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Community Health Clinics under Managed Competition: Navigating Uncharted Waters

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Abstract In this article, we consider how major changes in the health care system, both real and proposed, may affect the future of community health clinics (CHCs) in the United States and their ability to continue to provide comprehensive care to underserved populations. We discuss the constraints and opportunities that CHCs face in a health care system that is rapidly moving away from fee-for-service medical care toward a model of managed competition. We describe the role that the National Association of Community Health Centers has played in advocating for CHCs in Congress and the role state primary care associations are playing in spearheading the development of statewide CHC-sponsored health maintenance organizations. We also analyze CHC reactions to the changes in federal policies that were proposed in the major health care reform bills of the 103d Congress, as well as the prospects for CHCs under Medicaid managed care as it sweeps rapidly across the nation. As a case study, we examine California's policies that mandate that Medicaid recipients enroll in either a private managed care plan or a newly created public plan, which compete against each other within each county. CHCs are vulnerable during the transition to managed care and managed competition, and they have neither the resources nor the ability to integrate or compete successfully with private health maintenance organizations without safeguards, new sources of funding, technical assistance, improved infrastructure, and vigorous monitoring and oversight from federal and state governments, as well as the continued education, training, and policy advocacy provided by the National Association of Community Health Centers and state primary care associations.

As the U.S. Congress and individual states consider and adopt reforms in the health care system, community health clinics (CHCs) are uncertain

Journal of Health Politics, Policy and Law, Vol. 21, No. 3, Fall 1996.

of their role in a future that is rapidly changing to a model of managed competition, in which managed care plans compete in a health care environment that is largely controlled by public and private health insurance purchasing groups. The place of CHCs in a reformed health care system and under state and local Medicaid managed care systems is unclear, and the route to their successful integration into these systems is relatively uncharted. CHCs are particularly vulnerable as the nation veers sharply away from fee-for-service medical care toward managed competition.

Even in the absence of comprehensive reform at either the national or state level, the rapid growth of managed care plans and health insurance purchasing groups and increased state efforts to enroll their Medicaid clients in managed care call into question the role and future of publicly funded clinics. What will be the relationship between CHCs and private health maintenance organizations (HMOs) and managed care plans? Will the health clinics be able to survive and maintain their independence? Will they be able to continue to serve those who will remain without any health insurance coverage, such as undocumented workers and their families? Will national, state, and local policy makers try to mainstream CHC clients into the private medical care system? Or will they instead ensure that CHC's are included and strengthened under a reformed health care system? How do CHCs define their needs in this changing environment and how have they tried to influence their fate?

CHCs argue that they are critical and essential providers in the American health care system; that they have developed unique and effective methods to meet the needs of vulnerable and underserved communities (Freeman et al. 1982; Gardner 1993; Blumenthal et al. 1993). In this article, we examine the opportunities and constraints that CHCs may face in a system of competing managed health care plans. Using California as a case study, we also consider how national health care reform proposals and recent Medicaid managed care initiatives may shape the future of CHCs. Finally, we discuss federal and state policies that, as part of health policy reforms, could help to secure the future of CHCs in the United States.

Importance of CHCs to Vulnerable Populations

For more than thirty years, CHCs have provided comprehensive primary care for persons living in medically underserved urban and rural communities in the United States. Federal support for neighborhood health

centers began in 1964 as part of the War on Poverty, with the original funds coming from the Economic Opportunity Act of 1964 and Community Action Programs, rather than from the health policy reforms of 1965 (Sardell 1988). In their original conception, neighborhood health centers were "to be a model for change in the existing health care delivery system" (Sardell 1988: 124). However, the mission changed when funding for CHCs was secured as a separate categorical grant program within the Department of Health, Education, and Welfare in 1975, with the enactment of P.L. 94-63. Passage of this legislation, which required a congressional override of President Gerald Ford's veto, shifted the concept of CHCs toward delivering primary health care to underserved populations (Sardell 1988).

Despite many challenges to their existence in the last twenty-five years, CHCs have survived and continue to serve persons isolated from mainstream medical care because of economic, geographic, cultural, and social barriers (Blumenthal et al. 1993; NACHC 1990). In the absence of a national, comprehensive health care program, historically underserved communities have grown to depend on these health centers for quality preventive, primary, and acute medical care; health information; and important enabling and support services that increase access to comprehensive health care and make it culturally appropriate (Freeman et al. 1982; Blumenthal et al. 1993).

The term *community clinic* usually refers to organized outpatient facilities that provide general medical, primary, and preventive care (*Community Clinic Fact Book* 1992). Within this broadly defined group are distinctions among different types of clinics. Most community clinics are federally funded and are designated "community and migrant health centers." If they meet specific criteria defined by the federal government, they can qualify as federally qualified health centers (FQHCs). At a minimum, their services must include diagnostic laboratory and radiological services, preventive services, well-child care, family planning, emergency medical services, transportation, preventive dental care, and pharmacy services. All medical care is provided by physicians, physician assistants, and nurse clinicians. In addition, CHCs may provide supplemental services including mental health care, vision care, health education, physical therapy, therapeutic radiology, and other rehabilitative care. In 1994, 627 CHCs served more than 5.8 million persons nationwide (General Accounting Office 1995).

In addition, an estimated 500 non–federally funded clinics meet the needs of the medically underserved throughout the United States (Blu-

menthal et al. 1993). Often called "look-alikes," these clinics provide many of the same services as CHCs and see similar patient populations. Most of these clinics are state and locally funded or operated by charitable organizations (Blumenthal et al. 1993). Both CHCs and look-alikes have been essential providers to medically underserved communities by ensuring culturally sensitive and linguistically appropriate care, maintaining evening and weekend hours, developing outreach and mobile services, and offering critical support and referral services (NACHC 1990).

In 1989, the National Association of Community Health Centers (NACHC) surveyed their member clinics to collect descriptive data about the clinics and the populations they serve. The survey sample only included federally funded clinics, so we cannot use it to make generalizations about all community clinics in the United States. However, the survey findings are the only national data available about persons who use CHCs.

