured low-income children that year.³⁶ Key to a successful partnership will be fostering an active collaboration between health centers, state and regional primary care associations, and state Medicaid and CHIP agencies to design enrollment and retention innovations that link strongly to health centers and the communities in which they are located.

Strengthening CHIP benefits. CHIPRA strengthens dental and mental health benefits for children in CHIP, including requiring states to include dental benefits in their CHIP plans. This benefit expansion is vital to improving children's health, but will also help those health centers providing these services. As coverage improves for children who may have been under-insured when it came to dental and mental health needs, health centers will be able to use the additional revenues to support these services for patients without coverage.

Payment reforms. CHIPRA extends to CHIP the same payment methodology for health centers used in Medicaid. This provision establishes a cost-related payment system in those states that operate separate CHIP programs, use private health insurers to administer their separate state CHIP plans, and that have not already directed their CHIP plan administrators to pay health centers in accordance with the Medicaid prospective payment methodology. Although the impact of this reform is considered so small as to not merit discussion in the Congressional Budget Office cost estimates accompanying the reauthorization,³⁷ the extension of the Medicaid prospective payment system to CHIP will be important to health centers, enhancing their ability to care for low-income children.

The American Recovery and Reinvestment Act of 2009 (ARRA).³⁸ Passed in February 2009 in an effort to stimulate the faltering U.S. economy, the ARRA provides important support to health centers in the areas of capital investment, workforce, modernization, and operations.³⁹ Provisions in ARRA include funding for infrastructure and HIT adoption and direct grants to expand services. ARRA also includes Medicaid provisions that are of major importance to health centers.

The law makes a \$1.5 billion capital investment over two years in health centers for construction, renovation, equipment purchase, and HIT acquisition. These funds will support the opening of new centers, expansions of current centers, and the broader adoption of HIT by health centers. The legislation also provides \$500 million over two years to support expanded services to uninsured patients, whose numbers appear to be surging in many communities as a result of the economic recession. In addition, ARRA allocates \$300 million to the National Health Service

Corps scholarship and loan repayment program, funding that is expected to benefit health centers because of their heavy reliance on physicians from the National Health Service Corps.

Through the Medicaid program, ARRA includes additional incentives to spur HIT adoption. These Medicaid incentives provide federal funding to certain providers, including health centers, for the purchase, implementation, use, and maintenance of HIT. Approximately 13 percent of health centers have achieved adoption of minimum HIT functionalities⁴⁰ and this federal support should dramatically increase the number of health centers that are able to incorporate HIT into their ongoing practice. The emphasis in ARRA on HIT, coupled with the necessary funding to support adoption at the provider level, are expected to bring widespread changes to the way in which health centers practice medicine, leading to improvements in the quality and efficiency of the care provided.

Finally, ARRA includes a temporary increase in federal Medicaid contributions to states as a major dimension of economic recovery. These enhanced payments are intended to support state Medicaid programs at a time of increased demand and to prevent states from making cuts to their programs. To be eligible for the enhanced federal financing states are not permitted to restrict eligibility or make it more difficult for people to enroll in the program. Because of the high proportion of health center patients who have Medicaid coverage, these Medicaid funds will be important to health centers, ensuring stable Medicaid funding during a time of growth and expansion.

Measuring the cumulative effects on health centers and their patients of these three major sets of reforms will pose a significant policy challenge in coming years. Key issues that will need to be monitored include:

- The number and location of new health centers and their impact on previously unserved communities;
- The creation of new delivery sites in underserved communities by existing health centers;
- The number of patients served, their demographic characteristics and insurance status;
- Deployment of Health Service Corps personnel and the impact on health center services;
- Service expansions to include dental and mental health services;
- Medicaid and CHIP enrollment;
- HIT adoption and use and the impact on health care quality and costs;
- Improvements in population health status measures particularly in areas with a high concentration of health centers.

How these changes interact with one another can be known only with the benefit of time and research, but one of the most important areas of focus will be the association between state Medicaid policies in the area of child and adult coverage and intermediate measures of health center performance. Health centers are highly sensitive to Medicaid policies because of the importance of Medicaid as a predominant source of revenue. A key question, therefore, will be whether health centers in states that maintain and expand Medicaid and CHIP enrollment will experience greater overall growth over time.

Beyond the three important pieces of legislation already passed, the nation seems poised for the first major discussion in more than a decade over how to reform our health care system and provide coverage to the millions of uninsured. This debate will necessarily focus not only on coverage but also on questions of health care access, quality, and efficiency. Efforts to reform the system will likely involve strategies aimed at strengthening the primary health care workforce and shifting health care investments toward primary care, investing in a modern health care infrastructure, reducing health care disparities, and achieving improvements in health care quality while simultaneously fostering greater efficiencies through wiser use of resources. In light of their location, their mission, and their performance, health centers appear to lie at the nexus of this broadened concept of health reform.

Endnotes

¹ UDS reporting is compulsory for all federally funded community health centers in operation for 13 years and provides comprehensive, grantee-level information on program performance in the areas of patients, services, revenues, staffing, and clinical, management and financial operations. In one form or another, many of the data elements contained in the UDS have been collected since 1996. At the same time, because of certain modifications to the reporting requirements over time, portions of our analysis may be limited to a shorter time period. For example, the 1996 UDS did not include grantee financial data; furthermore, beginning with the 2005 UDS data, the Health Resources Services Administration (HRSA) began to withhold previously publicly available grantee-level information related to staffing and financial matters. As a result of this HRSA policy, certain aspects of our analysis are complete only through 2006, when we were able to secure data as a result of a formal legal protest followed by Congressional intervention.

