Community Health Centers as a Model for Health Care Reform

Timothy Li
COMMUNITY HEALTH CENTERS AS A MODEL FOR HEALTH CARE REFORM

Timothy Li*

ABSTRACT

This Note evaluates Community Health Centers (“CHCs”) as a model for health care reform by considering access, cost, and effectiveness of health care delivered through CHCs, as well as their system of corporate governance. This Note proposes that every medically underserved community adopt a CHC-based model to function as a health care safety net. Not only should the federal government increase support for CHCs, but CHCs should also continue to raise funds from government sources, private foundations, and community supporters. Even though alternative proposals for health care reform may exist, those proposals do not provide an adequate remedy to increase access to primary health care for people in poverty, people without health insurance, and people in medically underserved areas. CHCs, by contrast, provide both an essential health care safety net for the medically underserved population and an opportunity for health education and preventive health to reduce the overall cost of health care for these people.

# TABLE OF CONTENTS

INTRODUCTION .......................................................................................................................... 1  

I.  BACKGROUND: THE FIRST COMMUNITY HEALTH CENTERS AND FEDERAL FUNDING UNDER THE PUBLIC HEALTH SERVICE ACT ................................. 6  
   A.  The First Community Health Centers (“CHCs”) .......................................................... 6  
   B.  The Public Health Service Act of 1975 (“PHSA”) .................................................... 8  
   C.  Federal Funding Requirements Under Section 330 of the PHSA ............................. 9  

II. ANALYSIS: COMMUNITY HEALTH CENTERS AS A MODEL FOR HEALTH CARE REFORM .............................................................................................................. 10  
   A.  CHCs Provide Crucial Access to Health Care and Alleviate the Shortage of Primary Care Doctors in Medically Underserved Areas ......................................... 11  
   B.  Community Governance at CHCs Help CHCs Target Community Needs ......... 13  
   C.  CHCs Achieve Improved Outcomes and Treatment Effectiveness ....................... 14  
   D.  The Patient Protection and Affordable Care Act of 2010 (“PPACA”) and The Health Care and Education Reconciliation Act of 2010 (“HCERA”) .................... 16  

III. PROPOSAL: MEDICALLY UNDERSERVED COMMUNITIES SHOULD ADOPT COMMUNITY HEALTH CENTERS TO SERVE AS A HEALTH CARE SAFETY NET FOR THEIR COMMUNITIES ................................................................. 18  
   A.  Federal Support Should Be Expanded for CHCs ................................................... 19  
   B.  CHCs Should Continue to Raise Funds from Other Government Sources, Private Foundations, and Community Supporters .................................................... 21  
   C.  CHCs Should Become Patient-Centered Medical Homes (“Medical Homes”) ... 22  
   D.  The Federal Government Should Increase Education About the Role of CHCs in Providing Access to Primary Health Care ......................................................... 23  

IV. COUNTERARGUMENTS AND ALTERNATIVE PROPOSALS FOR HEALTH CARE REFORM .......................................................................................................................... 24  
   A.  Although CHCs Do Not Provide Specialty Care, They Do Provide Primary Care and Create Relationships With Specialty Care Providers .......................... 25  
   B.  Although CHCs Do Not Provide Access to Emergency Room Care, They Do Provide Primary Care and Improve Health Care Outcomes for Patients .......... 25  
   C.  Employer-Based Health Insurance Is Not Effective Because It Does Not Target Low-Income Populations .......................................................... 27  
   D.  Universal Health Insurance Is Not Effective Because It Is Cost Prohibitive ..... 27  
   E.  Retail Health Clinics Are Not Effective Because They Do Not Help the Uninsured and Medically Underserved Populations .................................................. 28  

V. CONCLUSION ....................................................................................................................... 28
COMMUNITY HEALTH CENTERS AS A MODEL FOR HEALTH CARE REFORM

Timothy Li

INTRODUCTION

An eighteen-year-old [Chinese] high school student living with her parents became pregnant by her nineteen-year-old boyfriend. The parents were extremely upset and refused to accept the boyfriend who was not Chinese. They told [their daughter] that she had to terminate the pregnancy or leave home. When [she] refused, her father destroyed all of her identity documents (citizenship paper[s], birth certificate, and social security card) out of anger.

. . .

Without identification documents, [she] was unable to apply for government benefits. She could not apply for a copy of her citizenship certificate. Since the family had cut her financial support, [she] had no money to attend school and was not eating or sleeping well. . . . Eventually, [she] became homeless when [her] boyfriend’s aunt asked her to leave. She was extremely overwhelmed by her situation.¹

The Charles B. Wang Community Health Center (“CBWCHC”) was founded in 1971 by a group of volunteers with the following mission: “Be a leader in providing quality, culturally relevant, and affordable health care and education, and advocate on behalf of the health and social needs of underserved Asian Americans.”² CBWCHC is a community health center (“CHC”) that provides access to primary health care doctors for the Chinatown community in New York City, where 31% of the residents live below poverty.³ In the story of this eighteen-year-old girl, social workers at CBWCHC were able to locate a shelter for pregnant teens that could provide her with temporary housing, food, and maternity clothing.⁴ Two months later, her boyfriend found a job and rented a small bedroom for them.⁵ She became much happier and

¹ CHARLES B. WANG COMMUNITY HEALTH CENTER, FROM STREET FAIR TO MEDICAL HOME 105 (Dorothy & Thomas Hoobler eds., 2011).
³ Id. (noting that 31% of New York City Chinatown residents live below poverty, as compared to 21% in New York City overall, according to the 2000 U.S. Census).
⁴ CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 105.
⁵ CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 105.
more relaxed, attended her prenatal care appointments, and had a stable and healthy pregnancy. CBWCHC continued to help her prepare for childbirth and parenthood, budget planning and childcare planning. Had there been no CHC to help her, both the girl and her newborn child could have been in a much more precarious situation. Even if she had gone to a hospital emergency room, her baby was not due for many months. She was not looking for a one-time medical procedure or a diagnosis, but for primary care and the assistance of a social worker.

Most Americans consider access to health care to be a right and not a privilege. Health care is not a “luxury good, reserved for the rich,” but a “fundamental need, a precondition to being able to do virtually anything else—work, play, love, serve.” Nevertheless, in August 2000, when the World Health Organization (“WHO”) evaluated national health care systems across the world, the United States ranked 37th in overall health system performance. One commentator writes that “[t]his dismal showing occurred despite the fact that the United States spends more on health care than any other of the 191 WHO nations.” Health care is “steered more by profit motives than by health outcomes,” leading the cost of health care to “spiral out of control.” Even in 2010, 49.9 million people in the United States still did not have health insurance (corresponding to 16.3% of the U.S. population), and 46.2 million lived in poverty (corresponding to 15.1% of the U.S. population).

---

6 CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 105.
7 CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 105.
8 CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 105.
9 See CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 105.
11 Id.
12 Id. at 2 (quoting NORMAN DANIELS, DONALD W. LIGHT & RONALD L. CAPLAN, BENCHMARKS OF FAIRNESS FOR HEALTH CARE REFORM 18 (Oxford University Press, 1996)).
13 Id. at 1–2.
14 Id. at 5.
In the midst of these “shocking failures,” the CHC model is an “underreported success.”\textsuperscript{16} CHCs nationwide serve 19.5 million patients, two-thirds of whom are below poverty\textsuperscript{17} and 93% of whom qualify as low income residents (less than 200% of poverty).\textsuperscript{18} One third of CHC patients are uninsured, and another 50% receive government health insurance.\textsuperscript{19} CHCs provide “access to non-emergency and preventive care; they virtually eliminate racial disparities in care; and they provide a setting for the practice of quality, cost-effective primary care.”\textsuperscript{20} Through CHCs, uninsured and other low income residents in both rural and urban medically underserved communities gain “family-oriented primary and preventive health care services” without regard to their ability to pay.\textsuperscript{21} CHCs “overcome economic, geographic, and cultural barriers to primary health care, and they tailor services to the needs of the community.”\textsuperscript{22} Yet even though CHCs serve 19.5 million patients, more than 60 million Americans still do not have access to health care because of the shortage of primary care providers—these “medically disenfranchised” Americans “come from all economic backgrounds and live anywhere in America, but they all share one common feature: they are without a regular and continuous source of primary care.”\textsuperscript{23} These Americans have no place to go to for health care except a hospital emergency room.\textsuperscript{24}

