

**HEALTH CENTERS AND THE MEDICALLY  
UNDERSERVED:  
BUILDING A RESEARCH AGENDA**

**Friday, December 2, 2005**

**Agency for Healthcare Research and Quality Conference Center  
540 Gaither Road  
Rockville, MD 20850**

**Background Paper: The  
Community Health Center Model**

## **Purpose Statement**

This paper was prepared to provide a common foundation on the community health center model for the December 2<sup>nd</sup> meeting “Health Centers and the Medically Underserved: Building a Research Agenda.” This paper provides a detailed description of the health center program and is therefore a useful resource for all interested parties. For more information on this paper and the meeting, please email [research@nachc.com](mailto:research@nachc.com).

## **Acknowledgement**

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## Health Center\* Requirements†

### Facilitating Access to Care for Defined Medically Underserved Areas and Populations

- Health centers must be located in or serve an urban or rural federally designated medically underserved area (MUA) or serve a federally designated medically underserved population (MUP) (e.g., migrant and seasonal farm workers, the homeless, residents of public housing).<sup>2</sup>
  - A rational service area must be defined by a health center.<sup>2</sup>
  - The specific population groups to be served by a health center are defined by that health center through a process of assessing the needs, resources, demographic and geographic features, and priorities in their community.<sup>1</sup>
- Health centers must provide comprehensive preventive and primary health services to all residents in the service area regardless of ability to pay. They must offer discounts off charges that adjust based on ability to pay for uninsured and underinsured individuals with incomes at or below 200% of federal poverty guidelines, with full discounts for individuals with annual incomes below 100% of poverty.<sup>2</sup>
- Health centers must provide services at locations and times that ensure services are reasonably accessible and responsive to the community being served.<sup>1</sup>

### Providing Healthcare Services

- Health centers must provide comprehensive primary health care services, either directly or through contracts or cooperative arrangements, referrals (including one or more hospital referral relationships), and other services needed to facilitate access to care.<sup>2</sup>
  - Basic health services must include: primary care; diagnostic laboratory and radiology services; preventive services, including prenatal and perinatal services, cancer and other disease screening, well child services, immunizations against vaccine-preventable diseases, screening for elevated blood lead levels, communicable diseases and cholesterol; eye, ear and dental screening for children, family planning services and preventive dental services, emergency medical and dental services, and pharmaceutical services as appropriate to a particular health center.<sup>1</sup>
  - Enabling services to help ensure access to basic health services, as well as facilitate access to comprehensive health and social services must include: case management services; services to assist the health center's patients gain financial support for health and social services; referrals to other providers of medical and health-related services including substance abuse and mental health services; services that enable patients to access health center services such as outreach, transportation and interpretive services; and education of patients and the community regarding the availability and appropriate use of health services.<sup>1</sup>
- Health centers must collaborate appropriately with other health care and social service providers in their area to ensure the effective use of limited health center resources, providing a comprehensive array of services for clients, and gaining access to critical assistance and support.<sup>1</sup>

### Governance, Operations, Policies and Procedures

- Health centers must have public, or nonprofit, tax-exempt status.<sup>2</sup>
- Health centers must have a community-based governing board that meets the following requirements:

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\* Refers to all health center programs covered under Section 330 of the Public Health Service Act

† This summary of health center requirements is taken from the following sources:

1. Section 330 of the Public Health Service Act [42 U.S.C. 254b], 42 C.F.R. Part 51c, 42 C.F.R. Part 491. Also, see Bureau of Primary Health Care Policy Information Notice: 98-23. Health Center Program Expectations. August 17, 1998.
2. Taylor J. The Fundamentals of Community Health Centers. The National Health Policy Forum, The George Washington University. August 31, 2004.

