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- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

BUREAU OF PRIMARY HEALTH CARE
UNIFORM DATA SYSTEM

PRELIMINARY NATIONAL SUMMARY DATA
1997

By

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Preliminary National Summary

EXHIBIT A: TOTAL REVENUE RECEIVED BY BPHC GRANTEES, 1997

	<u>Amount</u>	<u>Percent of Total</u>
<u>GRANT REVENUE</u>	<u>1,105,037,289</u>	<u>41.4%</u>
FEDERAL	731,321,469	27.4%
BPHC Grants	661,206,758	24.8%
Other Federal Grants	70,114,711	2.6%
NON- FEDERAL	373,715,820	14.0%
State and Local Grants/Contracts	318,185,400	11.9%
Foundation/ Private Grants/Contracts	55,530,420	2.1%
<u>REVENUE FROM SERVICE TO PATIENTS</u>	<u>1,496,202,908</u>	<u>56.1%</u>
PATIENT SELF-PAY	169,138,312	6.3%
THIRD-PARTY PAYERS	1,327,064,596	49.7%
Medicaid	919,211,285	34.4%
Medicare	181,447,605	6.8%
Other (Private)Third Party	181,259,007	6.8%
Other Public	45,146,699	1.7%
<u>OTHER REVENUE</u>	<u>67,972,008</u>	<u>2.5%</u>
<u>TOTAL REVENUE</u>	<u>2,669,212,205</u>	<u>100.0%</u>

Preliminary National Summary
TABLE 4 SOCIOECONOMIC USER CHARACTERISTICS

	<u>Number</u>	<u>Percent</u>
USERS BY INCOME		
1. < 100% OF POVERTY	4,407,849	57.6%
2. 101-150%:	861,296	11.2%
3. 151-200%	468,787	6.1%
4. > 200%	970,055	12.7%
5. UNKNOWN	950,071	12.4%
6. TOTAL	7,658,058	100.0%
USERS BY PRIMARY 3RD PARTY PAYOR		
7. NONE/UNINSURED	3,142,493	40.6%
8. MEDICAID	2,602,861	33.6%
9. MEDICARE	591,296	7.6%
10. OTHER PUBLIC	322,299	4.2%
11. PRIVATE	1,088,500	14.0%
12. TOTAL	7,747,449	100.0%
SELECTED USER CHARACTERISTICS		
MIGRANT/SEASONAL USERS	503,522	100.0%
13. Migrant	269,649	53.6%
14. Seasonal	233,873	46.4%
ALL HOMELESS USERS	437,226	
<u>Total Homeless by Housing Status</u>	421,137	100.0%
16. Homeless Shelter	184,232	43.7%
17. Transitional	38,811	9.2%
18. Doubling Up	54,068	12.8%
19. Street	61,552	14.6%
20. Other	45,575	10.8%
21. Unknown	36,899	8.8%

Note: Pending final editing, totals have not been controlled across tables. Total users by income and by payor differ by about 1%; users by income (the lower figure) and total users on Table 3A differ by about 2%.

Preliminary National Summary

TABLE 9E. OTHER (NON-PATIENT CARE) REVENUE

	<u>Amount</u>	<u>% of Total</u>
<i>BPHC GRANTS (AMT. DRAWN DOWN)</i>		
1a. Migrant Health Center	77,910,598	6.6%
1b. Community Health Center	515,539,123	44.0%
1c. Health Care for the Homeless	50,119,333	4.3%
1d. Homeless Children	1,220,656	0.1%
1e. Public Housing Primary Care	11,516,219	1.0%
1f. TOTAL HEALTH CENTER CLUSTER	656,305,929	56.0%
1g. Healthy Schools, Healthy Communities	4,900,829	0.4%
1. TOTAL BPHC GRANTS	661,206,758	56.4%
<i>OTHER FEDERAL GRANTS</i>		
2. Ryan White HIV Early Intervention	27,822,238	2.4%
3. Other Federal Grants	32,540,108	2.8%
4. Other Federal Grants	9,752,365	0.8%
5. TOTAL OTHER FEDERAL GRANTS	70,114,711	6.0%
<i>NON-FEDERAL GRANTS OR CONTRACTS</i>		
6. State Government Grants/Contracts	201,783,122	17.2%
7. Local Government Grants/Contracts	116,402,278	9.9%
8. Foundation/Private Grants/Contracts	55,530,420	4.7%
9. TOTAL NON-FEDERAL GRANTS/CONTRACTS	373,715,820	31.9%
10. OTHER REVENUE	67,972,008	5.8%
11. TOTAL REVENUE	1,173,009,297	100.0%

Preliminary National Summary
TABLE 5: STAFFING AND UTILIZATION

<u>Personnel by Service Category</u>	<u>FTEs</u>	<u>Encounters</u>	<u>Users</u>
1. Family Practitioners	1,371.7	5,693,271	
2. General Practitioners	301.2	1,335,121	
3. Internists	880.6	3,516,272	
4. Ob-Gyns	315.7	1,194,383	
5. Pediatricians	820.2	3,385,097	
6. Psychiatrists	55.8	133,591	
7. Other Specialists	91.7	427,135	
8. TOTAL PHYSICIANS	3,836.7	15,684,870	
9. NPs / PAs	1,874.6	4,971,729	
10. Certified Nurse Midwives	204.4	462,361	
11. Nurses	5,187.2	3,038,390	
12. Other Medical Personnel	4,031.8		
13. Laboratory Personnel	1,236.8		
14. X-ray Personnel	379.2		
15. TOTAL MEDICAL SERVICES	16,750.7	24,157,350	6,478,638
16. Dentists	833.5	2,279,570	
17. Dental Hygienists	2,232.4	331,185	
18. Dental Assts. etc.	1,369.9		
19. TOTAL DENTAL SERVICES	4,435.8	2,610,755	1,043,582
20. MENTAL HEALTH SERVICES	750.2	665,573	118,715
21. SUBSTANCE ABUSE SERVICES	299.5	485,928	56,582
22. OTHER HEALTH SERVICES	584.6	980,708	258,584
23. PHARMACY PERSONNEL	683.8		
24. Case Managers	2,051.9	1,879,092	
25. Education Specialists	1,216.5	1,592,104	
26. Outreach Workers	878.3		
27. Transportation Staff	1,510.5		
28. Other Enabling Services	1,527.3		
29. TOTAL ENABLING	7,184.4	3,471,196	930,568
30. Administrative Staff	8,574.1		
31. Facility Staff	1,543.6		
32. Patient Support Staff	7,527.8		
33. TOTAL ADMINISTRATIVE/FACILITY	17,645.6		
TOTAL STAFF AND ENCOUNTERS	48,334.6	32,371,510	

Note: Staffing numbers may differ by 0.1 due to rounding.

**AN ANALYSIS OF
THE POLITICAL AND ECONOMIC VIABILITY
OF COMMUNITY HEALTH CENTERS:
IMPLICATIONS FOR THEIR FUTURE**

by

David A. V. Reynolds

A dissertation submitted in partial fulfillment
of the requirement for the degree of
Doctor of Public Health
(Health Policy)
in the University of Michigan
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Doctoral Committee:

Professor Rashid Bashshur, Chairman
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Professor Dean Smith

CHAPTER II

**AN ASSESSMENT OF THE ECONOMIC VIABILITY
OF COMMUNITY HEALTH CENTERS:
A COMPARISON OF COST, UTILIZATION, AND QUALITY
IN CHCS AND HMOS**

Introduction

As noted in Chapter I, since the passage of Medicare and Medicaid, federal health policy has attempted to balance two seemingly conflicting demands: expanding access to care and containing costs. CHCs were supported initially for their ability to do the former. Later, in 1973, the development of HMOs became a federal interest because of the belief that HMOs would do both, while also assuring quality care. This chapter reviews some of this evidence for HMOs and compares CHC performance to them. It will examine whether HMOs have lived up to their promise in the areas of cost, utilization, and quality. If so, and if CHCs match HMO performance, this will have implications for CHCs as federal health policy continues to develop.