\textsuperscript{16}Lesnik, supra note 10, at 5 (internal quotation marks omitted).
\textsuperscript{17}Poverty levels are set by the federal government based on household income, the number of adults, and the number of children in the household. See DeNavas-Walt, Proctor & Smith, supra note 15, at 61.
\textsuperscript{19}\textit{See} id.
\textsuperscript{20}Lesnik, supra note 10, at 5.
\textsuperscript{21}Lesnik, supra note 10, at 5; see also Ku, Cunningham, Goetz-Goldberg, Darnell & Hiller, supra note 18, at 30 (noting that 13.9% of CHC patients have private health insurance and 38.5% qualify for Medicaid).
\textsuperscript{22}Lesnik, supra note 10, at 5.
\textsuperscript{24}\textit{See} id.
This Note argues that CHCs provide a unique opportunity to serve as a community-based health care safety net for the underserved and uninsured population. The Patient Protection and Affordable Care Act of 2010 (“PPACA”), as amended by the Health Care and Education Reconciliation Act of 2010 (“HCERA”), establishes minimum “mandatory” funding for CHCs of $11 billion in new federal grants from 2011 to 2015, and up to $11 billion in additional “authorized” funding. At the minimum funding levels, CHCs could serve up to 36.3 million people by 2019, and at the authorized levels, CHCs could serve up to 50 million people. This Note argues that the government should appropriate all authorized funding to CHCs and take the next step by increasing education about CHCs as a more cost-effective alternative to hospital-based primary care. States should educate high school students about CHCs in public health classes. Recipients of Medicare, Medicaid, Military Health Care, the Children’s Health Insurance Program, and even privately insured persons living in medically underserved areas, 

28 Id.
29 For additional information regarding the minimum and authorized funding levels under PPACA, see supra notes 121–22 and accompanying text.
31 Medicaid is means-tested, needs-based social welfare, or social protection program, expanded by PPACA to include people with income up to 133% of poverty. See Nondisabled Adults, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Adults/Non-Disabled-Adults.html (last visited Apr. 10, 2012).
should be made aware of CHCs and the services that they provide. Disclosures regarding the benefits of CHCs should also be given to recipients of other forms of government aid, such as subsidized housing, food stamps, welfare, and unemployment insurance programs.

Part I provides a basic overview of CHCs, beginning with President Lyndon B. Johnson’s 1964 War on Poverty. Under federal law, CHCs qualify for federal funding only after meeting five statutory requirements. Part II analyzes CHCs as an essential element of a cost-effective health care system, discussing access, cost, and effectiveness of health care delivered through CHCs, as well as their community-based governance. Part III proposes a sufficient level of public investment in financing CHCs and their workforce so that every medically underserved community can adopt a CHC-based model to function as a health care safety net. Not only should CHCs become Patient-Centered Medical Homes, but they should also continue to raise funds from federal, state, and local government sources, private foundations, and community supporters. Funding is crucial because if CHCs must accept deeply discounted payments from Medicaid or private insurers, they will be unable to raise sufficient revenue needed to provide for services that health insurance does not finance. Part IV addresses additional components to a health care system, including specialty care, emergency care, employer-based health insurance, universal health insurance, and retail health clinics. These components are not alternatives to CHCs, however, because they do not target the uninsured and underserved medical populations with cost-effective primary care and preventive medicine. The CHC-based model, by contrast,

---


35 Patient Centered Medical Homes (“Medical Homes”) focus on a holistic approach to health care that includes a personal physician, coordinated patient care, high quality and safety, enhanced medical access, and reimbursement reform. For additional information concerning Medical Homes and how CHCs can qualify for a Medical Home designation, see Eligibility for PCMH Recognition, NAT’L COMMITTEE FOR QUALITY ASSURANCE, http://www.ncqa.org/tabid/1472/Default.aspx (last visited Apr. 10, 2012).
provides an essential health care safety net for medically underserved populations and an opportunity for community-based education and preventive medicine to reduce the long-term cost of health care in these communities.

I. BACKGROUND: THE FIRST COMMUNITY HEALTH CENTERS AND FEDERAL FUNDING UNDER THE PUBLIC HEALTH SERVICE ACT

The CHC Program first began in 1964 during President Lyndon B. Johnson's War on Poverty. The Office of Economic Opportunity established the goal of eliminating poverty through “developing employment opportunities, improving human performance, motivation, and productivity, or bettering the conditions under which people live, learn, and work.” CHCs became part of the Community Action Program under the Economic Opportunity Act of 1964 because they encouraged high levels of community participation in the areas that they served.

A. The First Community Health Centers (“CHCs”)

In 1965, Dr. Jack Geiger and Dr. Count Gibson opened the first two CHCs in a Boston Public Housing Project and in Bolivar County, Mississippi after receiving “the first grant to develop a health care delivery model aligned with the objectives of the War on Poverty.” Dr. Geiger had found “a third world within the United States: African-Americans in the rural south and northern inner cities, Hispanics in the urban barrios of the north and west, poor whites in Appalachia, Native Americans on the reservations, and streams of migrant workers.” In an

37 Id. at 404.
38 Id. at 403–04 (quoting 42 U.S.C. § 2782(a)(3) (1964)).
39 Id. at 405; see also H. Jack Geiger, The Origins of Community Health Centers, in UNITED HEALTH FOUND., FACES OF HOPE: CELEBRATING COMMUNITY HEALTH CENTERS 7 (2008) (CHCs were a response to “devastating poverty, skyrocketing infant mortality rates, rural black sharecroppers displaced by mechanization and living in crumbling shacks, high unemployment, inferior education and lack of access to (entirely segregated) medical care”). As of 2010, there are 1124 CHCs spanning all fifty states, serving both urban and rural medically underserved communities. For additional information concerning CHCs in 2010, see infra Part III.A.
40 Campbell, supra note 36, at 404–05.
41 Geiger, supra note 39, at 7.
address at the Policy and Issues Forum sponsored by the National Association of Community Health Centers (“NACHC”), Dr. Geiger explained that CHCs began as an early pilot program that grew out of the civil rights movement and the desire among health professionals to translate civic engagement into practical solutions for communities—i.e., improved health care. Even though academics may “argue over what influences health the most—medical care, personal behavior, racial disparities, or social, economic, and environmental facts,” CHCs illustrate that all these factors are “inextricably linked” to the functioning of a healthy society.

CHCs were thus more than just an economic intervention, but a way to give a full voice to communities experiencing discrimination and exclusion. CHCs were “neighborhood health centers” with “social medicine,” “comprehensive health care,” and community governance. The CHC model provided “comprehensive personal health care delivered by teams of physicians and other health professionals assigned to specific communities, community outreach, attention to environmental and economic contributors to poor health, and patient involvement in the setup and delivery of health programs.” From the beginning, CHCs were “firmly committed” to a comprehensive community-focused health care model. As a complement to the social insurance programs of Medicare and Medicaid, CHCs also offered a “model of health care reform that include[d] social services, job training, community outreach and empowerment, mental health services, nutrition, and other public health and community organizing

---

42 The National Association of Community Health Centers (“NACHC”), established in 1971, educates the public and provides research-based advocacy for CHCs and their communities. CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 124. NACHC also assists CHCs and their communities by collecting and analyzing data on medically underserved populations, CHCs and their patient communities, and recent legislation affecting CHCs. CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 124.