- Be comprised of majority of individuals whom are being served by the center and who, as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and gender.<sup>1</sup>
- Have no more than one-half of the non-user Board members be individuals who derive more than ten percent (10%) percent of their annual income from the health care industry.<sup>1</sup>
- Not be controlled by a third party, or delegate key authorities to a third party.<sup>1</sup>
- Meet at least once a month.<sup>1</sup>
- Determine the scope and location of services to be provided by the center.<sup>1</sup>
- Schedule the hours during which services will be provided.<sup>1</sup>
- Approve the center's grant application and annual budget to ensure the financial health of the organization.<sup>1</sup>
- Be involved in health center planning throughout the year.<sup>1</sup>
- Directly employ the executive director for the center.<sup>1</sup>
- Evaluate the performance of the executive director and hold him or her accountable for the performance of the health center.<sup>1</sup>
- Establish general policies (e.g., financial personnel) for the health center, except in the case of public entities.<sup>1</sup>
- Ensure that the health center is operating in accordance with applicable federal, state and local laws and regulations.<sup>1</sup>
- Evaluate patient utilization and satisfaction and establish a system for handling patient grievances.<sup>1</sup>
- Be knowledgeable about marketplace trends and be willing to adapt the health center's policies and priorities to reflect these trends.<sup>1</sup>
- Evaluate the health center's progress in meeting its annual and long-term programmatic and financial goals.<sup>1</sup>
- Health centers must have a thorough understanding of the diverse community and population groups served in terms of the health care needs of the target community, as well as available resources to meet those needs.<sup>1</sup>
  - They must ensure that organizational behaviors, practices, attitudes, and policies across all health center functions respect and respond to the cultural diversity of communities and clients served.<sup>1</sup>
  - They must assess the full health care needs of their target populations, form a comprehensive system of care incorporating appropriate health and social services, and manage the care of their patients throughout the system.<sup>1</sup>
- Health centers must have effective clinical and administrative leadership, systems and procedures to guide the provision of services, and ongoing quality improvement programs to ensure continuous performance improvement in both clinical services and management.<sup>1</sup>
- Health centers are expected to directly employ the management team (CEO, CFO, CMO) and core staff of primary care clinicians.
- Health centers must ensure that all staffing arrangements lead to the desired outcomes of availability, accessibility, quality, comprehensiveness and coordination of services for health center patients.<sup>1</sup>
- Health centers must have risk management policies and procedures in place.<sup>1</sup>
  - Risk management protocols must be incorporated in health center policies to assure that appropriate standards of care and clinical guidelines are established and followed.<sup>1</sup>

### **Financial Policies and Systems**

- Health centers must participate as Medicare and Medicaid providers.<sup>1</sup>
- At a minimum, health centers must maintain financial systems, including accounting and internal control systems, which are appropriate to the size and complexity of the organization. They must also accurately reflect the financial performance of the organization, safeguard assets, maintain adequate

cash flow to support operations and assure access to care, and maximize revenue from non-federal sources and ensure effective stewardship of federal funds.<sup>9</sup>

- The financial management systems must be capable of tracking, analyzing, and reporting key aspects of the organization's financial status, which include revenue generation by source, billing and collections, cash flow, expenditures and unit costs. It must also provide sufficient information to support necessary accounting functions and be designed in a way which protects the confidentiality of client information.<sup>1</sup>
- A set of routine financial reports must be generated and reviewed by appropriate management staff and members of the health center's governing body on a regular basis.<sup>1</sup>
- The health center budget must attempt to accurately project both the revenues (including non-federal sources) available in the coming budget period and the expenditures required to achieve the health center's goals and objectives.<sup>1</sup>
- Health centers must maximize revenue by making every reasonable effort to collect reimbursement from patients (subject to the schedule of discounts for low-income uninsured and underinsured patients, and third party payors).<sup>1</sup>
- Health centers must have an adequate and competitive fee schedule and a corresponding schedule of discounts, prompt and accurate billing of third party payers, billing of patients in accordance with the schedule of discounts, and timely follow-up on all uncollected amounts.<sup>1</sup>
- The billing of clients without insurance, collection of co-payments and minimum fees, and screening for financial status, must be done in a culturally appropriate manner to assure that these important administrative steps do not, themselves, present a barrier to care.<sup>1</sup>
- Health centers must ensure that an annual independent financial audit is performed in accordance with federal audit requirements.<sup>1</sup>