It should be noted that this paper was first completed in 1992. Therefore, it relies on evidence about HMOs and CHCs prior to that date. However, since the focus of this

dissertation is the CHC program and its future, it was deemed necessary to update the paper with new evidence. Therefore, endnotes to this chapter provide information on more recent studies related to CHCs. This is important because there have been no published papers which bring together the research on CHCs. Since the HMO studies included in the chapter provide sufficient information to enable the comparison of CHCs to HMOs, the HMO studies have not been updated.

The Effects of HMOs¹

A review of the studies on HMO performance reveals that methodological flaws rendered their initial findings inconclusive. Most of the early research on HMOs compared HMO enrollees and non-enrollees, often not adjusting for population characteristics. (Wolinsky, 1980) Luft (1980) pointed out that these studies were done on a few large, well-established plans, so that their external validity was questionable. Eventually, better study design and methods were employed, and studies controlled for such variables as age, sex, socio-economic status, health status, and prior utilization experience. Multivariate statistical techniques were used to estimate the effects of individual variables and their correlation. (Hellinger, 1987)

By far, the most serious threat to the internal validity of all HMO studies has come from selection bias, i.e.- that HMOs may attract and enroll populations with a greater or lesser propensity to utilize services as compared to those choosing other health insurance options. It was originally assumed that there was adverse self-selection into HMOs.

(Wolinsky, 1980; Wilensky and Rossiter, 1986) However, other studies have demonstrated that favorable selection exists. (Eggers, 1980; Eggers and Prihoda, 1982; Jackson-Beeck and Kleinman, 1983; Buchanan and Cretin, 1986; Lairson and Herd, 1987) Such favorable selection calls into question the extent of the positive effects of HMOs.

Given this, the Rand Health Insurance Study (Manning, et al, 1984) was a crucial addition to the research on HMOs. The Rand Study, conducted from 1974-1982, was the first study to assign individuals randomly to either an HMO or one of several fee-for-service options, each with a different level of copayment. It, thereby, controlled for self-selection bias. Its results, discussed throughout this chapter, suggested that HMO effects are not limited to favorable selection. However, caution is called for here as well, since the Rand Study included only one HMO and its findings are not necessarily generalizable across the range of HMOs in other locations.

There does appear to be a preponderance of evidence from various studies, conducted over several years and in several settings, that support certain conclusions about HMO performance, methodological flaws notwithstanding. As Goldstein, et al (1966) have posited, “. . . weak research is not worthless research. A series of individually faulty researches with no consistent methodological weakness may add up to a fairly, convincing conclusion.” With this in mind, the first part of this review will consider the effects of HMOs on cost.

HMO Effects on Cost

Several studies have reported that HMOs have the ability to reduce overall costs for health care for their enrollees in comparison to similar populations in traditional fee-for-service plans. In two comprehensive reviews of HMO performance, this reduction in costs has been found to range from 10% to 40%. (Luft, 1981; Wolinsky, 1980) These same reviews did not find that Independent Practice Associations demonstrated such savings.

Lower costs for enrollees in HMOs have also been confirmed in studies done subsequent to these reviews. For instance, in the Rand Health Insurance Study, there was a cost differential of approximately 25% between HMO experimental and control group enrollees and those provided free care from fee-for-service providers. (Manning, et al, 1984) Research on Medicare HMO enrollees indicated that their cost experience was less than that for a comparable non-HMO Medicare population. This was true even though, in this study, Medicare HMO enrollees retained their coverage for out-of-plan use, and the HMOs were paid on a cost-reimbursement basis. Hence, they were not at risk. (Weil, 1976) Luft (1986) noted that lower costs have allowed HMOs to offer a more comprehensive range of services than that of conventional insurance plans.

HMO Effects on Utilization

There is consistent evidence from research conducted over several years that the cost differences between HMOs and indemnity insurance plans derive from reduced hospital utilization by HMO members. (Luft, 1981; Manning, et al, 1984) This is brought about by lower admission rates. While HMO members were found to have approximately 10% more ambulatory visits than conventional plan subscribers in these studies, hospital admission rates were 25% to 45% less. In IPAs, the reduction in admissions was found to be far smaller (between 0-25%) and was offset by much higher ambulatory use - 20% more visits than that of conventionally insured patients. (Luft, 1981)

On the basis of conflicting evidence, Luft (1978) postulated that the reduction in hospital admissions was across the board. In other words, there were fewer admissions of all types, discretionary and non-discretionary for both medical and surgical conditions.² However, an analysis of the Rand data (Siu, et al, 1988) found that HMO patients did not have fewer non-discretionary surgical admissions, but that they did have fewer discretionary surgical admissions. In the case of medical admissions, both types of admissions were less than for fee-for-service plan subscribers. Siu, et al speculated that the HMO substituted more intensive ambulatory and/or home services in place of hospitalization. In addition, HMO members have had much better coverage and much higher utilization rates for preventive services than indemnity health insurance subscribers. (Luft, 1981)

It is in the financial interest of HMOs to control hospital utilization. Furthermore, there are economic incentives for HMO physicians to do so. Wolinsky (1980) pointed out that "discretionary service utilization represents a diseconomy for the (HMO) physician," who stands to decrease potential income (by reducing the HMO's profitability) and to increase workload by hospitalizing patients. In contrast, physicians compensated under fee-for-service arrangements have had incentives which favored hospitalization. Since indemnity insurance plans often covered most inpatient services, while offering less coverage for outpatient services, these plans have encouraged physicians to hospitalize patients as a means of attaining greater net revenue. In addition, this has served to reduce out-of-pocket costs to their patients. Similarly, IPA physicians, who retained a panel of indemnity plan subscribers, also had less incentive to reduce utilization. This may account for the fact that IPAs have been found to have higher admission rates than closed panel HMOs. (Luft, 1981)

More recent reports indicate that the financial incentives in HMOs actually play a minor role in physician utilization patterns. (Miller and Luft, 1993) A survey of HMOs found that peer review activities and efforts to attract physicians interested in a less intensive style of practice played a large role in influencing physician-generated utilization. (Homer, 1986) In fact, Homer found that peer review and selective recruitment are employed more than financial incentives in salaried-staff model HMOs to control hospitalization.

HMO Effects on Quality³

Research completed before 1980 revealed that health outcomes achieved by HMO subscribers were about the same or somewhat better than those achieved by indemnity insurance plan subscribers. The health outcomes examined were macro-level measurements of morbidity, mortality, and disability days. (Luft, 1980; Cunningham and Williamson, 1980) More refined measures were subsequently presented in two papers which analyzed data from the Rand Study. (Ware, *et al*, 1986; Sloss, *et al*, 1987) In their review of 33 health status measures, these researchers found health status to be comparable between individuals randomly assigned to an HMO and several fee-for-service options.

There was also some evidence that health status worsened among low income HMO enrollees who were ill when first seen. However, this outcome was not attributed to the care provided at the HMO. Rather, it was postulated that these low income individuals had difficulty in using the HMO due to a lack of familiarity with the more bureaucratic procedures necessary to gain access to care. It was concluded that the poor need outreach services and extensive orientation to assure their access to HMO services.