45 See Geiger, supra note 43.

46 Campbell, supra note 36, at 405.

47 Campbell, supra note 36, at 404–05.

48 Campbell, supra note 36, at 405.
initiatives.”49 By providing “community members with employment, job training, and skills,” CHCs “improved the economic well-being of poor communities.”50 In 1975, Congress passed Section 330 of the Public Health Service Act (“PHSA”)51 to formally codify the community-based model for CHCs based on the pioneering efforts by Dr. Geiger and Dr. Gibson.52

B. The Public Health Service Act of 1975 (“PHSA”)

Yet despite its early success “in creating a collaborative and decentralized framework” led by community representatives, CHCs soon became the target of opposition by “those who felt other institutions possessed better administrative capabilities.”53 Hospitals did not agree that improving the health care system could be achieved through CHCs, arguing that “improvement could only be accomplished by top-down funding to hospitals and institutions.”54 Community representatives, however, argued that CHCs offered the best opportunity for health care system improvement and structural changes within the system.55 In response to these debates, Congress enacted Section 330 of the PHSA to officially adopt the term, “community health center” and formally codify the basic organization and funding requirements for CHCs.56

The PHSA was a “turning point” for CHCs because it created a separate authority for CHCs under the Department of Health, Education, and Welfare, the precursor to the U.S. Department of Health and Human Services.57 The PHSA “authorized direct federal grants to

49 Campbell, supra note 36, at 405.
50 Campbell, supra note 36, at 405.
52 Campbell, supra note 36, at 405.
53 Campbell, supra note 36, at 406.
54 Campbell, supra note 36, at 406.
55 Campbell, supra note 36, at 406.
56 Campbell, supra note 36, at 406.
57 A precursor to CHCs, migrant health centers, were codified by the Migrant Health Program. See Pub. L. 87-692, 76 Stat. 592 (1962) (amending title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers). The statute also was expanded over the years to authorize investments in health care for the homeless, residents of public housing, as specific targeted groups. See PHSA, 42 U.S.C. § 254b.
public and private not-for-profit organizations to operate community health centers.”

Today, the PHSA continues to “regulate the administration and funding mechanisms” of CHCs.

C. **Federal Funding Requirements Under Section 330 of the PHSA**

CHCs must now satisfy numerous requirements before they qualify for PHSA Section 330 funding. First, CHCs must be “located in medically underserved areas in either rural or urban settings, or serve a federally designated medically underserved population.” Medically underserved areas “typically have higher rates of poverty, higher rates of infant mortality, or a shortage of physicians.” Second, CHCs must hold nonprofit, public, or tax exempt status.

Third, CHCs must provide “comprehensive primary care, dental care, x-ray, lab, and pharmacy services.” To provide these services, CHCs must “reduce barriers to health care through such services as transportation, translation services, health education, home visits, and specialty care referrals.” Fourth, CHCs must be “open to all residents of the neighborhood or target population they serve, regardless of income level or insurance status.” CHCs cannot deny

---

58 Campbell, supra note 36, at 407.
60 Campbell, supra note 36, at 407; Lesnik, supra note 10, at 6; see also Symposium, Medicaid at Thirty-Five, 45 S. LOUIS U. L.J. 7, 23 n.94 (2001) (“As a condition of funding, health centers must offer certain services, serve populations and communities designated as medically underserved, and prospectively adjust their charges in accordance with a fee schedule that reflects family income.”).
62 Campbell, supra note 36, at 407 (citing 42 U.S.C. § 254b(b)(3)).
63 Campbell, supra note 36, at 407; see also Lesnik, supra note 10, at 6 (noting that CHCs must “[f]ollow rigorous performance and accountability requirements regarding their administrative, clinical, and financing operations”).
64 Campbell, supra note 36, at 407 (citing 42 U.S.C. § 254b(b)(1)(A)(ii)); see also Lesnik, supra note 10, at 6 (CHCs must “[p]rovide comprehensive health and ‘enabling’ services” including “early and effective primary and preventative care, dental services, mental health services, X-rays and Lab services, pharmacy services, obstetrical and gynecological care, health education classes, transportation, outreach, interpretation/translation, and home visitation.”).
65 Campbell, supra note 36, at 407 (citing 42 U.S.C. § 254b(1)(A)(ii)–(iv)).
66 Campbell, supra note 36, at 407 (citing 42 U.S.C. § 254b(k)(3)(G)); see also Lesnik, supra note 10, at 7 (CHC’s must be “open to all residents, and scale all out-of-pocket charges according to each patient’s ability to pay. All patients seeking care will be served regardless of insurance status or inability to pay.”). Furthermore, funding for CHCs does not have conditions that require CHCs to turn away undocumented patients.
services to patients “due to inability to pay,” but must prospectively adjust their fees according to each patient’s ability to pay—i.e., “a sliding-fee income subsidy scale.” CHCs do not charge the patient a full fee and write the debt off due to their inability to collect that fee. Finally, CHCs must be “governed by a board of directors, more than half of whom must be patients.”

II. ANALYSIS: COMMUNITY HEALTH CENTERS AS A MODEL FOR HEALTH CARE REFORM

Yet despite federal funding under PHSA, CHCs continue to remain underfunded for the task of providing primary health care services to medically underserved communities. In fact, in 2002, President George W. Bush proposed to “increase CHCs’ funding as part of a multiyear initiative to increase the number of CHC sites and strengthen the health care safety net.” This health care safety net has become even more important in recent years. In 2010, 46.2 million people lived in poverty and 49.9 million people did not have health insurance. At the same time, 1124 CHCs provided access to health care in medically underserved areas, but only to 19.5 million patients. CHCs also achieve improved outcomes and treatment effectiveness.

67 Campbell, supra note 36, at 407 (citing 42 U.S.C. § 254b(k)(3)(G)).
68 Campbell, supra note 36, at 407 (citing 42 U.S.C. § 254b(k)(3)(G)).
70 See Sara Rosenbaum, Children in Heavy Traffic: Health Status, Health Policy, and Prospects for Reform, 4 HEALTH MATRIX 129, 142 (1994) (“[I]n 1990, funding for the community health centers program was sufficient to reach only fourteen percent of the under-served.”); Sara Rosenbaum, Rationing Without Justice: Children and the American Health System, 140 U. PA. L. REV. 1859, 1878 (1992) (“Despite their achievements and importance, health centers have never been adequately funded. Today, there are sufficient health centers to serve approximately six million patients-less than twenty percent of all medically underserved persons.”).
71 See Michael K. Gusmano, Gerry Fairbrother & Heidi Park, Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured, 21 HEALTH AFF. 188, 188 (2002) (quoting Tommy G. Thompson, Secretary of Health & Human Services) (“We want to double the number of patients served by our health centers. This is a central element in the President’s plan for expanding access to health care, especially for those without health insurance.”).
72 See DeNAVAS-WALT, PROCTOR & SMITH, supra note 15, at 62, 77.
73 CHCs serve a high percentage of minority populations, which are “disproportionately represented among the uninsured and those lacking access to health care.” Lesnik, supra note 10, at 11.
74 See Ku, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 1.
75 “[P]atients who receive care at community health centers have lower medical costs because providing quality primary care services can reduce the need for other ambulatory and hospital-based medical care, thereby lowering overall medical costs.” Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at Executive Summary.
A. **CHCs Provide Crucial Access to Health Care and Alleviate the Shortage of Primary Care Doctors in Medically Underserved Areas**

There are four types of Federally Qualified Health Center (“FQHC”) entities: (1) Health Center Grantees, which receive federal funding under Section 330 of the PHSA, (2) Look-alikes, which meet funding requirements, but do not receive funding, (3) grandfathered facilities, and (4) Indian health service providers. When this Note refers to CHCs, it is referring exclusively to Health Center Grantees because they qualify for and receive federal funding. Health Center Grantees constitute the vast majority of FQHC entities (1,124) as compared with Look-alikes (approximately 100) that meet CHC qualifications, but do not receive funding. CHCs also differ from Rural Health Clinics (“RHCs”) and free clinics, because RHCs and free clinics do not have the same obligations as CHCs other than providing service to a medically underserved area. RHCs can also be for-profit, non-profit, publicly-owned, or unincorporated, which makes RHCs distinct from CHCs. All of these organizations are crucial components of the health care safety net—the network of “providers who organize and deliver a significant level of health care and other related services to the uninsured, Medicaid, and other vulnerable patients.”