### **Information Systems and Reporting**

- A clinical records system must be in place, including written procedures, to protect the confidentiality of medical records and other data.<sup>1</sup>
- Health centers must have systems in place which accurately collect and organize data for required reporting of program related statistics, as well as for internal monitoring, quality improvement and the support of management decisions and planning.<sup>1</sup>
- All health centers are required to submit data electronically each year to the Health Resources and Services Administration (HRSA) for the Uniform Data System (UDS), which contains aggregate information on health center patients, staff size and composition, utilization, financing, and other characteristics.<sup>2</sup>

## Health Center Benefits

### Health Centers under the Medicaid Statute

- Under the Medicaid statute, health centers are designated as federally qualified health centers (FQHC). FQHCs consist of:
  - Health centers (including migrant and health care for the homeless centers) that receive a federal grant under section 330 of the Public Health Services Act.<sup>12</sup>
  - Health centers that receive funding by contracting with a grantee health center and that meet Section 330 grant requirements in their own right.<sup>12</sup>
  - Health centers that do not receive Section 330 funding but have been determined by the Centers for Medicare and Medicaid Services (CMS) (based on recommendation by HRSA) to meet the requirements of a Section 330 grantee. This last category of FQHCs are often referred to as "FQHC look-alikes".<sup>12</sup>
- FQHC services are mandatory Medicaid services and include the services of a physician, physician assistant, nurse practitioner, clinical psychologist, clinical social worker, services incident to the services of these practitioners, and any ambulatory service that the state must cover (*e.g.* services of a certified pediatric nurse practitioner) or chooses to cover (*e.g.* dental services) in its state Medicaid plan.<sup>13</sup>
- FQHCs are reimbursed by Medicaid under the Prospective Payment System.
  - The FQHC prospective payment system (PPS) refers to Medicaid's per visit reimbursement methodology for FQHCs.<sup>8</sup>
  - For a health center in operation at the time PPS was put into effect (Jan 1, 2001), its PPS per visit rate was calculated as the average of the per visit rates paid the center in 1999 and 2000 plus an annual increase thereafter based on the Medicare Economic Index (MEI), plus (or minus) any cost the center may incur by adding (or dropping) a new service.<sup>8</sup>
  - For a health center established after 2001, an initial per visit rate is based on the rate(s) of a comparable adjacent health center(s) or based on a reasonable cost estimate, with subsequent increases (or decreases) per the MEI and the addition (or dropping) of services.<sup>8</sup>
  - To the extent that health centers serve Medicaid managed care patients, FQHCs are entitled under Medicaid law to be paid by the state the difference between what the Medicaid managed care company pays and the cost of that service (called the "wrap around payment" under Medicaid).

### Reimbursement under the Medicare Modernization Act

- Under the Medicare Modernization Act, to the extent that health centers serve Medicare managed care patients, they are entitled under Medicare law to be paid by the federal government the difference between what the Medicare managed care company pays and the cost of that service (called the "wrap around payment" under Medicare).

### Federal Torts Claims Act

- Health centers that are Section 330 grantees or sub-grantees (but not FQHC look-alikes) can request to be deemed by HRSA for coverage under the Federal Torts Claims Act (FTCA). If they are so deemed, then the center, its governing board, officers, employees and certain of its contractors, are covered under the FTCA for purposes of medical malpractice. Being covered under FTCA means that suing any of these parties is tantamount to suing the federal government, with the defense of such suit provided by federal government attorneys and any resulting liability paid for by federal funds.<sup>14</sup>

## Health Center Characteristics Beyond the Requirements

### Location

- Health centers are located in all 50 states, the District of Columbia, and the territories and commonwealths in urban and rural areas.<sup>2</sup>
- Grants are required to be allocated per a statutory mandate that requires the ratio of the medically underserved populations in rural areas to the medically underserved populations in urban areas served by health centers not be less than two to three or greater than three to two.