Based on the NACHC survey, approximately 41.3 percent of CHC patients are white, 33.1 percent are African American, 20.5 percent are Latino, 2 percent are Native American, 1.9 percent are Asian American, and 1.2 percent belong to some other ethnic group. However, the characteristics of the patient population vary considerably between CHCs operating in urban and rural areas. More than one-half of the patients seeking care at rural centers are white (56.5 percent), compared with patients in urban clinics, where African Americans represent the largest proportion (47.4 percent). Rural centers also see a greater percentage of Latino patients, at 24.8 percent, than do urban centers, at 17.2 percent (NACHC 1990).

CHCs often serve the most vulnerable populations in our society, including low-income pregnant women, migrant farm workers, persons with the human immunodeficiency virus, substance abusers, and the homeless. According to the NACHC survey, 31 percent of CHC patients fit into one of these groups and have special medical and social needs. Thus CHCs provide care for a population that functions largely outside of mainstream politics, persons whose collective voice is only a faint cry compared with the professional and moneyed interests of the major health care institutions and providers. These patients require a comprehensive array of services that extends well beyond primary medical care to include social welfare services, nutrition and environmental programs, transportation, outreach, and health education (Blumenthal et al. 1993; NACHC 1990).

Patient insurance status directly affects the revenues of CHCs. Almost

one-half (46.6 percent) of CHC patients are uninsured. Because so many of the clinics' patients are not covered by health insurance, clinics largely depend on government grants and contracts in addition to the revenues they receive from public insurance (Medicaid and Medicare), private insurance, and sliding-scale fees. Proportions of revenue sources are different for federally funded clinics and those that are not certified CHCs. Non–federally funded clinics rely even more heavily on Medicaid and private donations for their revenue (*Community Clinic Annual Report* 1990). Most clients with insurance are publicly insured (38.8 percent). The remaining clients are either privately insured (12.6 percent) or their source of payment is unknown (2 percent). In urban and rural regions, the proportion of persons receiving public rather than private insurance varies. In urban areas, 41 percent have public insurance, often Medicaid, and 14.3 percent have private insurance. In rural areas, 36.3 percent have public insurance and 11.2 percent have private insurance. In all areas, Medicaid is the primary source of public insurance that clients receive (NACHC 1990).

For all of these reasons, most private providers of medical care have chosen not to care for the populations that CHCs now serve. CHC clients represent a financial loss to private providers, because more than 80 percent are either uninsured or are recipients of Medicaid, which on average pays less than one-half of the costs of care. CHC clients also represent a financial risk to managed care plans, because these populations on average have poorer health status than do the employed populations that comprise the rolls of most managed care plans. Finally, CHC clients have special needs associated with their economic, cultural, and social status, which most private providers are simply unprepared to address. Thus CHCs have provided not only a safety net for vulnerable and medically underserved populations that the private sector has been unwilling to serve but CHCs have also developed a comprehensive model for delivering and managing care that meets the needs of these populations. Proponents of maintaining publicly funded CHCs argue that because CHCs understand the needs of vulnerable and special populations and have a proven record of delivering culturally and socially appropriate care, they are uniquely qualified and must be preserved in plans to reform the health care system.

It remains an unresolved question whether managed care plans and other private medical care providers are willing or able to deliver appropriate, comprehensive care for the patients now served by CHCs. The answer may largely depend on the introduction of strong financial incen-

tives offered to private providers to care for high-risk populations and on clear expectations, with accountability for performance, for both the content and quality of care provided to meet their special needs. The answer may also vary considerably from community to community, as a function of the availability and accessibility of private alternatives to publicly provided care. In either case, financial access to health care only solves one small piece of the total access equation. Health insurance contributes little to improving health security if needed services are not available and accessible geographically, physically, culturally, linguistically, temporally, and psychologically. CHCs address these nonfinancial barriers in a way that private providers have not. Finally, the answer may depend on patient preferences. Given the choice, would the populations served by CHCs prefer to be served by private providers and HMOs or would they prefer to continue to receive care in CHCs and CHC-sponsored HMOs? Few clients have been presented with these options, and thus the answer is not clear.

CHCs in a Changing Health Care Environment

Only a short time ago, our nation was engaged in a heated political debate over national health care reform. President Bill Clinton's health care reform plan, as well as most of the major proposals offered in Congress, were all modified versions of managed competition. Although comprehensive health care reform was not enacted in the 103d Congress and has not reemerged in the Republican-controlled 104th Congress, the U.S. health care system continues in a rapid transition that in many ways does not look very different from the managed competition proposals that were considered in the 103d Congress.

We are rapidly leaving behind a system of fee-for-service medicine, solo practitioners, fragmented care, and unlimited choices, where the focus was on inpatients, technology, and acute care. In the emerging health care system, nearly everyone will receive health services in integrated delivery systems operating under capitated managed care plans controlled by large purchasing groups. These groups will negotiate and buy insurance and demand accountability for improved quality for population groups that number in the hundreds of thousands, and even millions, so that a comprehensive standard benefit package can be purchased at a lower cost.

HMO enrollment is growing in every state and in every sector of the health care industry, both public and private. To illustrate, in 1984 fewer than 15 million persons were enrolled in HMOs. By 1994, approximately 50 million persons were estimated to be enrolled in HMOs; by the year 2000, projections show that more than 112 million Americans will be enrolled in HMOs, 46 million through large employers, 27 million through small employers or as individuals, 15 million through Medicare, and 24 million as Medicaid recipients (or nearly the entire Medicaid population).

Health insurance purchasing groups have also been established in at least twenty-one states, and enabling legislation has been proposed in several others. Ten states have state government–run purchasing groups, such as the CalPERS public employee purchasing group in California that served as a model for the Clinton health reform plan. In more and more states, the state government also acts as a purchasing group on behalf of the Medicaid population, offering Medicaid enrollees a choice among several competing health plans. At least seventeen states have small-business purchasing groups that typically serve businesses with two to fifty employees, giving them the same purchasing power as the largest companies. And there are estimated to be at least forty large-business purchasing groups, such as the Pacific Business Group on Health in San Francisco that includes thirty large companies with 2,000 or more employees, representing more than 2.5 million employees and dependents with $3 billion in annual health care expenditures. In addition, six states (California, Florida, Kentucky, Minnesota, New Mexico, and Washington) have both government-run and employer-sponsored health insurance purchasing groups.