---

76 See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 1.
77 See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 1.
78 See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 1.
79 Rural Health Clinics (“RHCs”) provide primary care services to eight million patients in medically underserved or health professional shortage areas in non-urban locations. See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 2. RHCs must have at least one physician and an assistant—which can be a nurse practitioner, physician assistant, or certified nurse or midwife—available at least fifty percent of the time the clinic operates. See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 2.
80 Free clinics are licensed or certified nonprofit health care facilities that do not accept reimbursement from third-party payers and do not charge patients. See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 2. Free clinics serve uninsured patients either for free or for a nominal charge. See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 2. A 2006 survey estimated that approximately 1,000 free clinics served 1.8 million patients. See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 2.
81 See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 2.
82 FQHCs, RHCs, and free clinics “constitute an essential core of the health care safety net” and “deliver preventive and primary care services to well over 25 million patients who would otherwise find it difficult to access quality primary care on an affordable basis.” See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 81.
83 See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 1.
CHCs are a crucial source of access to primary care for people in poverty. Even though
1124 CHCs served 19.5 million patients in 8100 service sites,\textsuperscript{84} 46.2 million people (15.3% of
the population) fell below poverty levels established by the federal government, as of 2010.\textsuperscript{85} The poverty line is based on household income, the number of adults in the household, and the
number of children below eighteen years of age.\textsuperscript{86} For example, in 2010, the weighted average
poverty threshold ranged from $11,139 for a one-person household to $45,220 for a nine-person
household.\textsuperscript{87} At the same time, 71.8% of CHC patients fell below the poverty line,\textsuperscript{88} and 92.7%
of CHC patients qualified as low-income patients (200% of poverty or below) as of 2010.\textsuperscript{89} CHCs thus provide a critical source of access to primary health care for low-income patients.

CHCs also provide access to health care for those without health insurance. In 2010, 49.9
million people in the United States (16.3% of the population) did not have health insurance.\textsuperscript{90} Between 1991 and 2010, the number of uninsured people increased 40% from 35.4 million to
49.9 million.\textsuperscript{91} Even before the 2008 Financial Crisis, 45 million people did not have health
insurance from 2006 through 2008.\textsuperscript{92} In 2010, 37.5% of CHC patients were uninsured, and
48.5% qualified for Medicare, Medicaid, or other public insurance.\textsuperscript{93} CHCs thus provide a
critical source of access to health care for the uninsured population.

Health care reform, moreover, must also address medical underservice, which affects 96
million people in both urban and rural medically underserved communities.\textsuperscript{94} Medical

\textsuperscript{84}See Ku, Cunningham, Goetz-Goldberg, Darnell & Hiller, \textit{supra} note 18, at 1.
\textsuperscript{85}See DeNavas-Walt, Proctor & Smith, \textit{supra} note 15, at 62.
\textsuperscript{86}See DeNavas-Walt, Proctor & Smith, \textit{supra} note 15, at 61.
\textsuperscript{87}See DeNavas-Walt, Proctor & Smith, \textit{supra} note 15, at 61.
\textsuperscript{88}See Ku, Cunningham, Goetz-Goldberg, Darnell & Hiller, \textit{supra} note 18, at 29.
\textsuperscript{89}See Ku, Cunningham, Goetz-Goldberg, Darnell & Hiller, \textit{supra} note 18, at 29.
\textsuperscript{90}See DeNavas-Walt, Proctor & Smith, \textit{supra} note 15, at 77.
\textsuperscript{91}See DeNavas-Walt, Proctor & Smith, \textit{supra} note 15, at 77.
\textsuperscript{92}See DeNavas-Walt, Proctor & Smith, \textit{supra} note 15, at 77.
\textsuperscript{93}See Ku, Cunningham, Goetz-Goldberg, Darnell & Hiller, \textit{supra} note 18, at 30.
\textsuperscript{94}See Rosenbaum, Jones, Shin & Ku, \textit{supra} note 34, at 2.
underservice increases the burdens of illness and disability.\textsuperscript{95} Medical underservice also increases the cost of health care because the lack of access to primary health care leads to more expensive subsequent interventions.\textsuperscript{96} CHCs solve medical underservice problems because they enhance access to primary health care for poor, low income, at risk and minority populations.\textsuperscript{97} In fact, Jack Geiger documents that “[a]t no time in the history of the United States has the health status of minority populations—African Americans, Native Americans and, more recently, Hispanics, and several Asian subgroups—equaled or even approximated that of white Americans.”\textsuperscript{98} These minority populations disproportionately lack access to health care.\textsuperscript{99} In sum, CHCs are a crucial source of access to primary health care for people in poverty, people without health insurance, and people in medically underserved communities.

**B. Community Governance at CHCs Help CHCs Target Community Needs**

CHCs also provide a unique community-based model for health care reform where at least fifty-one percent of the governing board must be CHC patients.\textsuperscript{100} The CHC board is not simply an advisory committee, but a full board with fiduciary responsibilities to the patients that the CHC serves.\textsuperscript{101} These duties require a CHC’s board to maintain control of the CHC though its authority to hire and replace the CHC director, just as a board of directors maintains control of

\textsuperscript{95} Rosenbaum, Jones, Shin & Ku, supra note 34, at 2.

\textsuperscript{96} Rosenbaum, Jones, Shin & Ku, supra note 34, at 2.

\textsuperscript{97} CHCs have “demonstrated their effectiveness in addressing health care access for poor, low income, at risk, and minority populations over almost four decades.” A.H. Strelnick, Symposium, Increasing Access to Health Care and Reducing Minority Health Disparities: A Brief History and the Impact of Community Health Centers, 8 N.Y.U. J. LEG. & PUB. POL’Y 63, 80 (2004–2005). CHCs reach “only a modest fraction of low-income and underserved populations, but hold the promise of effectively addressing access to primary care and reducing minority health disparities for all those they serve.” Id.


\textsuperscript{99} Lesnik, supra note 10, at 11.

\textsuperscript{100} Campbell, supra note 36, at 410–11 (citing 42 U.S.C. § 254b(k)(3)(H)(i) (2006)).

\textsuperscript{101} Campbell, supra note 36, at 414.
a corporate entity. This community governance ensures that CHCs adequately address community needs such as health facilities, services, and expectations. CHCs also decentralize health care and stimulate the local economy. Decentralized health care benefits the community because it lowers costs and promotes access to health care and volunteering by community members. Thus, community governance is helpful because individuals whom the CHC benefits take an active role in management of the CHC.

C. CHCs Achieve Improved Outcomes and Treatment Effectiveness

Not only do CHCs target medically underserved areas, but they also achieve improved health care outcomes for their patients. To qualify for PHSA Section 330 federal funding, CHCs must provide annual reports on the quality of their services to the Health Resources & Services Administration (“HRSA”) under the Uniform Data System. These annual reports document the “high-quality primary care that helps reduce the need for other more expensive specialty or hospital care, thus reducing overall health care costs.” Primary care provided by CHCs includes family medicine, internal medicine, pediatrics, women’s health and prenatal care, and dental services. CHCs also provide access to preventive health services (which includes health education and social services provided by social workers), cancer screenings, vaccines, and immunizations. CHC success stories include more effective management of chronic long

---

102 Campbell, supra note 36, at 414.
103 Campbell, supra note 36, at 410–11, 414 (citing 42 U.S.C. § 254b(k)(3)(H)(i)).
104 Community representation was essential as “a way of giving communities resources and developing independent systems which [were] dedicated to ambulatory care and not simply filling hospital beds.” Campbell, supra note 36, at 416.
105 According to Senator Kennedy, “hospitals ‘ought to go an extra mile’ and meet the governing board requirements if they wanted to participate in the [CHC] program.” Campbell, supra note 36, at 416.
106 CHCs employ community members to visit patients and act as liaisons between professionals and patients. Campbell, supra note 36, at 409.
107 CHCs today “continue to employ local community residents and stimulate community development and economic growth.” Campbell, supra note 36, at 409.
108 Campbell, supra note 36, at 414.
109 See KU, CUNNINGHAM, GOETZ-GOLDBERG, DARNELL & HILLER, supra note 18, at 83.
term illnesses, fewer lower birth weight babies, and more preventive services, which translate into healthier patients. At the same time, CHCs qualify for medical malpractice insurance under the Federal Tort Claims Act (“FTCA”), which reduces the cost of delivery of primary health care through CHCs.