### Patient Characteristics

- In general, health centers serve low-income (and disproportionately women and children) populations.<sup>2</sup>
- For the most recent data on patients served by health centers, see Appendix C.

### Services

- As health centers are expected to provide additional health services that are appropriate to meet the needs of the population they serve, some health centers also provide educational services to meet the needs of their communities such as diabetes self-management education.
- In cases where health centers do not offer services on-site or where demand exceeds on-site capacity, referrals are made to other providers and, subject to budget constraints and priorities, some health centers pay for those services.<sup>2</sup>
- For the most recent data on select services provided by health centers, see Appendix C.

### Source of Revenues

- Medicaid, which made up 36% of health center revenues in 2004, is the largest source of revenue for health centers.<sup>7</sup>
- Federal Section 330 grants, which made up 24% of health center revenues in 2004, is the second largest source of revenue for health center grantees.<sup>7</sup>
- Other sources of health center revenues include funding from the state government, the local government, foundations, other federal grants, Medicare, private insurance, and self paying patients fees.<sup>2</sup>

### Relationships with other Healthcare Entities

- All centers have one or more relationships with hospitals and/or academic medical centers (AMCs). These relationships can vary from the minimum required ó referral for needed specialty and inpatient care ó to a highly integrated system (subject to the health center governance autonomy requirements and expectations and relevant fraud, abuse and anti-trust prohibitions).<sup>4,10,11</sup>
- A number of health centers participate in networks with other health centers or other safety net providers to jointly negotiate contracts with MCOs, centralize clinical or administrative support services and pool resources for particular projects, *e.g.*, purchase and/or operation of network-wide information systems.<sup>2</sup>
  - HRSA has stimulated these efforts by providing some grant funds through the Integrated Services Development Initiative (ISDI).<sup>2</sup>
  - Network grantees focus on integrating a chosen area ó such as financial, pharmacy, or information systems ó across member health centers.<sup>2</sup>
- Some health centers are partnering with other providers to draw on community and federal resources to provide specialty care to their uninsured patients.<sup>2</sup>
  - In some communities, health centers are working with free clinics to take advantage of their referral networks.<sup>2</sup>
  - Other health centers have become part of community consortia that apply to HRSA for Healthy Communities Access Program (HCAP) grants.<sup>2</sup>

- HCAP grants are designed to help communities better coordinate their health care system for the uninsured, which can mean establishing a network of specialty care providers willing to see uninsured patients, as well as managing the number of uninsured patients referred to each provider to ensure their continued participation.<sup>2</sup>

### **Efforts in Reducing Health Disparities**

- Community health centers are a part of the national effort to reduce and eventually eliminate racial/ethnic and socioeconomic disparities in healthcare and health status.<sup>3</sup>
- Over 600 health centers participate in the Health Disparities Collaboratives (HDCs), a quality assurance program that transforms the delivery of health care via the chronic care model, employing patient registries to identify and track which patients need care, creating a team approach to delivery care, using evidence-based guidelines to apply the most current clinical knowledge and practices, and involving patients in self-management with guidance from the care team. The HDCs were originally designed to focus on the treatment of chronic conditions that disproportionately affect poor and minority populations, as well as to be spread or implemented in all health center services.<sup>15</sup>
  - The HDCs have shown to improve patient outcomes and processes of care.<sup>15</sup>
  - The Bureau of Primary Health Care recently began moving towards integrating the HDCs into a more comprehensive Primary Health Care Collaborative. The intention of this move is to spread the care model into all aspects of health center care, including all acute care, thereby covering all patients.<sup>15</sup>