In general, the constraints on utilization do not appear to have a negative effect on the health status of those receiving their care from an HMO. However, another aspect of HMO quality concerns the satisfaction of those who receive its services and those who deliver them. An HMO will not succeed if its members and physician staff are

dissatisfied. Therefore, it is important to review the findings from studies which have examined satisfaction with and within HMOs.

The majority of evidence suggests that patients are mostly satisfied with the care they receive in HMOs, but there appears to have been some dissatisfaction concerning specific access issues. Most frequently mentioned were limited continuity of care, lack of identification with a single physician, and length of time to get an appointment. These issues have continued to appear from the earliest studies through more recent ones.

(Bashshur, et al, 1967; Tessler and Mechanic, 1975; Luft, 1980; Davies, et al, 1986; Murray, 1988)

Outweighing these access concerns, however, were the broad coverage and financial advantages of HMOs. (Luft, 1981; National Center for Health Services Research, 1981) Indicative of this, disenrollment from HMOs has been consistently low over time. For example, Tessler and Mechanic (1975) reported a non-renewal rate of only 6% in the HMO they studied. This was so despite greater dissatisfaction reported with waiting times for appointments and longer travel times to the site of care, as compared to subscribers of other insurance arrangements. This finding was consistent with an earlier study of United Auto Workers. (Bashshur, et al, 1967) Luft (1980) found an average of 10% disenrollment in the studies he examined, but this included those who did so involuntarily due to a change in employment. A survey of HMO members in 1984 indicated that only 7% were not likely to renew with their current plan. (Harris and Associates, 1984)

In terms of the satisfaction of physicians within an HMO practice, studies have identified that it exists and noted several reasons for it. (Luft, 1980 and 1981; National

Center for Health Services Research, 1981; Mick, et al, 1983) Retention is one indication of satisfaction, and in a study of eight New England-based prepaid group practices, Mick, et al found the rate of physician “disenrollment” to be within the range of other practice settings. Overall, there were many aspects of HMO practice which were consistently rated highly by physicians. They reported that they were able to provide medical services without having to worry about the expense to the patient. Physicians in HMOs noted that they have been able to give up practice management concerns in favor of patient management. They perceived that HMO practice has meant a shorter work week and more of a fixed schedule than their private practice counterparts. While HMOs had an upper limitation on income, physicians had more time for other professional and personal activities.

An issue around which there was conflicting evidence about the level of physician satisfaction dealt with the loss of clinical autonomy. While physicians did not indicate a concern about this in the studies cited, a later survey by Kohrman (1986) found this to be a growing issue among older physicians in the Minneapolis-St. Paul, an area with one of the highest rates of HMO enrollment in the country. For these physicians, there was unhappiness that the HMOs now “called the tune.”

The Effects of CHCs

A thorough literature search was conducted in order to examine the effects of CHCs on cost, utilization, and quality. Since the establishment of the first community

health centers in 1965 through 1997, a total of 44 published articles, books, and government studies were produced. Twelve of these were descriptive overviews of the CHC program and/or summarized the results of the studies which preceded them. (Sparer and Johnson, 1971; Zwick, 1972; Reynolds, 1976; Davis and Schoen, 1977; Zeppas, 1979; Maykovich, 1980; Davis, et al, 1981; Geiger, 1984; Horner, 1988; Sardell, 1988; Zuvekas, 1990; and Darnell and Rosenbaum, 1992) Therefore, this chapter will concentrate on the remaining 32 original studies. See Table 2.1.

The first analytical study of a CHC appeared four years after the establishment of the first CHCs. (Bellin, et al, 1969) As shown in Table 2.1, the majority (17) of CHC studies were published in the ten years after this first one. Over the subsequent 18 year period, only fifteen additional studies were produced. In the 1980s, it appears that research interests followed federal health policy ones in shifting the emphasis to examining HMOs as the preferred delivery system. For example, this chapter alone cites 23 HMO studies conducted in the 1980s. By comparison, between 1983 and 1992, there were only 3 new studies published on CHC effects. (Deprez, et al, 1987; Goldman and Grossman, 1988; Schwartz and Poppen, 1988)

In addition, the nature of CHC studies over time has reflected another change in health policy emphasis from promoting access to containing costs. See Table 2.1. Early CHC studies were aimed at examining utilization from the standpoint of penetration rates and quality of care by reviewing health status -- both key outcomes of improved access. Only one study between 1969 and 1979 focused on cost exclusively. (Sparer and Anderson, 1972) After 1979, the overwhelming majority of CHC studies analyzed their

Table 2.1
CHC Study Emphasis by Time Periods
(N = 32)

	1969-1979	1980-1989	1990-1997	Total
Cost Studies	1 ¹	4 ²	2 ³	7
Utilization Studies	11 ⁴	3 ⁵	3 ⁶	17
Quality Studies	5 ⁷	2 ⁸	1 ⁹	8

¹ Sparer and Anderson, 1972.

² Brecher and Foreman, 1981; JRB Associates, 1981; Wallach and Kretz, 1981; JRB Associates, 1982.

³ Center for Health Policy Studies and SysteMetrics, 1993; Center for Health Policy Studies, 1994.

⁴ Bellin, et al, 1969; Bellin and Geiger, 1970; Hochheiser, et al, 1971; Salber, et al, 1971; Strauss and Sparer, 1971; Langston, et al, 1972; Moore, et al, 1972; Klein, et al, 1973; Gold and Rosenberg, 1974; Moore and Bonnano, 1974; Wan and Gray, 1978.

⁵ Okada and Wan, 1980; Freeman, et al, 1982; Deprez, et al, 1987.

⁶ Stuart and Steinwachs, 1993; Howarth, et al, 1995; Stuart, et al, 1995.

⁷ Chabot, 1971; Morehead, et al, 1971; Anderson and Morgan, 1973; Gordis, 1973; Morehead and Donaldson, 1974.

⁸ Goldman and Grossman, 1988; Schwartz and Poppen, 1988.

⁹ Starfield, et al, 1994.

effects on reducing costs or concentrated on utilization only from a cost perspective, i.e. - in terms of CHCs' impact on reducing hospitalization and emergency room use. Similarly, the few studies on quality during this period tended to be cost-related as well, stressing the potential for CHCs to improve health status at a lower cost than other settings.

Before proceeding to the discussion of CHC effects, it is worth noting that early CHC studies and reports suffered from some of the same methodological flaws noted in the previous analysis of HMO studies. Looking at these studies with the same critical eye that Wolinsky (1980) and Luft (1980) employed toward early HMO research revealed small sample sizes, failure to control for differing characteristics in the populations studied, and an emphasis on larger, well-established, primarily-urban organizations. Study methodologies have improved since the late 1970s to correct for these deficiencies, but no experimental study design has been employed in assessing CHC performance. While such a study was crucial in the case of HMOs to test for selection bias, there is considerably less reason to suspect such bias in the case of CHCs. This is because CHCs have extremely high penetration rates in the communities they serve. In these locations, CHCs are the only or predominant source of primary care. For example, a study of 21 urban and rural CHCs revealed that an average of 66% of all eligible service area residents were registered with a CHC. (Langston, et al, 1972) Studies have also shown that a range of 67% to 89% of registrants report CHCs as their primary source of care. (Bellin and Geiger, 1970; Salber, et al, 1971; Langston, et al, 1972) Thus, given reduced concerns about selection effects and the uniformity of results among the wide range of studies over

a 28-year period, the available evidence is judged sufficient to demonstrate the effects of CHCs overall.