CHCs also eliminate racial disparities and socioeconomic disparities in access to health care because CHCs hire diverse community members at the point of service, making CHCs sensitive and responsive to the community’s cultural needs. These community members promote greater access to health care because patients can communicate in their own language with providers who understand community concerns. Many CHCs provide evening and weekend hours, which can be crucial for the working population in the community who may not have the ability to see the doctor on weekdays during the hours between nine and five. These workers also may not be able to predict their schedules in advance and frequently rely on CHCs

112 Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 1346(b), 2671–2680 (2006). Physicians in private practice must buy medical malpractice insurance, which is very expensive and one of the causes of high medical care costs.
113 Racial disparities in health care are almost completely eliminated among CHC patients. One study conducted at by Professor Sara Rosenbaum, The Harold and Jane Hirsh Professor and founding Chair of the Department of Health Policy at The George Washington University School of Public Health and Health Services, found that “compared against nationally accepted standards of quality,” the CHCs in her study provided health care that “equal[ed] or exceed[ed] that provided in the private sector.” Reed V. Tuckson, Introduction, in UNITED HEALTH FOUND., FACES OF HOPE: CELEBRATING COMMUNITY HEALTH CENTERS 5 (2008). In the study, “the overall black/white mortality rates drop from 286 additional black deaths per 100,000 lives to 166 deaths, and the disparities in Hispanic/white tuberculosis cases decline from 8.5 additional Hispanic tuberculosis cases per 100,000 lives to 6.7 cases.” Lesnik, supra note 10, at 16 (citing Peter Shin, Karen Jones & Sara Rosenbaum, Reducing Racial and Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low-Income Communities, at 4, GEORGE WASHINGTON MED. CENTER, CENTER FOR HEALTH SERVICES & RES. POL’Y (Sept. 2003), available at http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/GWU_Disparities_Report.pdf).
114 In 1994, a Health Center User Survey and a National Health Interview Survey found that while there were significant racial and ethnic disparities in health factors among the general population, even after controlling for socio-demographic factors, these disparities did not exist among health center users.” Lesnik, supra note 10, at 15. These surveys received national attention, and Tommy G. Thompson, the Secretary of Health and Human Services, acknowledged a top priority of reducing racial disparities in health care, and that CHCs were among the “most effective tools at accomplishing that goal.” Lesnik, supra note 10, at 15 (quoting Tommy Thompson, Secretary of Health & Human Services, Compassion and Service: The Importance of Community Health Centers to America’s Health Care Future, Address at the NACHC Policy & Issues Forum (Washington, D.C., Mar. 20, 2002)).
115 Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at 10.
116 See CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 104.
that provide walk-in hours without an advance appointment. Thus, CHCs achieve improved health care outcomes for medically underserved communities, which results in healthier patients, and deliver service through community members, overcoming cultural barriers to health care.

D. The Patient Protection and Affordable Care Act of 2010 (“PPACA”) and The Health Care and Education Reconciliation Act of 2010 (“HCERA”)

In 2010, Congress passed the health care reform bills, PPACA and HCERA. PPACA, as amended by HCERA, provides two new sources of funding for CHCs: (1) a minimum “mandatory” level of funding of $11 billion in new federal grants from 2011 to 2015, and (2) additional “authorized” funding of $11 billion. PPACA provides this funding to CHCs through: (1) increased FQHC grants, (2) increased Medicaid revenues for FQHCs, (3) increased Medicare revenues for FQHCs, and (4) by “expanding coverage for low- and middle-income people through the insurance exchanges and setting standards for qualified health plans regarding payments to FQHCs.” PPACA also appropriates an additional $1.5 billion for

---

117 See CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 104.
118 See Lesnik, supra note 10, at 5.
121 See Sara Rosenbaum, Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System, 7 J. HEALTH & BIOMED. L. 1, 18 (2011) (noting that PPACA contains a “financing provision to expand federally funded community health centers”); THE COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS FUND, HEALTHREFORMGPS (Apr. 15, 2010), available at http://www.healthreformgps.org/resources/the-community-health-centers-and-national-health-service-corps-fund/ (“The law authorizes and appropriates funding for the CHC Fund at a total of $9.5 billion over the FY 2011-FY 2015 time period, to be spent as follows: $1.0 billion in FY 2011, $1.2 billion in FY 2012, $1.5 billion in FY 2013, $2.2 billion in FY 2014, and $3.6 billion in FY 2015.”); see also HCERA, Pub. L. 111-152 § 2303, 42 USCA § 254b–2 (amending PPACA § 10503(b)(1) to provide for $9.5 billion from 2011 through 2015); PPACA § 10503(b)(1), Pub. L. 111-148, 2010 HR 3590 (“There is authorized to be appropriated . . . to the CHC Fund [§7.0 billion from 2011 through 2015].”); PPACA § 10503(c), Pub. L. 111-148 (“There is authorized to be appropriated . . . $1,500,000,000 to be available for fiscal years 2011 through 2015 to be used by the Secretary of Health and Human Services for the construction and renovation of community health centers.”).
122 See Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at 3 (calculating that the authorized funds under PPACA were $11 billion more than the mandatory funds under PPACA and HCERA); see also PPACA § 5601, Pub. L. 111-148 (authorizing appropriations of $3.862 billion in 2011, $4.991 billion in 2012, $6.449 billion in 2013, $7.333 billion in 2014, and $8.333 billion in 2015). But see Personal Communication from Daniel Hawkins, Senior Vice President for Pub. Pol’y & Res., Nat’l Ass’n of Community Health Centers, in Washington D.C. (Mar. 26, 2012) (on file with author) (noting that all $22 billion in authorized funds may never be distributed to CHCs, but the $11 billion in minimum mandatory funding is officially appropriated and distributed to CHCs through PPACA).
123 Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at 6.
the National Health Service Corps (“NHSC”)—“an indispensable CHC partner” that helps recruit and place health care professionals in health professional shortage areas (“HPSAs”)\textsuperscript{124} by providing student loan forgiveness programs to medical students.\textsuperscript{125} Under PPACA, CHCs can effectively serve more patients because PPACA reduces the percentage of their uninsured patients.\textsuperscript{126} PPACA also establishes a national framework to study the comparative effectiveness of different strategies to provide access to health care to medically underserved communities.\textsuperscript{127}

At the minimum funding levels under the PPACA, CHCs could serve up to 36.3 million patients in 2019 (an 86\% increase in patients from 19.5 million in 2010), achieving $52 billion in federal Medicaid savings.\textsuperscript{128} Under the authorized funding levels, CHCs would be able to serve up to 50 million patients in 2019 (a 156\% increase in patients) achieving $90 billion in federal Medicaid savings.\textsuperscript{129} These numbers do not include the savings of $24 billion in out-of-pocket medical expenses per year based on the patients that CHCs already serve.\textsuperscript{130} This expansion in the ability for CHCs to serve populations living in poverty will represent a major increase in the health and welfare of up to 10\% of the American population, leading to improved worker productivity and efficiency.\textsuperscript{131}


\textsuperscript{125} “The NHSC Scholarship Program (SP) awards scholarships each year to students pursuing careers in primary care. In return, students commit to serving for two to four years, upon graduation and completion of training.”\textit{ See NHSC Scholarship Program Application Cycle Is Now Open}, U.S. DEPARTMENT HEALTH & HUMAN SERVICES, http://nhsc.hrsa.gov/scholarships/index.html (last visited Apr. 10, 2012).

\textsuperscript{126} Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at 6.