### **Community Involvement**

- Health centers provide entry-level jobs for community residents, and many offer employment and educational counseling to support professional development. They also contribute to the community by serving as anchors for attracting new businesses and investments.<sup>5</sup>
- Many health centers work with agencies and programs in other social services sectors to improve the health status of their entire service area.<sup>3</sup>
- Health centers make regular and systematic assessments of major health needs in their service areas, and conduct health education and outreach activities, as well as interventions for environmental change.<sup>3</sup>

### **Efficacy of Care**

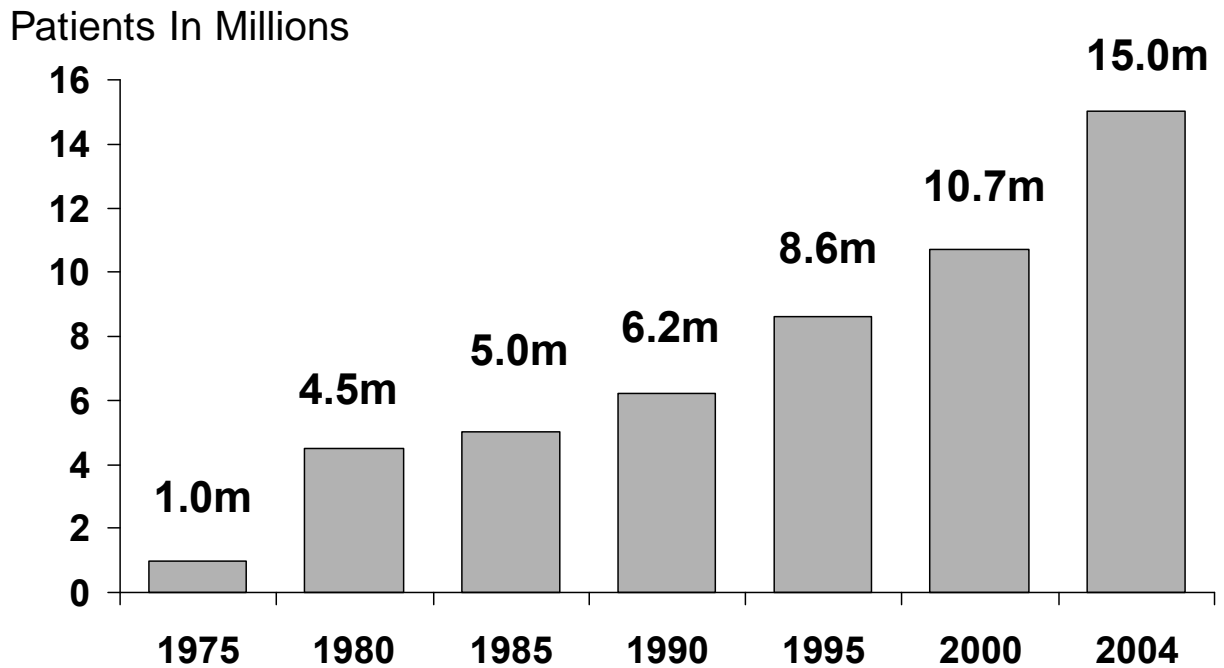
- Multiple studies document health centers' efficacy in reducing the delivery of low birth weight babies, reducing hospitalizations for patients with chronic conditions, and providing effective preventive women's health services.<sup>2</sup>
- Studies over the years have found that health centers successfully manage patients' care in ways that reduce the need for and use of emergency room, hospital inpatient and specialty care services. Many of these services have found that this management leads to significant savings for payors of healthcare.<sup>6</sup>