CHC Effects on Cost

In the first cost study done on CHCs, Sparer and Anderson (1972) sought to examine whether cost in neighborhood health centers was "high." They noted that this general claim had frequently been leveled at health centers, particularly by organized medicine. Citing the more comprehensive services offered by health centers in comparison to the typical private practice, they proposed to unbundle these services to assure a comparison of costs for similar sets of ambulatory care services. In so doing, they found that the cost for a basic set of primary care services at four urban and two rural CHCs was comparable to that at four well-established HMOs -- Health Insurance Plan of New York, Kaiser at Fontana and Portland, and Group Health of Puget Sound. Furthermore, the findings were the same for a comprehensive set of services, which included home health, mental health, and other support services.

Two later studies, one rural-based (Wallach and Kretz, 1981) and the other urban-based (Brecher and Foreman, 1981) looked at the issue of cost, but only as part of analyses of the financial viability of subsidized practices vs. non-subsidized ones. The studies' findings were admittedly inconclusive regarding CHCs. Only some of the subsidized practices were federally-funded CHCs. In addition, the studies were

characterized by small sample sizes and lack of control for differences in patient characteristics and the intensity of service mix in the practices chosen for study.

Wallach and Kretz found a much higher volume of hospital visits (almost 3:1) among private, non-subsidized practices compared to subsidized practices. This raised the question for them "of whether the price being paid for self-sufficient rural practices exceeds the costs of subsidizing non-self-sufficient practices which hospitalize at a low rate." However, the thrust of these studies was the costs of the practices themselves, not the substitutability of their costs for those elsewhere in the system. Both studies noted that, on average, the costs of operating the subsidized practices appeared to be higher than the non-subsidized ones, but not conclusively. Brecher and Foreman pointed out that considerable overlap existed in the costs of the practices. Seven of the nine subsidized health centers were more costly than the lowest least expensive private practice, but all of the private practices cost more to operate than the most efficient subsidized site.

Given the paucity of CHC cost studies and the lack of clear evidence of CHC cost effects, two comprehensive, government-sponsored studies were essential and important additions to this analysis. (JRB Associates, 1981 and 1982) AFDC recipients who were users of CHCs were compared to recipients utilizing other primary care providers. The Medicaid experience of approximately 21,000 recipients in four cities was reviewed over a one year period (1977-78 in Kalamazoo, Louisville, and Minneapolis; 1980-81 in Denver). These studies were the first CHC studies to control for both patient characteristics and service mix. Overall, the studies showed a savings of almost \$3,000,000 to Medicaid among users of CHCs as compared to users of other providers. Only in Minneapolis were

the inpatient costs higher for CHC users. However, this finding was judged to be not statistically significant. As at all other sites, combined hospital and ambulatory care costs were less at the Minneapolis CHCs than at private practices. The studies found an overall 23% reduction in costs among Medicaid CHC users compared to users of other providers, a figure similar to the cost-saving experience of HMO members compared to fee-for-service plan enrollees.⁴

CHC Effects on Utilization

As in the case of HMOs, CHCs have achieved most of their cost-savings vis-à-vis other practice settings through reduced hospital utilization. For example, when health center users are compared to those who use other sources of care or to their own experience prior to the establishment of a CHC, studies over the first twenty-five years of the CHC program have shown lower hospital admission rates ranging from 6.5% to 78.5%, with the average being approximately 45%.⁵ (Bellin, et al, 1969; Klein, et al, 1973; Wan and Gray, 1978; Okada and Wan, 1980; JRB Associates, 1981 and 1982; Freeman, et al, 1982; Deprez, et al, 1987⁶) In their 1982 study of Denver's CHCs, JRB Associates attributed two-thirds of the cost savings they discovered to differences in payments for inpatient care between CHC users and non-users.⁷

Generally, and again similar to HMO experience, the reduction in the use of hospitals has been accompanied by a higher use of ambulatory and preventive services.⁸ Most studies indicate that this "higher use" represents appropriate use. Given their mission and location, CHCs serve predominantly poor populations. Wan and Gray (1978) point out that having a CHC as a regular source of care removes the differences in the use of preventive services which is typical between lower and higher socio-economic status families. They found that, among children younger than six years old, CHC users had the same rates of immunization and the same likelihood of having had a physical exam as those in a private practice setting.⁹ In their study of one health center, Salber, *et al* (1971) found that "non-white" children under the age of five had twice the number of physician visits as the average pre-school, "non-white" child, according to National Health Survey data. Bellin and Geiger (1970) found that CHC users had approximately the same number of physician encounters in a year as did affluent populations and about 33% more than those with the lowest income. Similar findings were reported by Strauss and Sparer (1971), who noted that ambulatory care utilization rates at five CHCs were comparable to national averages in the National Health Survey.

Other studies have shown that, in addition to reduced hospital admissions, CHCs have had a significant impact on reducing inappropriate use of other services, notably hospital emergency rooms. For instance, Hochheiser, *et al* (1971) discovered a decrease of 38.3% in the use of three hospital pediatric emergency rooms among CHC service area children in Rochester, New York, three years after the CHC opened. No change in use was noted among city children outside the CHC service area, while there was an actual

29% increase in use among children residing in suburban areas. Although Moore, et al (1972) found no change in the rate of emergency room use after a CHC was established in a Boston neighborhood, such use was judged more appropriate, the result of physician referral and the need for after-hours care. In addition, the stable rate of use by CHC enrollees contrasted to a rising rate of use in other neighborhoods. Three and one-half years after the opening of the health center they studied, Gold and Rosenberg (1974) found that the hospital emergency room, previously a primary site of care, was now the primary source of care for only 7% of the children in the CHC service area.

CHCs are not known to promote controls on hospital utilization nor do they encourage substituting ambulatory care for inpatient services through financial incentives to their physicians. Since the CHCs studied were reimbursed on a fee-for-service basis, such controls would not necessarily be in their best interest financially. It has been speculated that the reduced hospital utilization patterns observed among CHCs are likely to reflect the preference of CHC physicians to engage in a less intensive style of practice. (Howarth, et al, 1995; Deprez, et al, 1987) The fact that CHC physicians are salaried also encourages a less intensive style. Deprez, et al (1987) echo Wolinsky's (1980) earlier comments related to HMO physicians. They note that there is a disincentive to provide hospital care, since this would mean more work for the CHC physician with no opportunity for additional compensation. Furthermore, it is reasonable to assume that a strong physician-patient relationship would lead the physician to act more as the patient's agent. Indeed, on the basis of their own and other studies, Marcus and Stone (1984) suggested that regular and ongoing physician-patient contact would improve physician

proficiency and efficiency. Such things as lab tests and referral consultations would be less likely to be required in arriving at a diagnosis.