Both the amount and pace of change in the health care system in the United States are daunting. In the next section, we consider the reactions and implications of these changes for CHCs, as they were proposed in national health care reform bills and as they are being implemented under state Medicaid managed care reforms.

Political Advocacy for Community Health Centers

In 1971, the NACHC (originally called the National Association of Neighborhood Health Centers) was created by health center leaders to address their common needs and concerns. Initially, there were conflicts among the members over the association's goals (Sardell 1988). Two factions formed, splitting the group geographically, with the representatives

of eastern states defining the primary function of the association as policy advocacy for the health centers in Congress, and the representatives of the western states defining the primary function as providing training and skills to CHCs (Sardell 1988). Although the leadership of the association since 1975 has focused primarily on educating Congress and the public about CHCs, the growth of the CHC program with its expanding constituency and its relationships with other organizations has meant that the NACHC has continued to play an important role in education and training for CHCs (Sardell 1988).

Practically since its inception, the CHC program has been threatened by funding cuts and integration into state block-grant programs. From 1970 to 1975, under the Nixon and Ford administrations, several attempts were made to end the health center program or to incorporate it into a block grant. During this period, NACHC was not active in trying to influence national policy, but instead the Democratically controlled Congress led the political battle against the Nixon and Ford administrations over the fate of the CHC program (Sardell 1988). However, NACHC, enjoying the full support of the Carter administration, did become an active and visible player in supporting the 1978 reauthorization bill that funded the CHC program (Sardell 1988).

In 1980, the NACHC helped to develop state- and regional-level primary care associations that could be incorporated into the national association, giving them grassroots support and direct access to the states (Sardell 1988). By 1993, state and regional primary care associations were operating in forty-six states, representing most CHCs in their state or region and providing them with technical assistance. Thirty-five of these state and regional associations receive federal funding to support their operations (Blumenthal et al. 1993). With the election of President Ronald Reagan in 1980, along with Republican control of the Senate and substantial gains in the House, CHCs were again threatened. However, this time NACHC worked closely with selected senators who supported CHCs and relied on state and regional primary care associations for constituency support, and ultimately the activities of NACHC "were very important to the eventual outcome of the reconciliation process as it affected health centers" (Sardell 1988: 173). Every year while in office, Reagan tried to incorporate CHCs into a health services block grant, and every year since 1981 Congress, with NACHC support, rejected the idea.

By 1993, in the wake of the unveiling of President Clinton's health care reform proposal, the NACHC had grown to represent more than 700 community, migrant, and homeless health centers, providing comprehensive primary care services to more than 7 million medically underserved persons in 1,400 sites nationwide (NACHC 1994). During the national health care reform debate, NACHC performed a range of important activities on behalf of CHCs, including education and training, information dissemination, technical assistance, advocacy, research, policy analysis, and monitoring, and it maintained a clearinghouse for information on health care reform (NACHC 1992). On 22 October 1993, NACHC made the following plea to its member clinics in response to President Clinton's reform proposal:

> This is no time to be divided, or to panic—Migrant, Homeless, Community, Urban, Rural, Clinician, Administrator, Consumer, FQHC look-alike or PHS Grantee. We need to be united because all of us are at risk. . . . everything is up for grabs—FQHC, our clinicians, our federal grants, our legislative protections, and most importantly our patients. . . . we need to work together very efficiently on a variety of levels to protect them and to protect our role as essential providers of quality services for them. (NACHC 1993b: 7)

The NACHC (1993b) soon realized that, to be incorporated into the reformed health care system, community clinics must collectively fight their way to the national, state, and county bargaining tables. The organization recognized that individual clinics are too small and represent too insignificant a proportion of market share, compared with the new, large, organized, private integrated delivery systems, to be effective players in most markets. As a result, the NACHC, the only national organization representing CHCs, played a crucial role in fighting to protect the interests of community providers in national health care reform proposals. In its efforts to rally the troops to defend their interests, NACHC encouraged community providers to "work together in a concentrated campaign to influence key decision-makers" (NACHC 1993b). Their strategy to affect national health reform included the following:

1. Letters: Every health center was asked to generate at least 5,000 letters to senators, representatives, and the White House by the end of 1993.
2. Petitions: Health centers were asked to submit to the White House petitions signed by every patient they serve.
3. Education: Health centers were asked to distribute NACHC literature and information on the effect of health care reform to clinic patients and staff.

4. Humanizing the issue: Health centers were encouraged to invite legislators to visit their centers to increase their understanding of the centers' contributions to maintaining and improving the health of the community.
5. Media events: Health centers were encouraged to use the media effectively to call attention to the critical role the health center plays in the community (NACHC 1993b).

All indications, based on a review of the major health care reform proposals introduced in the 103d Congress, suggest that the NACHC was effective in achieving many, if not all, of its goals. However, this success occurred within the context of the ultimate defeat of national health care reform, and it not clear which of the provisions in the bills addressing CHCs would have survived a final floor battle and conference committee negotiations, had it ever come to that.

Interestingly, the debate over whether to continue to support CHCs in a reformed health care system was never conducted as part of the public record of health care reform in the 103d Congress. Instead, the issue was framed more in terms of what form and level of support was necessary for CHCs. In addition, the question of continued support did not emerge along traditional partisan political lines as it had in the past (Sardell 1988). In fact, proposals to fund and safeguard community clinics were relatively strong in Democratic, Republican, and bipartisan national health care reform proposals.

Universal support for CHCs that spanned ideological and party lines suggests that there was and is widespread recognition that, regardless of the mechanism proposed to finance medical care or increase health insurance coverage of the population, the federal government has an important role in continuing to subsidize CHCs. NACHC, through congressional testimony and close working relationships with key senators and representatives, was successful in increasing understanding that federal subsidies are required to address the failure of the market to locate and provide services in areas where the population is dispersed, low income, at high risk for disease and injury, or has special social service needs that must be met in the community.