## Appendix A: Time Line of Events Affecting Health Centers

<u>Year</u>	<u>Event</u>
Late 1800s	Settlement Houses
Early 1900s	“First Generation” of CHCs
1920s	Demise of the 1 <sup>st</sup> Generation of CHCs
1962	1 <sup>st</sup> Migrant Health Centers
1965	Office of Economic Opportunity’s (OEO) 1 <sup>st</sup> CHCs
1968	Public Health Service’s (PHS) 1 <sup>st</sup> CHCs
1969	Direct funding to CHCs/Consumer Board Majority
1970	Hill Burton Act Expanded to include CHCs’ Construction
1971	100 OEO sites & 50 PHS sites = \$418 million
1970-2	National Health Service Corps Starts
1973	Consolidation of OEO & PHS CHCs
1975	Section 330 Funding Initiated
1981	800 Programs = \$324 million
1986-8	Block Granting Repealed
	Stewart B. McKinney Act
	NHSC Reauthorized
	Ryan White Act
	Section 330 funding = \$383 million
1989	FQHC Cost-based Reimbursement
1994	Failure to Pass National Health Care Reform
	Welfare Reform & Medicaid Managed Care Waivers
1996	Consolidation of Health Care Programs
1997	Balanced Budget Act – Phase Out of FQHC
1998-9	700+ CHCs = \$982 million
2000	Prospective Payment System (PPS)
	REACH Initiative
2001-2	Health Center Reauthorization Law
2002-4	Section 330 Reauthorized
	NHSC Reauthorized
	Medicare Prescription Drug Benefit Enacted

Source: From the National Association of Community Health Centers Medical Director Orientation Training Curriculum.

## Appendix B: Health Center Patients Served, 1975-2004



Notes: Figures are estimated and include both federally-funded and non-federally funded health centers.  
Source: National Association of Community Health Centers, 2005. For more information, email [research@nachc.com](mailto:research@nachc.com).



National Association of  
Community Health Centers, Inc.