CHC Effects on Quality

During the first 25 years of the CHC program, only 7 studies were published on the quality of care offered by CHCs.¹⁰ Two of these (Morehead and Donaldson, 1974; Morehead, *et al*, 1971) assessed aspects of the process of care in relation to standards of care and clinical management. The remaining five concentrated on outcome assessment. (Goldman and Grossman, 1988; Schwartz and Poppen, 1982; Anderson and Morgan, 1973; Gordis, 1973; Chabot, 1971)

In the first Morehead study (1971), audits of the quality of care provided to adults, infants, and pregnant and recently-delivered women were conducted at a variety of settings, including 33 CHCs. The quality of care at CHCs was found to be "generally equal to and in some instances superior to that" found in medical school-affiliated hospital outpatient departments, Children's Bureau maternal and infant care programs, health department well-baby clinics, 7 group practice settings, and 20 rural private practices. In their later study, Morehead and Donaldson (1974) conducted a peer review of 40 CHCs to assess clinical management in the specialties of internal medicine, pediatrics, and obstetrics and gynecology. Only records of patients with serious or potentially serious illnesses were reviewed. Based on this review, the performance of each physician at the CHCs was judged to be either satisfactory or unsatisfactory. Morehead and Donaldson

concluded that well over two-thirds of the physicians were functioning in a satisfactory manner, a figure comparable to findings in studies of individual practitioners in other practice settings.¹¹

In terms of outcome measures, Gordis (1973) analyzed the incidence of rheumatic fever in Baltimore for a ten year period. He examined the change in the rate of infection for an African-American pediatric population prior to and after the establishment of four comprehensive care programs, one of which was a CHC serving 60% of the population studied. The three others were smaller Children and Youth projects. Gordis also compared the change in the incidence of rheumatic fever of the enrolled population to a similar population not served by the comprehensive programs. He found that the incidence of rheumatic fever among children served by the CHC and C&Y projects had declined 60% over the ten year period. Furthermore, this rate was one-third below that of the unserved areas.

Most dramatic has been the impact of CHCs on the critical outcome measure of infant mortality, a generally accepted proxy for health status in a community. Two studies (Chabot, 1971; Anderson and Morgan, 1973) found the infant mortality rate among African-Americans and other minorities at CHCs dropped by more than 40% compared to the rate prior to the establishment of CHCs in Denver (Chabot, 1971) and in selected communities in the South (Anderson and Morgan, 1973). This rate of decline far exceeded that achieved by minority users of other sources of care in Denver. Comparable, neighboring counties in the South without a CHC actually registered small increases in infant mortality over the same period studied. In an ambitious study, Goldman and

Grossman (1988) attributed 12% of the total decline in the U.S. African-American infant mortality rate between 1970 and 1978 to the CHC program.

Seeking a more fine-grained measure of outcome than infant mortality, Schwartz and Poppen (1988) sought to determine if the site of care had an impact on birth weight or gestational age. After controlling for socio-demographic factors and medical obstetrical complications, the authors found that CHCs had similar outcomes as other sources of care. Citing other studies, they note that such outcomes were achieved at a lower cost than other settings, an important factor to them in an era of constrained resources.

As noted in the HMO section of this chapter, satisfaction is an important aspect in assessing overall quality. In the case of CHC patients, studies have found high rates of satisfaction. Bellin and Geiger (1970 and 1972) and Salber, *et al* (1972) examined this issue at single sites in the Boston area. In their first study, Bellin and Geiger found that the CHC was used by 97% of the children and 71% of the adults living in the service area. Overwhelmingly, the CHC was rated superior to the users' previous source of care (private physicians and hospital outpatient clinics) in terms of quality, personal manner, comprehensiveness, and waiting time.

A follow-up survey of community residents, two years later, compared attitudes about local health care and facilities prior to and since the CHC's establishment. While 56% were very satisfied with their medical care pre-CHC, this had increased to 81% at the time of the second survey. Indicative of widespread satisfaction was the response to the question: "If all alternative sources of care were free, which would be preferred?" The

CHC was preferred by rates exceeding 3:1 over private practitioners, the next most preferred source.

Salber, et al (1972) noted similar results at the CHC they studied. Regarding specific issues, 98% were satisfied with the convenience, friendliness, and helpful attitude at the health center. Ninety-one per cent of users residing in the housing project studied were satisfied with the amount of time they spent with their CHC doctor. Two-thirds of the mothers reported being "very satisfied" with their own care, while 90% were "very satisfied" with the care their children received.

The findings of these single site surveys were confirmed in a study of 21 CHCs. (Langston, et al, 1972) Low income users of the CHCs noted greater satisfaction with the care at their CHC than did a middle class population using other providers and facilities. The CHC users were also more likely than the middle class population to recommend their own source of care to others.¹²

In terms of physician satisfaction at CHCs, the only three published studies were conducted when the CHC program was new and its continuance uncertain. (Tilson, 1973 and 1973a; Pantell, et al, 1980) Their relevance to today's environment is questionable, but they do contain some interesting speculation about the potential for physician satisfaction and retention within CHCs.

There was significant physician turnover in the early CHC years. Tilson discovered that fewer than half of the physicians hired in the first five years of the CHC program remained at the health centers for more than two years. Looking at a subsequent five-year period (1971-1976), Pantell, et al showed that fewer than 20% of physicians

remained at CHCs for four years or more. Neither of these findings is surprising given that, initially, CHCs relied heavily on the National Health Service Corps for physician staffing. NHSC physicians generally had only a two to four year commitment to practice in underserved areas in order to meet their obligation for federal support of their education.

The Pantell study cited issues related to organizational instability as a major cause of physician dissatisfaction. The most frequently mentioned complaints by physicians who left CHC practices were 1) the perception of incompetence in administration and governance and 2) the vagueness and uncertainty of federal policy regarding CHCs. These are issues which the authors noted commonly arise during the start-up phase of any program. Nevertheless, the Tilson and Pantell studies found there were opportunities for CHCs to attract and retain physicians. Among the physicians surveyed who had remained in practice at CHCs, satisfaction was expressed with several key elements of CHC employment. Physicians were satisfied with their salaries, the community in which they worked, and the CHC emphasis on continuity of care. These factors were found to be favorable even among those physicians who left CHC practice.

A more recent report by the U. S. Public Health Service (1990) indicates that physician satisfaction and retention at CHCs has improved since the 1970s. In a survey returned by 138 CHC physicians in New England, 76% indicated their intention to stay, with 14% undecided, and only 10% planning to leave. Thirty-one per cent had been at their site for five years or longer, and, of these, 95% planned to stay. Salary was not the most important factor among those electing to leave or stay. Those leaving were seeking

more personal control over their schedules. Those remaining cited as primary reasons: their relationships with other staff, the opportunity to fill a social need, location and climate factors, and the mission of the CHC.

Discussion

Having compared HMOs and CHCs to traditional fee-for-service settings, it is useful to use these findings to compare HMOs and CHCs to each other. Table 2.2 provides a summary of the key findings in the literature concerning HMO and CHC effects on cost, utilization, and quality. Overall, the positive effects of HMOs and CHCs are quite similar. Moreover, CHCs seem to have matched HMO performance while serving a predominantly disadvantaged population. When HMOs have attempted to serve the same population, results have been mixed. Health status measures were seen to worsen for some low-income HMO enrollees. (Ware, et al, 1986; Sloss, et al, 1987) It has been posited that these results may have been due to the difficulty which these enrollees had in gaining access to the HMO. In contrast, CHCs have posed no such access barriers for low income users. They are required to support outreach programs in their service areas, and they foster continuity in their physician-patient relationships.

Aside from differences in their reimbursement systems, HMOs and CHCs have several common characteristics which may account for the similarity of their effects. (These characteristics were previously outlined in Tables 1.1 and 1.4 in Chapter I) CHC studies have made note of this. (Okada and Wan, 1980; JRB Associates, 1982) First, both

Table 2.2
Summary of Findings from Studies:
HMOs and CHCs vs. Other Practice Settings

	HMOs	CHCs
Cost	10% - 40% lower ¹	23% - 58% lower; ² similar to well-established HMOs ³
Utilization	25% - 45% lower hospital admission rates ⁴	6.5% - 78.5% lower hospital admission rates ⁵
	more ambulatory visits; higher number of pre- ventive visits ⁶	similar or more ambulatory higher number of preventive visits ⁷
Quality	comparable health status ⁸	comparable or better health status ⁹

¹ Luft, 1981.