However, the failure of the 103d Congress to enact health care reform legislation, coupled with the recent Republican capture of both houses of Congress, suggest that future health reform efforts will not be comprehensive or seek to achieve universal coverage, and may even seek once again to relegate to block grants and cut federal funding for CHCs. Ironically, in the absence of universal coverage, the need to maintain CHCs may be even greater. In fact, in the bills that did not guarantee universal coverage, the funding levels authorized for CHCs were among the highest proposed. Paradoxically, continued support for CHCs may be seen by some as obviating the need for universal coverage, rather than the other way around.

The NACHC has, for many years, also recognized the importance of the adoption of state-level Medicaid managed care programs to the future of CHCs. As early as 1981, NACHC identified capitated managed care arrangements between CHCs and the states as a key issue for the survival of CHCs (Sardell 1988). In the early 1980s, NACHC developed a technical assistance document for CHCs and states considering Medicaid managed care (Sardell 1988). More recently, NACHC has included sessions addressing CHC experiences with Medicaid managed care in its annual meeting programs (Lambert and Gonzalez 1993).

In addition to their strategies of educating Congress and using grassroots political mobilization to influence planners of national health care reform, NACHC has also pursued a legal strategy to protect the future of CHCs under state Medicaid managed care reforms. On 9 June 1994, the NACHC filed a lawsuit against Donna E. Shalala, Secretary of the Department of Health and Human Services, for approving waivers for experimental state Medicaid programs in Oregon, Tennessee, Hawaii, Kentucky, and Rhode Island (Pear 1994). The federal waivers, according to Thomas Van Coverden, Executive Director of NACHC, give states the authority to stop paying for many primary and preventive care services provided by CHCs, to enroll Medicaid beneficiaries in HMOs and other managed care plans that limit the use of CHCs, and to offer CHCs reimbursement rates that are considerably less than the costs of providing medical care services (Pear 1994). As a result, NACHC officials fear that many CHCs will be forced to reduce services, furlough physicians, or even close their doors. The NACHC lawsuit contends that the Clinton administration illegally approved waivers that "give the states the authority to eliminate nearly all of the basic protections in the Medicaid law" (Pear 1994: 14).

Clearly the NACHC views the outcome of health care reforms at the national and state levels as a matter of survival for CHCs. It remains to be seen just how effective their multiple political strategies of insider access to Congress, grassroots mobilization, and legal challenges to Medicaid waivers will be in influencing how CHCs are addressed in national and state reforms.

CHC Reactions to Managed Competition in National Health Reform

To reflect the range of approaches that were used to incorporate CHCs under national health care reform proposals, we selected four bills introduced during the 103d Congress:

- the Clinton administration's American Health Security Act (HR 3600/S1757) that proposed a universal managed competition plan,
- the bill introduced by James McDermott and Paul Wellstone (HR 1200/S491) that proposed a government-sponsored single-payer national health insurance plan,
- the bipartisan bill written by James Cooper and John Breaux (HR 3222/S1579) that proposed a voluntary managed competition program, and
- the Republican-sponsored bill by William Thomas and John Chafee (HR 3704/S1770) that proposed an individual mandate to purchase insurance under managed competition.

With their record as providers of quality care for persons with limited access to mainstream services, and their emphasis on preventive services, CHCs were recognized to varying degrees in each of these bills as important assets in the move to a universal health care program.

The single-payer bill proposed by McDermott/Wellstone would have provided the greatest security for CHCs, because it would have enabled them to continue to operate with complete independence. This bill was also unique in establishing a mechanism for paying CHCs to provide care for persons not covered under universal health care, such as undocumented persons. However, the bill that had the strongest provisions for maintaining CHCs in their present form was the least likely to succeed politically. Increased federal control in the financing of the health care system, as envisioned in the single-payer bill, represented both the greatest hope for security and the greatest threat to security, depending on where one sat: the greatest hope for security for CHCs that wanted to remain independent, local providers and the greatest threat to security for the large, for-profit, private health care industry, which viewed government control as an unnecessary, unwarranted, and inefficient intrusion on their business. The single-payer proposal never received serious attention from either the administration or the majority of the congressional health subcommittees, and its future does not look promising in any of the states. As a result, most of the attention and debate was and still is focused on reforms that are variations on the theme of managed competition.

The specific provisions in the national health care bills we analyzed that were designed to support safety-net providers raised many questions among the representatives of CHCs. Specifically, the major concerns of the CHCs fell into four broad categories: (1) safeguards for existing community providers operating in underserved areas, (2) federal grant support to maintain and expand CHCs, (3) eligibility of undocumented persons for coverage, and (4) continued autonomy rather than integration into managed care systems.

The CHCs believed that the major health care reform bills addressed these issues incompletely, vaguely, and inadequately (New York City Health and Hospitals Corporation 1993).

Safeguards for Community Providers in Underserved Areas

In an attempt to increase access to health care providers, the Clinton administration's managed competition bill emphasized increasing the number of providers in traditionally underserved communities, better integrating primary care and specialized services, and reducing linguistic and cultural barriers to care (White House Domestic Policy Council 1993). The administration wanted to incorporate existing community providers into the reformed system through the designation of essential community provider (ECP) status. ECPs would have been extended special contracting and payment consideration by purchasing groups and health plans. The bill required health plans proposing to encompass underserved areas to contract with ECPs currently located there or to pay them for "out of plan" services for five years after the bill's enactment.

However, many CHCs regarded these essential provider safeguards as insufficient to protect them. NACHC (1993b) argued that the administration's provisions for ECPs would not ensure that current safety-net providers would not be excluded from some plans, lose their clients, or be inadequately protected from financial risk. In testimony before Congress on the administration's bill, NACHC (1994: 7) laid out the following scenario:

> A health plan agrees to contract with the ECP, but on a risk basis; the health plan assigns the ECP the sickest patients, and pays the ECP no less—but no more—than other providers for the same services, with

the ECP at risk for any costs in excess of the health plan's capitated payment. The ECP is out of business in 2–3 years.