914 Grantees (51% of which are Rural)

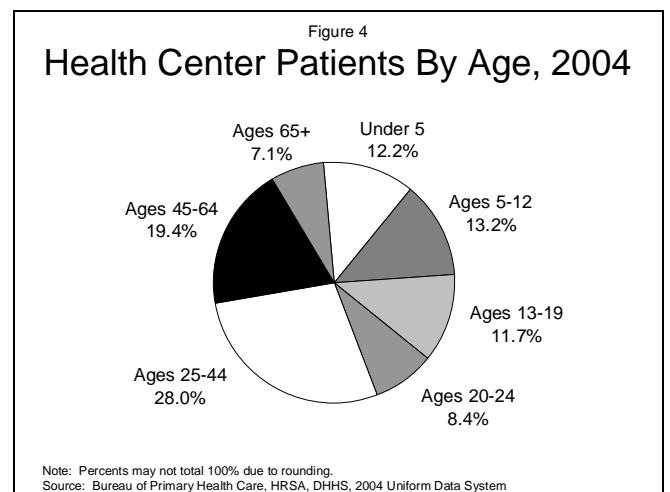
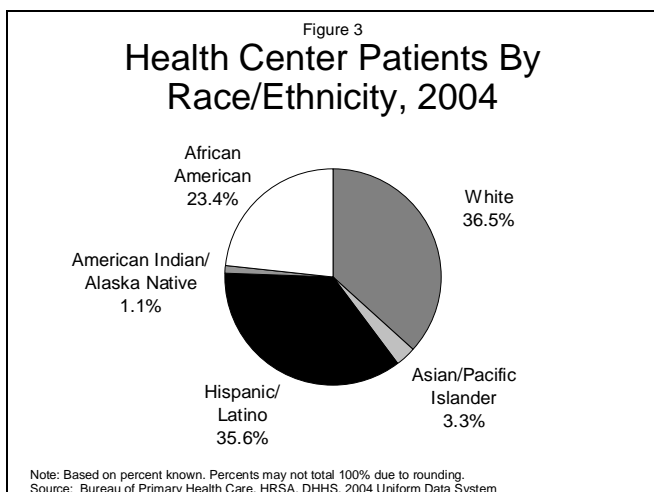
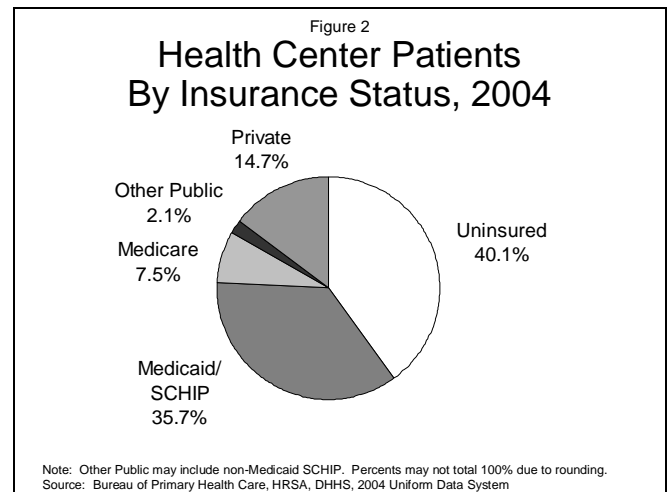
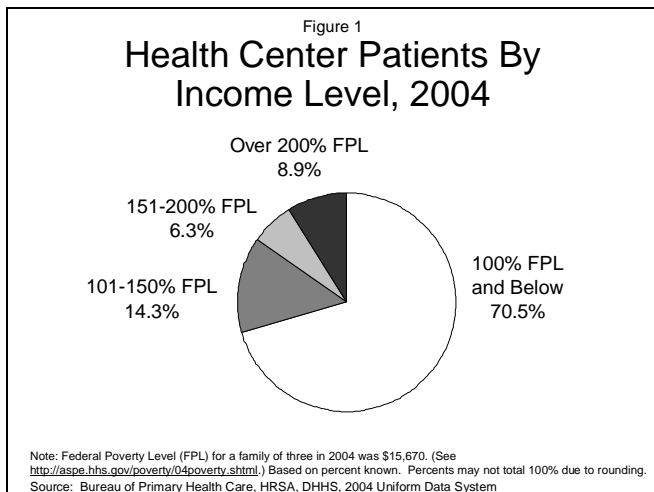
5,502 Service Delivery Sites

13,127,811 Patients

**What are Health Centers?**

Health centers are **local, non-profit, community-owned health care providers** serving low-income and medically underserved communities. For 40 years, health centers have provided **high-quality, affordable primary care and preventive services to the nation’s most vulnerable populations** of people who even if insured would nonetheless remain isolated from traditional forms of medical care because of where they live, who they are, the language they speak, and their higher levels of complex health care needs. Health centers **improve access** to care for millions of Americans regardless of their insurance status or ability to pay. They offer services that many other providers do not, such as transportation, translation, and culturally sensitive health care that can overcome common barriers. Their costs of care rank among the lowest, and they reduce the need for more expensive hospital in-patient and specialty care, producing significant savings for taxpayers.

In 2004, federally-funded health centers were the family doctor and medical home for 13,127,811 individuals throughout the **United States**.



# United States, 2004

## Health Center Staff and Related Patient Visits

	<u>FTE</u>	<u>Patient Visits</u>
Primary Care Physicians	6,487.6	25,325,866
NPs/PAs/CNMs	3,693.1	10,414,386
Nurses	8,075.5	3,091,731
Dentists	1,586.5	4,365,671
Dental Hygienists	547.8	760,986
Mental Health & Substance Abuse Specialists*	2,548.0	2,732,571
Pharmacy	1,633.7	N/A
Total Enabling Services <sup>#</sup>	8,575.0	3,842,581
Other Staff <sup>^</sup>	50,541.0	N/A
<b>Total</b>	<b>83,688.2</b>	<b>52,323,834</b>

\* Includes psychiatrists, psychologists, and licensed or credentialed behavioral health providers.