² JRB Associates, 1981 and 1982; Center for Health Policy Studies and SysteMetrics, 1993; Center for Health Policy Studies, 1994; Stuart and Steinwachs, 1994; Howarth, et al, 1995.

³ Sparer and Anderson, 1972.

⁴ Luft, 1981; Manning, et al, 1984.

⁵ Bellin, et al, 1969; Klein, et al, 1973; Wan and Gray, 1978; Okada and Wan, 1980; JRB Associates, 1981 and 1982; Freeman, et al, 1982; Deprez, et al, 1987; Stuart and Steinwachs, 1993; Center for Health Policy Studies and SysteMetrics, 1993; Center for Health Policy Studies, 1994; Howarth, et al, 1995.

⁶ Luft, 1981.

⁷ Bellin and Geiger, 1970; Strauss and Sparer, 1971; Wan and Gray, 1978; Stuart and Steinwachs, 1993; Stuart, et al, 1995.

⁸ Ware, et al; Sloss, et al, 1987.

⁹ Chabot, 1971; Gordis, 1973; Anderson and Morgan, 1973; Goldman and Grossman, 1988; Schwartz and Poppen, 1988.

delivery systems offer a comprehensive range of services. Comprehensive services in one facility enable less reliance on outside resources and more control over costs. Second, both serve defined populations. In the case of HMOs, these have generally been employee groups. For CHCs, these are the residents of a designated underserved area. Serving a defined population, consisting primarily of family units, enables HMOs and CHCs to develop integrated patient databases and records, which further enable coordinated care management.

The final common characteristic may have the most impact on HMO and CHC effects. Both tend to be staffed with salaried physicians. As noted in this chapter, salaried physicians have no personal economic incentive to hospitalize patients. Combine this with the fact that HMOs and CHCs attract physicians interested in a less-intensive, more conservative style of practice, and this probably explains a large part of their effects on cost and utilization.

Conclusion

The available evidence indicates that HMOs have achieved positive effects in the areas of cost, utilization and quality for the population they serve. This population has generally been employed, middle-class families. The evidence also suggests that CHCs have matched HMO effects while serving a predominantly disadvantaged population. These findings, particularly in the area of reduced costs, would no doubt surprise both the early adversaries and the advocates of CHCs. In their creation, there was no presumption

that CHCs would be cost-effective. CHCs were created to enhance access for isolated populations, many of whom had complex health and social problems. Advocates never claimed they would be economically viable. Viewing health care as a right, they promoted health centers as the price to be paid to assure equity and social justice. As Chapter I showed, Congress agreed, even in the face of untested presidential opinion that CHCs were a costly model.

The mounting evidence of CHC economic viability over the years no doubt enhanced support for continuing their funding. It ought to secure CHCs a place in the health policy future as well. While proponents of managed care expect to expand HMO-like cost savings throughout the country, this remains more of a promise than a reality for Medicaid and elderly populations. Managed care also provides no answer for the continuing problem of the uninsured. CHCs are an important safety net for these populations and, given the evidence of their positive effects on cost, utilization, and quality, they should continue to be critical access points for the disadvantaged and the underserved. One study, cited in this chapter, termed CHCs "an initiative of enduring utility." (Freeman, et al, 1982) It appears that their mission remains as relevant today as it was during the War on Poverty.

Notes to Chapter II

¹ The term "HMO" is used throughout this chapter to refer to closed panel or salaried-staff model prepaid group practices. These have been the most studied models. Any discussion of results from research on Independent Practice Associations (IPAs) will identify them as such.

² The term "discretionary" admission does not mean an unnecessary admission. Rather, a discretionary admission is one which is not urgent and/or for which alternative treatment options may be substituted.

³ In discussing quality of care, this chapter concentrates on measures of outcome. It should be noted that studies suggest that HMOs are equal to or better than the fee-for-service system in terms of structure and process measures. (National Center for Health Services Research, 1981)

⁴ At the time this paper was first written in 1992, the five studies cited were the only ones related to costs at CHCs. No others were published between 1982 and 1993. Since then, four have appeared which have produced results which bolster the findings in the two JRB studies. The Center for Health Policy Studies (1993 and 1994) replicated the JRB methodology at selected urban and rural CHCs in California and New York. Excluding maternity care, Medicaid costs for CHC users were 33% lower in California and 30% lower in New York. Maternity care alone was 8% less in California and 12.7% less in New York for CHC users vs. non-users. Howarth, *et al* (1995) analyzed all Medicaid claims in King County, Washington for a six-month period and compared CHC users to non-users. They found CHCs to have average costs 58% less than private sector practices. Perhaps the most important recent study, however, was conducted by Stuart and Steinwachs (1993), which analyzed CHC utilization and payments after adjusting for patient-mix differences. Prior to this adjustment, Medicaid payments to CHCs had been computed to be 50% less than for the population which used outpatient departments, the predominant source of care for the Medicaid population in the study. Payments were found to remain significantly lower (36% less) after patient-mix adjustments, similar to other office-based practices.

⁵ The only exception to these findings was a study by Moore and Bonanno (1974) that looked at hospital utilization at the time of one CHC's opening in 1968 and two years later. Hospital admission rates had increased. However, the authors noted that this may have reflected this particular community in which "an initial increase in hospital utilization may well occur as a neighborhood health center attracts into the medical system those with previously unmet medical need."

⁶ Interestingly, while Deprez, *et al* found a 71% lower admission rate for CHC users vs. non-users within its target population in Maine, they also found no difference when they compared the CHC community population with 24 comparison communities. They cited the need for additional study on disease-severity differences among CHC users and non-users. This occurred in 1993 in the previously-mentioned Stuart and Steinwachs study. After an adjustment for case mix differences, they found that 18% of those who rely on outpatient departments for care were hospitalized annually compared to 10% of those who used CHCs and office-based practices.

⁷ The Center for Health Policy Studies' reports on California (1993) and New York (1994) found cost savings to result from both significantly fewer admissions and fewer inpatient days for CHC users. In New York, the average length of stay was 16% lower for CHC users.

⁸ This was recently confirmed by Stuart and Steinwachs (1993) who found that, after adjusting for patient mix, health center users had a statistically significant higher number of ambulatory visits (7.75 per year) compared to users of hospital outpatient ~~users~~ (7.22 per year).

Services

⁹ A recent study (Stuart, et al, 1995) showed that 11-24 month olds in the Maryland Medicaid program were more apt to receive well-child care in a CHC than in any other setting studied. Ninety-two per cent of children seen at CHCs had had at least one well-child visit in the past year. At other care sources, the range was 57%-89%.

¹⁰ Subsequently, only one other study appeared in the 1990s. (Starfield, et al, 1994).

¹¹ Starfield, et al (1994) conducted a similar study which involved a retrospective, quality of care record review of 6 common primary care diagnoses in CHCs, hospital outpatient departments, and private physician offices. There were no consistent differences discovered in the quality of care delivered in the different settings. However, CHCs were found to rank first or second for most of the 21 comparisons made concerning quality. Citing that the CHCs were also "medium-cost" compared to the other settings, the authors called for further study of CHCs as a potential means for states to improve quality and reduce costs.