Specifically, NACHC (1993a) expressed five major concerns regarding the ECP provisions:

1. What safeguards would be provided for ECPs that contract with health plans to protect them from excessive risk? Would payment rates acknowledge the higher costs of serving underserved populations? The protection offered to ECPs regarding assignment of enrolled clients, access to specialty/inpatient services for ECP patients, payment rates or methods, and risk protection were uncertain.
2. What standards would ECPs be required to meet? There was great concern that standards would be set unreasonably high for CHCs that lack financial, staffing, and technical resources.
3. Would for-profit health plans that serve a "significant" number of underserved persons qualify as ECPs? If so, the value of ECP status could be diluted.
4. What level of cost sharing would be required for ECPs that have out-of-plan status? Would their clients face restricted access?
5. What would happen after the five-year provision of ECP status expired?

Despite these criticisms, the administration's bill was the only one of the major reform plans that established specific safeguards for CHCs with a designation of essential provider status within the framework of managed competition. The only other proposal in which similar protections were given was the Thomas/Chafee bill, in which the safeguards applied more broadly to all providers serving the Medicaid population.

The McDermott/Wellstone single-payer bill created payment methods that included strong incentives to provide services in underserved areas, and capitation payments would also be adjusted based on the number of medically underserved patients. The Cooper/Breaux and Thomas/Chafee bills had provisions that would have permitted purchasing groups to require that health plans include underserved areas in their service area (Cooper/Breaux) or required health plans to comply with any provisions related to services in underserved areas (Thomas/Chafee). However, neither of these bills specifically addressed how CHCs would be incorporated and integrated into a reformed health care system.

CHCs argued that, regardless of what form national health care legislation would take, realistic standards for essential provider status were needed and that adequate payment requirements for such providers must be specified in health care reform legislation. Joe Gallegos, Executive Director of the Health Centers of Northern New Mexico, in his testimony before Congress on the administration's bill, pointed to Wisconsin and Minnesota as examples of rural states that have ensured essential community providers a reasonable payment rate through a gap coverage mechanism that protects them from undue risk. As a substitute for the ECP provisions in the administration's bill, he suggested that each health plan, as a condition of certification, be required to contract with all certified ECPs located in its service area, giving the ECPs the options of participating as in-plan providers with the same terms as other providers, or as out-of-plan providers without gatekeeping restrictions and with rates established by a fee schedule. Safeguards for in-plan ECPs could be established through a federal community health security payment to cover shortfalls between reasonable costs and health plan payments to ECPs (Gallegos 1994).

Minnesota state law requires managed care plans to contract with local CHCs (both federally funded CHCs and others) as primary care providers, although it does not require that the plans send clients to the clinics. However, during the first several years of Minnesota's Medicaid managed care program, this requirement to contract with CHCs was not enforced. Since 1994, this requirement has been integrated into the state's requests for proposals from health plans (NACCHO 1995).

Federal Grant Support for CHCs

The adequacy of federal funding for community providers in the various health care reform bills was also controversial. The Thomas/Chafee bill allocated the greatest increases in grant funding for CHCs. This bill authorized two new provisions under the Public Health Service Act; section 330A provided for allotments to states for grants to CHCs that serve medically underserved and low-income populations, and section 330B provided funds to expand CHCs to serve more medically underserved persons. The authorizations for these two new programs started at $400 million in 1995, with increases by $400 million per year to $1.6 billion in fiscal years 1998 and 1999.

In the administration's bill, the Health Care Access Initiative (Title 3) authorized an investment of approximately $1 billion over five years to expand primary care services in underserved communities. This funding

would have continued to pay for personal health services for targeted populations that experienced barriers to care (CHCs, for example). However, the administration's bill called for funding to be shifted gradually away from support of clinical services to expansion of health care capacity in underserved areas. In addition, flexible grants would have provided start-up, capital expenditure, and operating funds to community providers and to public and nonprofit health care organizations. These funds were to be supplemented by money redirected from other programs. Furthermore, formula grants would have been available to states as they implemented reform (White House Domestic Policy Council 1993).

CHC concerns regarding these funding strategies centered around the proposal to cut existing programs to fund the Health Care Access Initiatives in these bills. NACHC (1993a) estimated that as much as $650 million would have been offset in 1998, with $300 million from CHCs, $103 million from maternal and child health, $75 million from family planning, $132 million from the Ryan White Act (for acquired immunodeficiency syndrome services), and $40 million from health services for the homeless and public housing. In addition, cuts in Medicaid may have helped finance expansion efforts and were a serious concern to national and state community health leaders. Although expanding health care services into underserved regions was seen as crucial, controversy arose over whether funding should go to the development of new and duplicative programs with no preference for existing community health providers (NACHC 1993a).

The Cooper/Breaux bill authorized funding for the development of networks in underserved areas and to assist CHCs to integrate with health plans, with funding levels set lower than the other bills.

The CHCs' position was that health care reform must renew its commitment to support community health care and expand the federal investment in CHC programs. NACHC (1993b) advocated for at least $2 billion in new spending for CHCs, and argued that investing in the current system of health centers made more sense than cutting existing programs or developing a duplicative network. None of the bills supported CHCs at the desired level, but all of them made at least some provisions for continued maintenance and expansion of federal funding.

Eligibility for Undocumented Persons

Although the Clinton administration's bill was promoted as a proposal for universal health care coverage, all persons residing in the United States would not have been insured; undocumented persons were excluded. Only the McDermott/Wellstone single-payer bill made any provision for the possibility of covering undocumented persons by permitting decisions regarding their exclusion on a state-by-state basis. The Cooper/Breaux bill excluded undocumented persons who do not work, but all workers under their bill were to be *offered* coverage by their employers; no employer would have been mandated to *pay* for coverage. The Thomas/Chafee bill excluded all undocumented persons from mandatory coverage.