<sup>#</sup> Includes health educators, case managers, translators, transportation, eligibility workers, etc. Not all staff have related patient visits. Does not include workers for other social services, such as WIC, Head Start, housing assistance, food banks, and employment counselors.

<sup>^</sup> Includes specialists and other medical, dental, and professional personnel, as well as administrative, patient services, and other staff.

## Percent of Health Centers Providing Select Services Onsite\*

<i>Professional Services</i>	
General Primary Medical Care	100%
Prenatal Care	72%
Preventive Dental Care	71%
Mental Health Treatment/Counseling	72%
Substance Abuse Treatment/Counseling	48%
Hearing Screening	87%
Vision Screening	93%
Pharmacy	35%
<i>Preventive Services</i>	
Pap Smear	97%
Smoking Cessation Program	57%
HIV Testing And Counseling	93%
Glycosylated Hemoglobin Measurement, Diabetes	83%
Blood Pressure Monitoring	99%
Blood Cholesterol Screening	89%
Weight Reduction Program	76%
<i>Enabling Services</i>	
Outreach	91%
Case Management	91%
Eligibility Assistance	88%
Health Education	98%
Interpretation/Translation Services	88%
Transportation	55%
Outstationed Eligibility Workers	42%

\* Onsite includes services rendered by salaried employees, contracted providers, National Health Service Corps Staff, volunteers and others such as out-stationed eligibility workers who render services in the health center's name. Health centers may also provide services through formal referral arrangements.

## Patient Visits and Patients by Selected Primary Diagnoses and Services

	<u>Patient Visits</u>	<u>Patients</u>
<i>Medical Conditions</i>		
Hypertension	3,006,082	1,257,930
Diabetes mellitus	2,476,613	778,628
Heart Disease (Selected)	556,625	230,596
Asthma	773,763	418,256
Depression & Other Mood Disorders	1,128,109	402,148
All Mental Health & Substance Abuse	3,494,668	N/A
<i>Preventive Services</i>		
Health Supervision Ages 0-11*	2,994,513	1,764,835
Selected Immunizations <sup>#</sup>	2,364,496	1,610,822
Pap Smear	1,509,973	1,333,253
Mammogram	256,811	234,083
HIV Test	425,266	376,358
Oral Dental Exams	813,324	631,739

\* Well child visits.

<sup>#</sup> Includes DPT, MMR, oral polio vaccine, influenza, hepatitis B, HIB.

## Health Center Costs of Care

<i>Average Cost per Patient</i>	
Medical Costs per Medical Patient	\$370
Dental Costs per Dental Patient	\$306
Total Cost per Total Patient*	\$504
<i>Average Cost per Patient Visit</i>	
Medical Cost per Medical Patient Visit	\$109
Dental Costs per Dental Patient Visit	\$128
Pharmacy Costs per Medical Patient Visit	\$13
Lab & X-ray Cost per Medical Patient Visit	\$9

\* Includes the total cost of all services over total users.

Note: This fact sheet includes data from Federally-Qualified Health Centers (FQHCs) who meet federal health center grant requirements and are required to report administrative, clinical and other information to the federal Bureau of Primary Health Care. Only FQHCs receiving federal health center grants report data, and therefore this fact sheet does not include data from a category of FQHCs that does not receive these funds, known as FQHC Look-Alikes. Data reflected in this fact sheet may consequently underreport the volume of health care delivered by health centers. There are approximately 100 FQHC Look-Alikes across the United States.

For more information, email [research@nachc.com](mailto:research@nachc.com) or visit [www.nachc.com](http://www.nachc.com).

Source: NACHC, 2005. Based on Bureau of Primary Health Care, HRSA, DHHS, 2004 Uniform Data System. State statistics can be found at [www.bphc.hrsa.gov/uds/data.htm](http://www.bphc.hrsa.gov/uds/data.htm).

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