² Bonnie Lefkowitz, 2007. *Community Health Centers: A Movement and the People Who Made It Happen*. Rutgers University Press, N.J.

³ National Association of Community Health Centers. *A Sketch of Community Health Centers: Chartbook 2009*. http://www.nachc.com/client/documents/Chartbook_Update_2009.pdf (Accessed February 25, 2008)

⁴ 2007 UDS data, HRSA.

⁵ 42 U.S.C. §254c

⁶ 42 U.S.C. §§ 1396a(bb). For a longer discussion of Medicaid and health center financing see Peter Shin, Brad Finnegan, Jessica Sharac, and Sara Rosenbaum, *Health Centers: An Overview and Analysis of Their Experiences with Private Health Insurance*, Kaiser Commission on Medicaid and the Uninsured (January 2008) <http://www.kff.org/uninsured/upload/7738.pdf> (Accessed November 8, 2008)

⁷ 42 U.S.C. §1396a(a)(55)

⁸ 42 U.S.C.

⁹ Most notably, employees of federally funded health centers are covered by the Federal Tort Claims Act (FTCA), Section 224 of the Public Health Service Act. See Health Resources and Services Administration (HRSA), Federal Tort Claims Act. <http://bphc.hrsa.gov/ftca/> (Accessed November 22, 2008). The FTCA coverage classifies health center clinical personnel (as well as health professionals who work at volunteer free clinics) as employees of the federal government for purposes of medical liability coverage.

¹⁰ General Accountability Office (2005), *Nonprofit, for-profit, and government hospitals: Uncompensated Care and Other Community Benefits*. GAO-05-743T

¹¹ 2009 HHS Poverty Guidelines. <http://aspe.hhs.gov/poverty/09Poverty.shtml> (Accessed November 8, 2008)

¹² Cunningham PJ, Felland LE, "Falling Behind: Americans' Access to Medical Care Deteriorates, 2003-2007," Tracking Report No. 19, June 2008. Accessed November 19, 2008 from: <http://www.hschange.com/CONTENT/993/>; Hurley RE, Felland LE, Lauer J, "Community Health Centers Tackle Rising Demands and Expectations" Issue Brief No. 116, December 2007 Accessed November 19, 2008 from: <http://www.hschange.com/CONTENT/958/>

¹³ *Health Centers: an Overview and Analysis of their Experiences with Private Health Insurance*, op. cit.

¹⁴ Chin MH, et al., 2004. "Improving diabetes care in Midwest community health centers with the health disparities collaborative. *Diabetes care* 27(1):2-8. Landon BE, et al., 2007. "Improving the management of chronic disease at community health centers." *NEJM* 356(9):921-934; Hadley J, et al., 2006. "Would Safety-Net Expansions Offset Reduced Access Resulting from Lost Insurance Coverage? Race/Ethnicity Differences." *Health Affairs* 25(6):1679-1687 (Nov/Dec); Hicks LS, et al., 2006. "The Quality of Chronic Disease Care in US Community Health Centers." *Health Affairs* 25(6):1713-1723 (Nov/Dec); Frick KD and Regan J, 2001. "Whether and Where Community Health Centers Users Obtain Screening Services." *Journal of Healthcare for the Poor and Underserved* 12(4): 429-45; Politzer RM, et al., 2003. "The Future Role of Health Centers in Improving National Health." *Journal of Public Health Policy* 24(3/4):296-306.

¹⁵ Shin P, Markus A, and Rosenbaum A. *Measuring Health Centers against Standard Indicators of High Quality Performance: Early Results from a Multi-Site Demonstration Project*. (United Health Foundation, 2006.) http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/United_Health_Foundation_report_082106.pdf (Accessed October 2, 2007)

¹⁶ Dor, A., Pylpynchuck, Y., Shin, P., and Rosenbaum, S. *Uninsured and Medicaid Patients' Access to Preventive Care: Comparison of Health Centers and Other Primary Care Providers*. Geiger Gibson/RCHN Community Health Foundation Research Brief #4. August 2008.

¹⁷ Cook NL, Hicks LS, O'Malley AJ, Keegan T, Guadagnoli E, and Landon BE, "Access to Specialty Care and Medical Services in Community Health Centers." *2007 Health Affairs* 26(5):1459-1468.

¹⁸ Based on 2006-07 census estimates of 1,840,000 infants < 1 year under 200% of FPL.

¹⁹ Based on U.S. Census' 3-year average for 2005-2007 estimates 30 million children are at or below 200% of the federal poverty level. <http://www.census.gov/hhes/www/hlthins/liuc07.html> (Accessed February 25, 2009)

- ²⁰ Hadley J, Cunningham P, and Hargraves JL, "Would safety-net expansions offset reduced access resulting from lost insurance coverage? Race/Ethnicity differences." 2006 *Health Affairs* 25(6): 1679-1687; O'Malley AS, et al. "Health center trends, 1994-2001: What do they portend for the federal growth initiative?" 2005 *Health Affairs* 24(2): 465-472; Shi L, et al., "America's health centers: Reducing racial and ethnic disparities in perinatal care and birth outcomes." 2004 *Health Services Research* 39(6/Part 1): 1881-1901; Shin P, et al., 2003. *Reducing Racial and Ethnic Health Disparities: Estimating the Impact of Community Health Centers on Low Income Communities*. (National Association of Community Health Centers, Washington, D.C.)
- ²¹ Health Centers: An Overview and Analysis of Their Experiences with Private Health Insurance, op. cit.
- ²² Health centers served 5 million patients in 1980.
- ²³ C. Sia et al., "History of the Medical Home Concept," *Pediatrics* 113, no. 5 Supp. (2004): 1473-1478.
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