As a result, immigrants illegally residing in the United States would have been increasingly isolated from the national health care system if any of these proposals had been enacted, and they probably would have been excluded entirely from the national health benefits package. However, millions of undocumented persons live in the United States, and they will continue to need and seek medical care, often at CHCs, and their advocates worry that adequate funding may not be available to continue to support care as a basic human right. Again, only the McDermott/Wellstone single-payer bill made any provisions to CHCs to pay for care for persons not covered under the health care reform plan.

The problem of public provision of medical care to undocumented workers and their families is particularly acute in California, Texas, and Florida. NACHC argues that all immigrants, documented or undocumented, should be included in a national program or financial support should be allocated to community providers to continue to care for this population. However, the politics of using public funds to support services for persons living in the United States illegally has become extremely contentious. In the present political climate in California, with the passage of Proposition 187, which denies medical and social services to undocumented workers, the public increasingly seeks to blame undocumented workers and their families for the state's economic and social problems. This suggests that it is unlikely that any effort to maintain or expand publicly funded health services to undocumented workers will be successful.

Autonomy versus Integration

NACHC, understanding that the single-payer bill was not politically viable, and that reform would probably assume some form of managed competition, made clear its preference that CHCs take the lead in developing their own networks, rather than be forced to contract with HMOs

or other managed care plans, or be incorporated into integrated delivery systems. CHCs expressed a strong desire to maintain control over their patients' care, how they manage referrals, and how they are paid. CHCs are reluctant to relinquish control to private providers with no history or commitment to caring for underserved populations. In testimony before Congress, NACHC stressed that

> there is no evidence that the presence of managed care in a community has successfully increased the level of available resources there, a critical factor in improving the health of underserved communities. Moreover, most managed care entities and HMOs have historically avoided the underserved because of their unique needs and inherently higher costs. (NACHC 1994)

Although this may be true, it may be unrealistic for CHCs to continue to argue for maintaining complete independence and autonomy from private managed care plans. The only type of health reform that would guarantee their complete autonomy and independence is a single-payer approach, which would provide fee-for-service payments to all persons using CHC services. Managed competition, which is based on competing managed care plans, directly threatens this autonomy.

Recent trends in several states where managed care plans have captured a considerable proportion of market share, such as California and Minnesota, suggest that providers that do not form contractual relationships with managed care plans or develop formal relationships, if not merge, with vertically integrated delivery systems may be left out of funding streams and the structure of future health care systems altogether. Increasingly, large purchasing groups, both public and private, are selecting only large managed care plans that have contracts with large networks of providers. Providers who are not part of these networks are, in effect, locked out as providers of medical care.

Interestingly, community clinics may have much greater leverage in these emerging delivery systems than many of them realize. CHCs provide groups of primary care providers an ingredient that is critical to the success of competing managed care plans. When CHCs view these new systems as opportunities, rather than threats, and negotiate contracts with managed care plans that meet their needs and guarantee them a fair payment for their services, their futures may be much more secure than under a system that leaves them vulnerable to fluctuations in annual federal appropriations and decreasing Medicaid payment rates.

The other alternative is for CHCs to maintain their autonomy by developing their own HMOs and openly competing with other private managed care plans. In fact, CHCs in many states have been pursuing both of these options as they have received 1115 waivers from the Health Care Financing Administration (HCFA) to implement Medicaid managed care programs.

The Effect of Medicaid Managed Care Reforms on CHCs

In the absence of comprehensive national health care reform, many states have begun to move toward a statewide, integrated managed care system by enrolling their Medicaid populations in managed care plans. States are looking to managed care as a way of controlling the costs of their Medicaid programs while integrating approaches to improve quality and access to care. With the failure of national health care reform, the states have again become the locus of innovation in reforming the health care system.

Enrollment of the Medicaid population in managed care plans has more than doubled since June 1993. Forty-two states and the District of Columbia have some type of Medicaid managed care plan, enrolling a total of 4.8 million persons, or 15 percent of the Medicaid population, in full-risk capitation programs, with an additional 2 percent enrolled in partially capitated arrangements (NIHCM 1995). Although all but eight states have begun to implement Medicaid managed care, as of 1995 only two states, Arizona and Tennessee, had 100 percent of Medicaid enrollees in capitated plans, and these two states plus Oregon are the only ones with more than 20 percent of Medicaid dollars paid through capitation arrangements. Only nine states have 25 percent or more of Medicaid recipients enrolled in capitated managed care plans, because most states have initially approached implementation on a demonstration project basis (NIHCM 1995). But future growth is expected to be rapid, because many of the twelve states that have approval of Section 1115 waivers from the HCFA to operate statewide capitated Medicaid managed care systems were only recently granted approval for their federal waivers. As many as seven more states have submitted statewide Medicaid capitation waivers to HCFA that are pending approval. However, two states that have HCFA waivers for statewide programs have temporarily suspended their implementation—Kentucky because of budgetary problems, and Mississippi because of a shortage of operating HMOs.

Thus Medicaid managed care has penetrated broadly across the nation.

The states that have the highest penetration of Medicaid managed care are those where private-sector HMO enrollment is highest and those that have the most competing HMO plans operating in their state (NIHCM 1995). As HMO enrollment increases, the growth of Medicaid managed care should follow closely behind.

Many states are creating HMOs out of the network of CHCs operating in their states. The first two CHC-sponsored HMOs were created in Tennessee in 1985 and in Massachusetts in 1986. In 1994, primary care associations in five states (Hawaii, Rhode Island, Oregon, Washington, and Connecticut) took the lead to create HMOs for their networks of CHCs. Three additional states, New Jersey, Florida, and Illinois, are also forming statewide CHC-sponsored HMOs that will begin operation in 1996. One of the major issues for CHCs in these HMOs is tension over control. To establish themselves and to operate in a competitive environment, CHCs have frequently contracted with private management services organizations, both to obtain needed capital and to provide the management services required to operate the HMOs.