¹² Twenty-two years after these studies, the Commonwealth Fund (1994) conducted a national survey of 1,784 patients at 46 randomly selected community and migrant health centers. Patient satisfaction was consistent with the earlier studies' results. Only 4% rated their satisfaction with the quality of care as "not so satisfied," with 41% very satisfied and 55% satisfied. Ninety-seven per cent would recommend the health center to their family and friends.

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CHAPTER III

AN ANALYSIS OF THE POLITICAL VIABILITY OF COMMUNITY HEALTH CENTERS: LIBERAL, MODERATE, AND CONSERVATIVE SUPPORT IN THE UNITED STATES SENATE

Introduction

The preceding chapters have shown that community health centers have been viable from an economic and political perspective. This chapter will examine that political viability in greater detail. Based on interviews with three United States' senators, intentionally selected to represent a range in the political spectrum, it will explore why this program has had such consistent congressional support and whether this support is likely to be sustained in the future.

Methodology

In determining whom to interview, I planned to concentrate on congresspersons who were serving at the time of the first authorization of the community health center program in 1975 and who were still serving in Congress at the present time. This would

Excerpt

Conclusion

“The available evidence indicates that HMOs have achieved positive effects in the areas of cost, utilization and quality for the population they serve. This population has generally been employed, middle-class families. *The evidence also suggests that CHCs have matched HMO effects while serving a predominantly disadvantaged population.*

These findings, particularly in the area of reduced costs, would no doubt surprise both the early adversaries and the advocates of CHCs. In their creation, there was no presumption that CHCs would be cost-effective. *CHCs were created to enhance access for isolated populations, many of whom had complex health and social problems. Advocates never claimed they would be economically viable.*”

- David A. V. Reynolds, *An Analysis of the Political and Economic Viability of Community Health Centers: Implications for the Future*. Doctoral Dissertation, Univ. of Mich., 1998 (69-70), *emphasis added*.

Table 2.2
Summary of Findings from Studies:
HMOs and CHCs vs. Other Practice Settings

	HMOs	CHCs
Cost	10% - 40% lower ¹	23% - 58% lower; ² similar to well-established HMOs ³
Utilization	25% - 45% lower hospital admission rates ⁴	6.5% - 78.5% lower hospital admission rates ⁵
	more ambulatory visits; higher number of pre- ventive visits ⁶	similar or more ambulatory higher number of preventive visits ⁷
Quality	comparable health status ⁸	comparable or better health status ⁹

¹ Luft, 1981.

² JRB Associates, 1981 and 1982; Center for Health Policy Studies and SysteMetrics, 1993; Center for Health Policy Studies, 1994; Stuart and Steinwachs, 1994; Howarth, et al, 1995.

³ Sparer and Anderson, 1972.

⁴ Luft, 1981; Manning, et al, 1984.

⁵ Bellin, et al, 1969; Klein, et al, 1973; Wan and Gray, 1978; Okada and Wan, 1980; JRB Associates, 1981 and 1982; Freeman, et al, 1982; Deprez, et al, 1987; Stuart and Steinwachs, 1993; Center for Health Policy Studies and SysteMetrics, 1993; Center for Health Policy Studies, 1994; Howarth, et al, 1995.

⁶ Luft, 1981.

⁷ Bellin and Geiger, 1970; Strauss and Sparer, 1971; Wan and Gray, 1978; Stuart and Steinwachs, 1993; Stuart, et al, 1995.

⁸ Ware, et al; Sloss, et al, 1987.

⁹ Chabot, 1971; Gordis, 1973; Anderson and Morgan, 1973; Goldman and Grossman, 1988; Schwartz and Poppen, 1988.



MEMORANDUM

TO: Devorah Adler
cc: Dan Mendelson

FROM: Dan Hawkins

DATE: November 20, 1998

RE: Requested Materials on Health Centers and Policy Priorities

Enclosed are several items submitted in follow-up to our conversation earlier this week. They include:

- A short description of our proposed options for correcting or fixing the Medicaid payment system for Health Centers. We would be very happy to discuss these or any other options with you further, at your convenience;
- A brief summary of the key findings from a recent (1996) NACHC survey of Health Centers on their experiences under managed care generally and more broadly in the changing health care environment;
- Summaries of the key findings from recent and historic studies of Health Centers regarding their cost-efficiency and overall effectiveness, together with copies of several of the most recent studies;
- An excerpt from a colleague's Doctoral dissertation, containing a comparative review of findings from independent studies of both HMO and Health Center effectiveness, especially related to access, cost and quality concerns;
- National Health Center data from the most recent (1997) annual Health Center reports (UDS). As you can see from the tables, Health Centers realized just under \$2.7 billion in revenues (including their federal BPHC grants) during the year, and cared for 7.7 million people; therefore, the average *total* annual cost of care per person served was approximately \$350. As you can see from the staffing & utilization table, these people averaged just under 4 medical visits each – very close to the average for all U.S. health care users. Note also that:
 - Medicaid revenues equaled \$919 million for care provided to some 2.6 million Medicaid beneficiaries, or about \$350 each annually;

- continued -

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Dan Hawkins to Devorah Adler re: Requested Materials on Health Centers and Policy Priorities (partial) (1 page)	11/20/1998	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20463

FOLDER TITLE:

Community Health Centers [Folder 2]

2012-0463-S

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RESTRICTION CODES

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P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

- Federal grants accounted for \$730 million in revenues, and patient payments (using the sliding fee system) accounted for \$169 million; these 2 sources were the principal source of revenue for the care provided to some 3.1 million uninsured persons, at an average grant cost of \$290 per person; however, the Health Centers also received \$373 million in non-federal grants & contracts, at least some of which supported care to the uninsured, while also covering some Medicare (co-pay) and private insurance shortfalls. Thus, if ½ of the non-federal grants supported care to the uninsured, then the average cost of care for this group would also equal \$350 annually.

I hope the enclosed help to answer your questions and address your concerns on the matters we discussed. Please feel free to call me at any time (best way is to page me at [REDACTED] P6(b)(6) if I can help in any way. Again, thanks for your interest in Health Centers and the people they serve.

[001.]

MEDICAID MUST PAY ITS FAIR SHARE FOR SERVICES PROVIDED BY FQHCS

Background

The Balanced Budget Act eliminated the requirement that Medicaid pay its fair share for the cost that health centers incur for providing care to Medicaid patients. The reason that Congress required Medicaid to pay its fair share in 1990 was to make sure that funds appropriated by Congress for the health center grant program are used to provide care for the uninsured. Now that the requirement that Medicaid pay its fair share is being eliminated, health centers will be forced to eliminate care for the uninsured because they have to compensate for Medicaid's failure to pay health centers what it costs to provide care.

In FY 1999 alone this change will result in a loss of \$50 million. The losses increase annually thereafter to \$100 million in FY 2000, \$150 million in FY 2001, and \$300 million in FY 2002. If this continues, it has been estimated that failing to require Medicaid to pay the cost of providing care will cost health centers \$500,000,000 a year beginning with FY 2003. ***This amount is equivalent to over half of the funding that Congress provides for health centers to provide care for the uninsured. Unless it is reversed, this elimination will force health centers to stop providing care for nearly 2,000,000 hard working uninsured people.***

It is absolutely essential that Congress reverse the elimination of adequate Medicaid payments and reaffirm its recognition of the health centers' key safety net role as the only health care providers with a federal obligation to make care available to anyone in their communities who needs it and especially to make their care affordable for those without insurance.