\textsuperscript{127} Rosenbaum, supra note 121, at 18 n.85; see also Sean R. Tunis et al., \textit{Comparative Effectiveness Research: Policy Context, Methods Development and Research Infrastructure}, 29 STATS. MED. 1963, 1963 (2009) (defining comparative effectiveness research as “the conduct and synthesis of systematic research comparing different interventions and strategies to prevent, diagnose, treat, and monitor health conditions.”).

\textsuperscript{128} Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at Executive Summary.

\textsuperscript{129} Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at Executive Summary.

\textsuperscript{130} Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at 8.

\textsuperscript{131} Ten percent of the American population is 30.5 million people out of 305.7 million people in the United States.
Furthermore, although $11 billion in federal grants over four years (2011–2015) may seem high, this amount pales in comparison with the bailouts given to the financial services sector—e.g., the Congressional Budget Office estimates that the cost of Freddie Mac and Fannie Mae alone to U.S. taxpayers is $317 billion, as of March 2011. One of the biggest concerns with funding under PPACA is that the Supreme Court may hold that the PPACA or portions of it are unconstitutional. Even if the Supreme Court holds that the PPACA’s individual mandate is unconstitutional, however, severability should apply and funding for CHCs should still be appropriated. In fact, federal funding for CHCs has been in place ever since the PHSA first established the criteria for FQHCs in 1975. As recently as 2009, moreover, Congress provided for new funds to CHCs. Thus, federal funding of CHCs has a long history and should be constitutional and severable from the individual mandate. Furthermore, PPACA funding of CHCs could create immediate savings and improved outcomes in access to health care for people in poverty, without health insurance, or in medically underserved areas.

III. PROPOSAL: MEDICALLY UNDERSERVED COMMUNITIES SHOULD ADOPT COMMUNITY HEALTH CENTERS TO SERVE AS A HEALTH CARE SAFETY NET FOR THEIR COMMUNITIES

This Note proposes that every medically underserved community adopt a CHC-based model to serve as a health care safety net for its community. Not only should the government appropriate all authorized funds to CHCs, but it should also increase its support for CHCs

135 See PHSA, 42 U.S.C. § 254b (2006); see also supra notes 154–58 and accompanying text.
137 See Sara Rosenbaum, Joel B. Teitelbaum & Katherine Hayes, Crossing the Rubicon: The Impact of Affordable Care on the Content of Insurance Coverage for Persons with Disabilities, 25 NOTRE DAME J.L. ETHICS & PUB. POL’y 527, 529 n.16 (2011) (noting that the PPACA addresses challenges in health care access through CHCs); see also Rosenbaum, supra note 121, at 17 (noting that CHCs address health care access barriers).
because CHCs provide an essential health care safety net for the low-income, uninsured, and underserved populations. The government should also increase education within these communities about the role of CHCs in providing cost-effective access to primary health care.

A. **Federal Support Should Be Expanded for CHCs**

The federal government should distribute all PPACA authorized funds to CHCs to provide them with the ability to serve up to 50 million people by 2019 and achieve out of pocket medical cost savings of $316 billion.\(^{138}\) CHCs span all 50 states\(^{139}\) and have the infrastructure to provide access to health care with a proven track record of success.\(^{140}\) Between 2000 and 2009, CHCs doubled the number of patients that they served.\(^{141}\) CHCs also serve both uninsured and newly insured people.\(^{142}\) Yet even though 1124 CHCs provided access to health care for 19.5 million patients,\(^{143}\) more than 46 million people live in poverty and close to 50 million people do not have health insurance.\(^{144}\) By enabling CHCs to provide access to primary care for these medically underserved patients, the government may even save money because, for example, Medicaid recipients could reduce their reliance on less cost-effective emergency room treatment for their primary health care needs.\(^{145}\) Thus, CHCs could provide access to primary health care for up to 50 million people if the government distributes all PPACA authorized funds.

The number of people in poverty and without health insurance, moreover, may increase to even higher levels over the course of the next decade. Although the number of people in

---

\(^{138}\) Ku, Richard, Dor, Tan, Shin & Rosenbaum, *supra* note 27, at Executive Summary.


\(^{140}\) See Ku, Richard, Dor, Tan, Shin & Rosenbaum, *supra* note 27, at Executive Summary.

\(^{141}\) See Ku, Richard, Dor, Tan, Shin & Rosenbaum, *supra* note 27, at Executive Summary.

\(^{142}\) Ku, Richard, Dor, Tan, Shin & Rosenbaum, *supra* note 27, at Executive Summary.

\(^{143}\) See Ku, Cunningham, Goetz-Goldberg, Darnell & Hiller, *supra* note 18, at 1.


\(^{145}\) See *supra* notes 128–30 and accompanying text.
poverty was 46.2 million in 2010, that number could increase to 56 million by 2019.\textsuperscript{146} Similarly, the number of people without health insurance was 49.9 million in 2010, but that number could increase to 61 million by 2019.\textsuperscript{147} As the number of people in poverty and without insurance increases throughout the decade, the role of CHCs within the health care safety net becomes even more important.\textsuperscript{148} According to the Bureau of Primary Health Care, “an estimated 50 million Americans do not have access to a primary health care provider, not even a community health center.”\textsuperscript{149} Even among people with health insurance, twelve percent of the population lacks health care because “there is no available doctor where they live.”\textsuperscript{150} CHCs play a vital role in providing access to health care in these underserved communities.\textsuperscript{151}

Federal grants, moreover, constitute a crucial base of funding for CHCs.\textsuperscript{152} Federal grants to CHCs not only increase access to health care, but also create thousands of jobs in the communities that CHCs serve.\textsuperscript{153} In 2009, for example, Congress invested $2 billion in CHCs

\textsuperscript{146} Fifty-six million is a rough approximation of the number of people in poverty in 2019, using a linear regression of the number of people in poverty from 2001–2010 ($y=1.2279x–1968.67$, $R^2=0.8376$), where the independent variable “$x$” represents the year and the dependent variable “$y$” represents the number of people in poverty. The data for the regression was obtained from the U.S. Census Bureau’s 2010 report on Income, Poverty, and Health Insurance Coverage in the United States. \textit{See DeNavas-Walt, Proctor & Smith, supra note 15, at 62.}

\textsuperscript{147} Sixty-one million is a rough approximation of the number of people without health insurance in 2019, using a linear regression of the number of people without health insurance from 2001–2010 ($y=1.1824x–1962.75$, $R^2=0.9215$), where the independent variable “$x$” represents the year and dependent variable “$y$” represents the number of people without health insurance. The data for the regression was also obtained from the U.S. Census Bureau’s 2010 report. \textit{See DeNavas-Walt, Proctor & Smith, supra note 15, at 77.}

\textsuperscript{148} Lesnik, \textit{supra} note 10, at 10.

\textsuperscript{149} Lesnik, \textit{supra} note 10, at 10.

\textsuperscript{150} Lesnik, \textit{supra} note 10, at 10–11 (“[N]o matter where they live, the story is the same: they can’t get health care because there aren’t enough doctors in their communities who are willing or able to care for them.”).

\textsuperscript{151} CHCs must be in medically underserved areas and make “a vital contribution to the high-risk situation faced by many Americans who would otherwise be stranded without health services.” Lesnik, \textit{supra} note 10, at 10–11.

\textsuperscript{152} CHCs raise funds through “federal and state grants, Medicaid and Medicare reimbursement, patient fees, private insurance, and donations.” Lesnik, \textit{supra} note 10, at 11.