There has been no systematic, comprehensive study of CHCs under Medicaid managed care or of how well they have been integrated into private HMOs or public managed care organizations. Recently, however, the National Association of City and County Health Officers (NACCHO 1995) began publishing a series of case studies on Medicaid managed care arrangements and the experiences of CHCs and local health departments. But anecdotal evidence suggests that CHC-sponsored HMOs have retained most of their Medicaid clients and have also negotiated contracts to serve as provider sites for private HMOs.

California as a Case Study in Medicaid Managed Care

California's history with prepaid Medicaid plans (called Medi-Cal in California) dates back to the early 1970s. The fraud and abuse associated with the marketing, access, and quality of services provided under the state's Medi-Cal Prepaid Health Plan program led to legislation in 1972 (the Waxman-Duffy Prepaid Health Plan Act) that was further amended in 1974 to address the serious marketing, access, and quality problems the state experienced. Subsequent legislation in 1975 (the Knox-Keene Act) established a state regulatory agency for all prepaid health plans in the state, and the Waxman-Duffy Act was further amended in 1977 to grant the state flexibility to develop capitated managed care projects,

including publicly operated plans (California Department of Health Services 1993).

Beginning in 1982, within the context of major reforms in the Medi-Cal program, several Medicaid managed care contracting initiatives were approved through many legislative actions, and in 1991 legislation (AB 336) was enacted that revised the statement of purpose and legislative intent of the Medi-Cal program to emphasize "managed care as the means for delivering mainstream health care to Medi-Cal beneficiaries."

Before 1994, two counties, San Mateo and Santa Barbara, operated Medi-Cal managed care programs under county-organized health systems (COHSs). Orange, Santa Cruz, and Solano counties are implementing similar programs. A COHS is defined as a local agency with representation from providers, beneficiaries, local government, and other interested parties created by the County Board of Supervisors to contract with the Medi-Cal program (California Department of Health Services 1993). The COHS administers a capitated, managed care plan that is the sole program for Medi-Cal beneficiaries in the county.

Another Medi-Cal managed care program being implemented is Sacramento County's Geographic Managed Care plan. Under this program, the Department of Health Services has entered into contracts with several private managed care plans to provide care for all patients who received Aid to Families with Dependent Children benefits. As in the other counties, these patients must be enrolled in the managed care system, although unlike the population in the COHS plans, Sacramento Medi-Cal recipients have a choice among several competing private managed care plans (California Department of Health Services 1993).

In the spring of 1993, the California Department of Health Services (1993) released a report entitled *Expanding Medi-Cal Managed Care.* California will soon become one of the states that enroll a majority of their Medicaid population in managed care programs on a mandatory basis. In 1994, 600,000 Medi-Cal clients were enrolled in managed care plans throughout the state. The new state initiative called for enrolling an additional 2,289,358 Medi-Cal recipients in managed care programs by the end of 1995 (California Department of Health Services 1993). The effect of these initiatives on California CHCs may help us to anticipate the responses of CHCs nationally to a health care system built on the idea of competing managed care plans.

The new state plan requires the development of a new model to expand mandatory Medi-Cal managed care programs in thirteen additional counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, River-

side, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. The counties with established Medi-Cal managed care programs will not have to comply with this new model.

The new model is called the "two-plan model." In each county, the Medicaid population can choose from two plans, the Mainstream Plan and the Local Initiative (California Department of Health Services 1993). The Mainstream Plan in each county will consist of one nongovernmentally operated or private HMO, or a joint venture among several private HMOs, that will contract with the Department of Health Services to provide care for a set number of Medi-Cal enrollees in a county. All HMOs operating in the state were invited by the Department of Health Services to bid for the Medi-Cal managed care Mainstream Plan contract in each county.

In contrast, the Local Initiative in each county is a locally developed comprehensive managed care system designed to provide for most Medi-Cal beneficiaries in the county. In the statewide plan, the requirements for the Local Initiative are not described in detail, "in order to provide local stakeholders with maximum flexibility in designing a managed care plan that reflects the needs and priorities of the community it serves" (California Department of Health Services 1993). However, the state plan suggests that the Local Initiative may take the form of a health care consortium, a COHS or look-alike, or any alternative system that the local stakeholders believe meets state requirements.

The new state initiative has serious repercussions for CHCs. According to the 1990 *Community Clinic Annual Report,* 352 community clinics are providing primary care in California, and they served approximately 1,635,489 patients in that year. Of these, 370,021 (22.6 percent) were Medi-Cal recipients, providing 16.4 percent of total revenue—overall the largest source of patient revenue for clinics (*Community Clinic Annual Report* 1990). Of these community clinics, approximately one-half, or 150, are FQHCs.

In the new expansion plan, the California Department of Health Services acknowledged the important role that community clinics and other safety-net providers play in the Medi-Cal system. As such, they were aware that their approach could shift a considerable number of Medi-Cal clients away from existing safety-net providers if these providers were not "affiliated" with the new systems. Much less clear is exactly how safety-net providers will be affiliated with the managed care plans and what safeguards will be provided for them. The state explains that it will furnish limited technical assistance to community providers, which will

include (1) suggestions for developing or obtaining access to management information systems, (2) assistance in expanding or developing provider networks, (3) education about complying with Medi-Cal managed care requirements, and (4) assistance in forming relationships with existing managed care organizations.

In addition, the Local Initiative will be required to include all safety-net providers that agree to meet the "standards of the plan." In contrast, the Mainstream Plan will be encouraged, but not required, to include safety-net providers in their network. This suggests that to the extent that CHCs are integrated into the new Medi-Cal managed care system, they are most likely to be affiliated with the Local Initiative. Thus California may be embarking on a natural experiment, giving Medicaid recipients the choice of receiving their medical care in a private HMO or continuing to receive services through the CHC that is affiliated with the publicly sponsored managed care plan developed by the Local Initiative in each county.

Admittedly, the state's provisions for integrating CHCs into the new initiative are general and do not guarantee that community clinics will be included in the new Medi-Cal systems. Furthermore, the state has allotted no new funds to assist counties in developing, organizing, or installing their Medi-Cal managed care program (California Department of Health Services 1993). The counties and their stakeholders must raise the needed funds and create a Local Initiative that includes a broad spectrum of Medi-Cal providers, including community clinics.