Action is Needed to Save Health Centers

With the number of uninsured Americans estimated to surpass 50 million within the next few years, community health centers will play an increasingly critical role in making care available for this growing population. However, if the law is not changed to require Medicaid to pay its fair share, community health centers will die a slow death that will leave their communities barren of health care and eliminate the health care that health center patients receive. Congress must ensure that Medicaid pays its fair share. The consequences of doing nothing will be the elimination of America's health centers and the loss of community institutions that provide vital care for millions of people in need, especially for low-income working families. Consistent treatment of health centers in all States is needed to ensure the continuation of their essential work across the country.

What are the policy options?

1. **Repeal the phase-out of cost-based reimbursement.** Under this option, the phase-out (which begins October 1, 1999) of the requirement that States pay health centers serving Medicaid patients 100 percent of their reasonable costs would be repealed and cost-based reimbursement (with, in the case of managed care enrollees, a wrap-around payment similar to that included in the Balanced Budget Act of 1997) would be fully reinstated as

the system determining the amount of payment health centers would receive for caring for Medicaid patients. This will ensure that Medicaid pays its fair share!

2. **Repeal phase-out of cost-based reimbursement and establish prospective payment system for health centers.** Under this option, States would be required to pay health centers on a prospective basis for services rendered to patients. The prospective rate for the first year of a prospective system could be based on the actual cost report for a base fiscal year (1998) and updated annually based on a growth factor such as the Medicare economic index in out-years. In the case of managed care, once a prospective rate is determined, the payment could be split into two components – the amount of payment a health center receives from a managed care plan after competing with other providers in the marketplace, and a supplemental wrap-around payment that the health center would receive from the state for the difference between the managed care payment and the prospective rate. This wrap-around system would be identical to that established for health centers by the Balanced Budget Act.
3. **Eliminate the State's obligation to pay cost-based reimbursement and establish a federal supplemental payment fund.** Under this option, the Federal Government would establish a permanent national safety net investment fund at HHS from which the Secretary would make direct supplemental payments to health centers in addition to the amounts they receive from other Medicaid payer sources. The amount of the payments to a health center would be equal to the difference between the health center's reasonable costs for serving Medicaid enrollees and the amount it collects from other Medicaid payers. The amount of the fund would be determined based on the historical level of supplemental payments in non-1115 states and a projected level of the need for these payments in 1115 states.

United States Representative**Bennie G. Thompson****Proudly Serving Mississippi's Second Congressional District****Please Deliver to:**Name Chris JenningsOffice White HouseFax Number 456-5557**From:**

Congressman Thompson _____

Tammy Boyd *

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Congress of the United States
House of Representatives
Washington, DC 20515

November 23, 1998

The Honorable William Jefferson Clinton
President
The White House
Washington, DC 20500

Dear Mr. President:

We are writing to voice our concern over the widening disparities in access to health care for low-income minorities and to encourage you to support policies that strengthen our nation's community health centers. Federally Qualified Community Health Centers care for over 7 million low-income minorities nationwide.

Community, migrant, and homeless health centers are located in urban and rural medically underserved communities all across the country. Community-owned, non-profit health centers provide families and individuals access to quality, affordable, primary and preventive health care-- regardless of ability to pay.

Health centers provide outstanding care to millions of our constituents -- working to reduce racial disparities in health outcomes and serving as a vital safety net for our communities. African American infants are twice as likely as white infants to die within their first year, with higher rates of low birthweight being the important contributing factor. However, community health centers provide prenatal care for mother-infant pairs in one of every five low-income births; and studies of health centers credit them with a 40 percent reduction in infant mortality, improved prenatal care and immunization rates, and increased use of preventive health services.

Community health centers are also the family doctor for one out of every ten minority smokers, providing them full access to culturally appropriate tobacco prevention and smoking cessation programs as well as treatment of their tobacco related illnesses. Health centers also provide care to 4 million uninsured people each year -- a figure that cannot go unnoticed in minority communities. Although African Americans represent 13 percent of our nation's population, we constitute 17 percent of the uninsured.

Mr. President, for these reasons, we strongly support the mission and vitality of our country's network of community health centers. Therefore, we are specifically asking you to include two items in your Budget to address the crises health centers are facing in providing health care to medically needy communities and populations. We urge you to

include in your budget sufficient funding to prevent the massive cuts health centers are facing in their Medicaid payments, as well as a legislative proposal to restore their payment system. As you may know, the Balanced Budget Act phases out the payment system that requires Medicaid to pay its fair share of the cost that health centers incur in providing care to Medicaid patients. The reason Congress established this system in 1990 was to protect the appropriated funding it provided for health centers to care for the uninsured. Now that this protection has been eliminated, health centers will be forced to eliminate care for the uninsured because they will be forced to use these appropriated funds to cover insufficient Medicaid payments.

In FY 1999 alone it is estimated that the changes made by the BBA will result in a loss of \$50 million for health centers nationwide. The losses increase annually thereafter to \$100 million in 2000, \$150 million in 2001, and \$300 million in 2002. If this continues, it has been estimated that failing to require Medicaid to pay health centers their costs of providing care to Medicaid patients will result in revenue losses of health centers \$500,000,000 annually after 2003. This amount is equivalent to more than half of the funding that Congress allocates for health centers to provide care for the uninsured. Unless the health center Medicaid payment system is fixed, health centers will be forced to terminate care for nearly 2,000,000 hard working uninsured people. We stand ready to work with you to develop a payment system for health centers which ensures that this does not occur and that Medicaid pays health centers its fair share for providing health care to Medicaid patients.

In addition, we also urge you to include in your Budget an increase of at least \$100 million for the health center grant program for FY 2000 so that health centers can provide high quality, comprehensive, primary and preventive care to more of the nation's uninsured. We made a good first step in supporting the health center mission by providing \$925 million for the grant program in the Consolidated Omnibus and Emergency Supplemental Appropriations Act, an increase of \$100 million over the FY 1998 level. Yet, most health centers will still not have the resources they need to serve all the uninsured who seek their care. Health centers have added more than 1 million uninsured to their patient rolls over the past 3 years, severely straining their budgets. As you are well aware, the number of uninsured is increasing nationally at a rate of 100,000 persons each month and many of these individuals will continue to seek care at health centers. In addition, while the new funding will help to establish new health centers in some communities that are currently unserved, it is not nearly enough to help all communities in need. More funding is needed to support the provision of care to the increasing numbers of uninsured individuals.

We are extremely concerned that the twin pressures affecting health centers – declining Medicaid revenues and increasing numbers of uninsured are putting the health center safety net at risk and will result in the reduction of care to the uninsured, particularly among minority populations.

We thank you in advance for your assistance in preserving these valuable providers of care for minority communities and for considering our request for the inclusion of these proposals in your Budget for FY 2000.

Sincerely,

Danny K. Davis

James E. Clyburn

Honore M. C. Green

Melvin L. Watt

William L. Clay

Isaiah. B. King, Jr.

Albert R. Wynn

Carolyn C. Kiepert

Red R. Blagden

C. S. McLean

Corrine Brown

Earl F. Hilliard

Donald E. Young

Ben H. Thompson

Thelma Waters

Elyse E. Cummings

Carrie P. Meek

James F. Dinkins

Deshaun Jackson

John Lewis

Mr. J. Jefferson

Bobby L. Rush

John L. Young

Elaine F. Norton

Chaka Fattah

Julia Carson

Allen L. Harting

Donald Wayne

~~James S. Harting~~

~~James S. Harting~~

Lura M. Clayton

Barbara Lee

Charles B. Harting

Shirley Jackson