\textsuperscript{153} \textit{See} Rosenbaum, \textit{supra} note 121, at 18 n.86 (“One strategy adopted by the Affordable Care Act in relation to U.S. health workers is the establishment of the National Health Workforce Commission, which is intended to ensure that the supply of health care workers meets demand.”); \textit{see also} Sara Rosenbaum & Peter Shin, \textit{Community Health Centers and the Economy: Assessing Centers Role in Immediate Job Creation Efforts}, GEIGER GIBSON/RCHN COMMUNITY HEALTH FOUND., POL’Y RES. BR. NO. 25, Sep 14, 2011, at Executive Summary, available at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_63C7B816-5056-9D20-3D6FC84132695FF2.pdf.
through the American Reinvestment and Recovery Act of 2009 ("ARRA") \footnote{ARRA, Pub. L. 111-5, 123 Stat 115 (2009).} and $300 million in the NHSC, \footnote{Adashi, Geiger & Fine, supra note 124, at 2048 (discussing NHSC and student loan programs).} creating 32,200 jobs \footnote{See Rosenbaum & Shin, supra note 153, at Executive Summary.} in the communities with the highest unemployment rates. \footnote{Because ARRA targeted the counties with the highest unemployment rates, ARRA’s “economic benefits and job creation, as well as increased primary care access, focused on the communities that needed the most help.” Leighton Ku, Peter Shin & Brian Bruen, Can Health Care Investments Stimulate the Economy, HEALTH AFFAIRS BLOG (March 16, 2010), http://healthaffairs.org/blog/2010/03/16/can-health-care-investments-stimulate-the-economy/.
} Through programs such as the NHSC, CHCs train medical students and employ licensed physicians. \footnote{Adashi, Geiger & Fine, supra note 124, at 2048.} Thus, CHCs have the unique ability to solve two of the biggest problems in modern health care: access to health care and the shortage of primary care doctors. \footnote{Lesnik, supra note 10, at 13.}

**B. CHCs Should Continue to Raise Funds from Other Government Sources, Private Foundations, and Community Supporters**

Although CHCs receive federal funding under PHSA section 330, \footnote{Campbell, supra note 36, at 399–400.} it is also essential to understand that “federal health center grants and payments under Medicaid and private health insurance represent only a portion of total health center revenue.” \footnote{Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at 6.} CHCs should seek funding from other federal, state, local, and private grants and contracts. \footnote{Ku, Richard, Dor, Tan, Shin & Rosenbaum, supra note 27, at 6.} For support in training or to develop alliances with private partners and other stakeholders, CHCs should join associations such as NACHC \footnote{See supra note 42 (discussing the role of NACHC in assisting CHCs).} and the Association of Asian Pacific Community Health Organizations. \footnote{The Association of Asian Pacific Community Health Organizations (AAPCHO) is “a national organization that seeks to improve the health care and access to health care of Asian Americans, Native Hawaiians, and other Pacific Islanders.” CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 125. AAPCHO focuses on three areas: (1) building capacity of local organizations, (2) coalition building with other organizations, (3) and implementing community-based culture. CHARLES B. WANG COMMUNITY HEALTH CENTER, supra note 1, at 126.
}

Look-Alike centers seeking to become federally-funded CHCs can strengthen their hand by applying for planning grants from private foundations. In 1976, for example, CBWCHC won
a “three-year planning grant from the Robert Wood Johnson Foundation.”¹⁶⁵ Through this grant, CBWCHC gathered the necessary information to file an application to become a CHC.¹⁶⁶ This information included “the total population in the service area, the physician-to-population ratio, the number of low birth-weight infants, and the number of people living below the poverty level,”¹⁶⁷ which was necessary to achieve designation as a Medically Underserved Area.¹⁶⁸

CHCs should also raise funds through local community-based fundraising. CHCs can hold fundraising events both to raise money from members of the community and raise awareness about the CHC’s role in improving access to health care in the community. In fact, many Health Center Grantee CHCs first began as free clinics or rural health clinics with only a few volunteer doctors.¹⁶⁹ Through community-based fundraising, volunteer efforts, and grants from private or public foundations, these clinics were able to raise enough money to enable them to meet federal guidelines under PHSA, become FQHC Look-alikes, and ensure the highest quality of service.¹⁷⁰ They then achieved Health Center Grantee status from HRSA.¹⁷¹ Even after achieving Grantee status, CHCs should continue to engage in community-based fundraising because it reduces dependence on federal grants, educates the community about CHC services, and enables CHCs to provide additional health education and preventive health services.

C. **CHCs Should Become Patient-Centered Medical Homes (“Medical Homes”)**

Health care, moreover, involves more than medical diagnosis and procedures.¹⁷² CHCs “present a model of health care that is an anomaly in the U.S. system” because despite the trend

¹⁶⁵ Charles B. Wang Community Health Center, supra note 1, at 59.
¹⁶⁶ “With the planning grant, the Clinic hired an architect and obtained help with financial management from two finance professionals.” Charles B. Wang Community Health Center, supra note 1, at 59.
¹⁶⁷ Charles B. Wang Community Health Center, supra note 1, at 60.
¹⁶⁸ Charles B. Wang Community Health Center, supra note 1, at 59.
¹⁶⁹ Charles B. Wang Community Health Center, supra note 1, at 56–64.
¹⁷⁰ See supra Part I.B for additional details concerning the requirements to qualify for federal funding.
¹⁷¹ See supra notes 165–68 and accompanying text.
¹⁷² See Lesnik, supra note 10, at 5–6.
to separate public health and related services from specialized medical care, CHCs “bucked this trend of bifurcated services in favor of a more holistic approach to improving the health of individuals.”\(^{173}\) This holistic approach “counteracts the increasing fragmentation found in the modern landscape of U.S. medical care.”\(^{174}\) Consistent with this approach, CHCs should take active steps to achieve designation as a Patient-Centered Medical Home (“Medical Home”).

Seven core features define Medical Homes: (1) personal physicians for each patient, (2) a physician-supervised practice, (3) a patient-physician relationship “center[ed] on a whole person orientation,” (4) coordinated patient care, (5) high quality and safety, (6) enhanced medical access, and (7) overall payment or reimbursement reform.\(^{175}\) In fact, at least four medical societies—The American Academy of Family Physicians, The American Academy of Pediatrics, The American College of Medicine, and The American Osteopathic Association—support CHCs that achieve Medical Home status.\(^{176}\) By becoming Medical Homes, moreover, CHCs provide patients with better access to primary care services and open up additional sources of funding.\(^{177}\)

**D. The Federal Government Should Increase Education About the Role of CHCs in Providing Access to Primary Health Care**

Because CHCs have the infrastructure and capacity to serve up to 50 million patients by 2019\(^{178}\) and enjoy strong bipartisan support,\(^{179}\) the government should distribute all authorized

---


\(^{177}\) The New York State Department of Health, for example, has begun a program where CHCs that achieve Level III Medical Home status (through the National Committee for Quality Assurance) qualify to receive an additional $6 per month per Medicaid managed-care patient. See *Eligibility for PCMH Recognition, supra* note 35, at 4.

\(^{178}\) See *supra* note 27 and accompanying text.

\(^{179}\) See PPACA, P.L. 111-148, 124 Stat 119 (2010) (general democratic support); Adashi, Geiger & Fine, *supra* note 124, at 2047–48 (“Ever since their inception, CHCs have received substantial legislative attention, in a remarkable
funding under PPACA and HCERA. The government should also take the next step to increase education and awareness among underserved communities about the role of CHCs in providing access to primary health care. Education should be provided not only to recipients of Medicare, Medicaid, Military Health Care, the Children’s Health Insurance Program, and privately insured people in medically underserved communities, but also to high school students in health education classes. Recipients of other forms of government aid, including unemployment insurance, subsidized housing, welfare, and food stamps should be made aware of the primary health care services and preventive medicine that CHCs provide. The government should also increase disclosure to medical students about NHSC student loan forgiveness programs linked to working in medically underserved areas through CHCs. By increasing awareness in medically underserved communities about the role of CHCs in providing access to primary health care, the government can further encourage community-based support and fundraising, leading to a broader base of funding for CHCs than solely PHSA section 330 grants.

IV. COUNTERARGUMENTS AND ALTERNATIVE PROPOSALS FOR HEALTH CARE REFORM

Thus, CHCs are a model for health care reform, though there are counterarguments and alternative proposals to CHCs. Two counterarguments against CHCs are that CHCs do not provide specialty care or emergency room care. Three alternative proposals to CHCs include employer-based health insurance, universal health insurance, and market-based health care. However, these alternatives are not substitutes for CHCs, but could actually benefit from the better access to health care that CHCs provide to those who might gain coverage under one or another of these alternatives; in effect, CHCs would help to complement any of them. Moreover,

---

180 See NHSC Scholarship Program Application Cycle Is Now Open, supra note 125.
none of these counterarguments or alternative proposals provides for a health care safety net for people in poverty, without health insurance, or in medically underserved communities, nor do any present the same opportunity to educate non-English speaking patients about preventive medicine to help them reduce their long-term health care costs.