As traditionally cost-effective providers of medical care, community clinics could benefit under a capitated system. Compared with mainstream providers, community clinics are accustomed to operating with limited resources and Medi-Cal's generally low rate of reimbursement. With a capitated system, clinics may actually be allotted more money per patient than in the traditional fee-for-service Medi-Cal system. However, the organizational level at which capitation is implemented and the adequacy of the payment rates established for CHCs ultimately will determine the ability of clinics to realize this potential benefit. For example, experience with Medicaid managed care in the Ramsey County Department of Public Health in Saint Paul, Minnesota, which involved a program with capitation on a global level but fee-for-service reimbursement for providers, left community clinics with lower levels of reimbursement than they had received under the fee-for-service Medicaid system (Fulton 1993).

The lack of state funding to support the Local Initiatives is an impor-

tant problem. According to Sheila Cohen, Director of the San Francisco Clinic Consortium, the $100,000 provided by a leadership group that formed to support San Francisco County's effort is about $900,000 short of the amount necessary to develop and implement the Local Initiative (San Francisco Clinic Consortium 1993). In 1990, San Francisco clinics averaged $1,595,741 in revenue, spending $1,554,670 for operating expenses, leaving a net revenue after expenses of only $41,071 (*Community Clinic Annual Report* 1990). Clearly, these clinics have limited resources from which to draw and they will have to identify other means of financial support if they are going to join the Medi-Cal managed care Local Initiative. Such shortfalls illustrate the lack of capital to CHCs for HMO development and demonstrate their need to identify new sources of capital in the private sector.

In addition, most clinics do not have the infrastructure or skills to meet the minimum standards required to participate in managed care (NACHC 1993b). Priorities for developing this infrastructure include having strong financial personnel on staff; upgrading data systems to track revenues, patient utilization, and provider performance; implementing cost-based reimbursement systems; acquiring staff skills in contracting and subcontracting negotiation; measuring and improving client satisfaction to maintain market share; and acquiring marketing skills on staff to promote the clinic and its services to HMOs and to the community's Medicaid population. Few clinics have these capabilities or the resources to acquire them quickly. However, without them CHCs face dim prospects for successfully establishing their own or joining networks that can compete in the marketplace. Again, this lack of infrastructure illustrates the need for CHC networks to contract with private management service organizations to provide the skills and expertise they lack.

Because of these financial obstacles and other barriers and concerns, some clinics are expected to choose not to participate in the Local Initiatives. Eventually, this may mean that these providers may be excluded from the Medi-Cal system entirely. To receive care, Medi-Cal patients will have to leave these providers, and the clinics will have to make up for the loss in Medi-Cal revenue. It is possible that for some clinics, this loss will be of such magnitude that they will have no choice but to close their doors.

Furthermore, clinics that do become part of the Medi-Cal managed care program will face new challenges in treating the uninsured, such as undocumented workers and their families. Under a capitated system and under the control of a managed care plan operating under a capitated

budget, the uninsured will be seen as a financial loss and a burden to be avoided. Clinics have traditionally subsidized the care of their uninsured patients by cost shifting to Medi-Cal and other insured patients. Under the capitated system created by the Local Initiative, this will become more difficult, if not impossible. Clinics that do not participate in the Local Initiative may be the only ones left to care for those that remain uninsured, saddling them with an even larger financial burden that will only compound the difficulties created by the loss of Medi-Cal dollars.

In most counties, the Local Initiatives have been struggling to succeed. Some fear that the Local Initiative model is doomed to fail and will never be able to compete successfully with the private Mainstream Plans. Some evidence already suggests that Medi-Cal beneficiaries do not understand what it means to enroll in a private managed care plan. One of the private managed care plans in the state, while marketing its Medicaid managed care program door-to-door to Medicaid recipients in San Francisco, reportedly failed to explain that, as enrollees in a private health plan, they would no longer be covered for care at their CHCs (Siegal 1995). These Medicaid recipients did not understand that their new health plan did not have a contract with their health center to provide for their care. Although the state encourages CHCs to affiliate with managed care providers, neither federal nor state law requires the health plans to contract with CHCs. The lack of requirements in both state and federal laws that would mandate that private managed care plans participating under Medicaid programs contract with CHCs operating in their service area leaves both the CHCs and the Medi-Cal population vulnerable in the new system.

Conclusions

The existence of CHCs is challenged by increasing managed care and managed competition at the state and national levels. This tidal wave of reform has the potential either to sweep them up and support them in the transition or to wipe them out entirely. To survive, these providers of the medically underserved will have to continue to work collaboratively at the national, state, and local levels through existing networks by sharing resources and staying abreast of policy developments in health reform. As individual organizations, community clinics are working from a position of relative weakness. However, if they can capitalize on their record of providing quality, culturally appropriate medical care, they can serve

as a model for all providers serving vulnerable populations under a managed care system.

CHCs are likely to survive only if they are given the safeguards, resources, and technical assistance necessary to participate as full partners in the development of local networks of health care providers or to contract successfully with private managed care plans. Given current trends in the health care industry, CHC survival may depend more on the ability to integrate and affiliate with public and private providers and health plans than on continued federal funding.

As the nation moves rapidly from a fee-for-service to a managed care system, CHC survival will require specific safeguards at the federal and state levels that ensure their ability to develop their own networks or that require health plans to incorporate them into existing networks. Federal provisions to maintain funding for CHCs to continue to care for the uninsured are also needed. Provisions relating to the uses of federal funding for CHCs also need to be expanded beyond providing patient care and supporting enabling services to cover the costs of improving CHC infrastructure, including hiring and training staff in financing, information systems, contracting, and marketing, as well as for acquiring, installing, and operating health information and cost accounting systems. Finally, it is also important that payment mechanisms incorporate incentives to continue to provide services to low-income, high-risk, medically underserved and vulnerable populations, and to protect CHCs from excessive financial risk. In the meantime, the future of CHCs hangs in the balance.

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