A. **Although CHCs Do Not Provide Specialty Care, They Do Provide Primary Care and Create Relationships With Specialty Care Providers**

One main counterargument to the effectiveness of CHCs is that CHCs cannot provide specialty care.\(^{181}\) Although it is true that—with a few exceptions—CHCs do not provide specialty care, all CHCs have developed relationships with specialists, hospitals, and academic medical centers.\(^{182}\) CHCs achieve these relationships by creating partnerships with hospitals to provide continuity of care.\(^{183}\) In fact, CHCs “must make and continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center.”\(^{184}\) These relationships range from basic referrals for specialty care to highly integrated systems.\(^{185}\) CHCs, moreover, “participate in networks with other health centers and safety-net providers to negotiate contracts with managed care organizations, pool resources, and centralize clinical or administrative support services.”\(^{186}\) These partnerships help CHCs provide specialty care to uninsured patients through community and federal resources.\(^{187}\)

B. **Although CHCs Do Not Provide Access to Emergency Room Care, They Do Provide Primary Care and Improve Health Care Outcomes for Patients**

Another counterargument is that CHCs cannot replace hospital-based care or 24-hour access to emergency rooms. Although CHCs do not provide hospital-based or emergency room

---

\(^{181}\) See Gusmano, Fairbrother & Park, *supra* note 71, at 188 (arguing that “[i]ncreasing the number of community health centers is not an adequate substitute for expanding health insurance coverage”).

\(^{182}\) Campbell, *supra* note 36, at 412.


\(^{185}\) Campbell, *supra* note 36, at 412.

\(^{186}\) Campbell, *supra* note 36, at 412.

\(^{187}\) Campbell, *supra* note 36, at 412.
care, CHCs do solve the problem of access to primary care physicians for the unemployed workforce, the uninsured population, minority populations, and other underserved medical communities, at costs far lower than the costs of emergency room care.

Health care reform must distinguish between primary care that CHCs can provide and emergency care that requires hospital interventions. Relying on hospital emergency rooms for primary care is not sustainable because emergency rooms are not designed to provide access to primary care on an episodic basis.\(^{188}\) Between 1998 and 2002, the number of visits to emergency rooms increased from 89.9 million to 110.2 million.\(^{189}\) One commentator notes, “[t]he uninsured depend on emergency rooms for medical care because, legally, they cannot be turned away.”\(^{190}\) This solution is ineffective, costly, and unsustainable;\(^{191}\) in fact, numerous hospital emergency rooms have been forced to close because they have been overwhelmed by uninsured patients.\(^{192}\)

One study of emergency department visits at ten consortium hospitals in 2004 found that 21.4% of visits were not urgent, and that 20.6% were emergent, but could have been treated outside the emergency room setting.\(^{193}\) The study also found that “low-income patients have considerable difficulties accessing specialty, mental health, and dental services,” and that “they were extremely reluctant to use emergency services, and would go to the emergency department only when, in their estimation, it was absolutely necessary.”\(^{194}\) Nevertheless, access to primary care services was relatively high, with the “highest presence in communities that had succeeded

---

\(^{188}\) Many uninsured Americans rely on hospital emergency rooms for medical care. Lesnik, *supra* note 10, at 8.

\(^{189}\) Lesnik, *supra* note 10, at 8.

\(^{190}\) Lesnik, *supra* note 10, at 8; *see also* 42 U.S.C. § 1395dd (2006) (mandating that hospitals screen and treat any individual who seeks emergency room treatment if that individual has emergency medical conditions).

\(^{191}\) Lesnik, *supra* note 10.

\(^{192}\) Between 1998 and 2002, the number of emergency rooms decreased by fifteen percent, while the number of uninsured Americans continues to increase. Lesnik, *supra* note 10, at 8.


\(^{194}\) *See* Rosenbaum, Siegel & Regenstein, *supra* note 193, at 526–27.
in securing dedicated financing through programs such as the federal health centers program.”

Thus, CHCs provide a cost effective alternative to emergency rooms for access to primary care.

**C. Employer-Based Health Insurance Is Not Effective Because It Does Not Target Low-Income Populations**

One alternative proposal for health care reform focuses on employer-based health insurance. Employer-based health insurance can help lower the costs of health care for the employed population, but it does not provide a health care safety net for poor, low income, at-risk, and minority populations. Even if an employer provides an employer health insurance plan to its workers, a minimum-wage worker may not qualify for coverage or even be able to pay for the cost of family coverage under the employer health insurance plan, which could exceed $250 per month. CHCs, by contrast, provide both a health care safety net for medically underserved populations and an opportunity for health education to reduce the ultimate cost of health care.

**D. Universal Health Insurance Is Not Effective Because It Is Cost Prohibitive**

Similarly, universal health insurance, without a CHC-based model, will not solve the problem of increasing health care costs for the same reasons that relying on hospital-based care for primary care is not sustainable. CHCs, by contrast, provide a cost-effective alternative for providing primary health care to all individuals in a community, regardless of their income level, even for people with public or private health insurance. CHCs, moreover, have also been found to be important and effective in nations with national health insurance coverage.

---

195 See Rosenbaum, Siegel & Regenstein, supra note 193, at 528.
196 Although another proposal might be a health insurance system where the employer pays for the full cost of health care, that system would be prohibitively expensive for employers, and could lead employers to reduce wages or increase worker hours to pay for the costs of the health insurance.
197 See supra notes 188–92. Universal health insurance does not lower health care costs because it does not provide a cost effective alternative to hospital emergency rooms, but only spreads the cost among the insured.
198 See Ku, Cunningham, Goetz-Goldberg, Darnell & Hiller, supra note 18, at 30 (noting that in 2010, 48.5% of CHC patients qualified for Medicare, Medicaid or other public insurance, and 13.9% held private insurance).
199 Dan Hawkins et al., The Use of Community Health Centers In Countries with National Health Insurance: Evidence from the Literature, 91 AM. J. PUB. HEALTH 3 (2001).
E. Retail Health Clinics Are Not Effective Because They Do Not Help the Uninsured and Medically Underserved Populations

A final alternative proposal is that primary care should be delivered through a market-based system such as retail health clinics. One commentator argues that because ninety percent of Americans live within fifteen miles of a Walmart store, Walmart could deliver primary care to nearly every American. However, retail clinics, unlike CHCs, are for-profit entities and do not provide health services for the uninsured and others who do not have the ability to pay. Moreover, most retail clinics are located in economically stable areas rather than low-income and medically underserved communities.

V. CONCLUSION

This Note evaluates CHCs as a model for health care reform by considering access, cost, and effectiveness of health care delivered through CHCs, as well as their system of corporate governance. This Note proposes that every medically underserved community adopt a CHC-based model to function as a health care safety net. Not only should the federal government increase support for CHCs, but CHCs should also continue to raise funds from government sources, private foundations, and community supporters. Even though alternative proposals for health care reform may exist, those proposals do not provide an adequate remedy to increase access to primary health care for people in poverty, people without health insurance, and people in medically underserved areas. CHCs, by contrast, provide both an essential health care safety net for the medically underserved population and an opportunity for health education and preventive health to reduce the overall long-term costs of health care for these people.

200 Health care reform in the United States is “nearly always framed as access to insurance.” William M. Sage, Symposium, Might the Fact That 90% of Americans Live Within 15 Miles of a Wal-Mart Help Achieve Universal Health Care?, 55 KAN. L. REV. 1233, 1234 (2007). Health care reform does not have to focus on insurance, but instead could focus on providing medical services. See id.

201 “[R]etail clinics exist to make money and therefore cater to people with money, even if many clinic customers have less money than the people who are best served by the existing system.” See id. at 1244.