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NEW GOVERNANCE IN ACTION: COMMUNITY HEALTH CENTERS AND THE PUBLIC HEALTH SERVICE ACT

I. INTRODUCTION

Comprehensive health reform has been a predominant goal of the United States legislative system over the past several decades.¹ However, attempts to repair the broken and fragmented United States health care system have been relatively futile.² Self-regulation, social contract, and market competition theories of law have attempted to facilitate health reform, but the United States continues to fail in adopting a successful mechanism for regulating and governing health care.³ As the United States seeks a model of comprehensive health reform, legislators should be cognizant of an increasingly recognized theory of health law that appears to have coexisted with the older theories of law.⁴ This fourth theory of health law is deemed new governance and offers a politically feasible and promising framework for change.⁵

New governance is not a recently devised legal theory, but instead refers to “the widespread and explicit use of nonconventional forms of

1. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* 235-89 (1982) (providing a historical look at health reform in the United States).

2. See generally *id.*

3. Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 155 (2004). The failure of the Clinton health plan in 1993 highlighted the inability of prior tools and institutions to resolve health care problems by attempting to solve the problems “with a national health insurance proposal that ingeniously combined the social contract, market competition, and professional authority models, but was unable to mobilize the political support needed to overcome intense opposition.” *Id.* at 157.

4. Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 139, 165 (2006) [hereinafter Trubek, *New Governance and Soft Law*]. See also Tara J. Melish, *Maximum Feasible Participation of the Poor: New Governance, New Accountability, and a 21st Century War on the Sources of Poverty*, 13 YALE HUMAN RTS. & DEV. L.J. 1, 34 (2008) (providing an example of how new governance has been previously used in federal reform by the Clinton administration under the National Partnership for Reinventing Government).

5. See Wendy A. Bach, *Welfare Reform, Privatization, and Power: Reconfiguring Administrative Law Structures from the Ground Up*, 74 BROOK. L. REV. 275, 307-08 (2009) (explaining how new governance may be an effective framework for change in the welfare reform context); Rosenblatt, *supra* note 3, at 160, 193.

governing.”⁶ The new governance paradigm recognizes “the collaborative nature of modern efforts to meet human needs, the widespread use of tools of action that engage complex networks of public and private actors, and the resulting need for a different style of public management, and a different type of public sector, emphasizing collaboration and enablement rather than hierarchy and control.”⁷ It promotes a more responsive and flexible regulatory structure through decentralization, public-private partnerships, and active patient participation.⁸ An exemplary working model of the new governance paradigm is found within the existing governing structure of community health centers⁹ in the United States.

Community health centers began as a small demonstration project during the War on Poverty¹⁰ and have transformed into the nation’s largest single system for comprehensive primary care.¹¹ Community health centers are local, non-profit, community-governed health care providers that serve many low-income and medically underserved communities in the United States.¹² They provide a comprehensive array of specified primary care services to predominately low-income and diverse populations.¹³ They also

6. Trubek, *New Governance and Soft Law*, *supra* note 4, at 147-48.

7. THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE vii (Lester M. Salamon ed., 2002) [hereinafter THE TOOLS OF GOVERNMENT].

8. Trubek, *New Governance and Soft Law*, *supra* note 4, at 139.

9. For the purposes of this article, the term “community health center” refers to “federally qualified health centers” that are regulated under § 330 of the Public Health Service Act. *See* SARA ROSENBAUM, BRAD FINNEGAN & PETER SHIN, COMMUNITY HEALTH CENTERS IN AN ERA OF HEALTH SYSTEM REFORM AND ECONOMIC DOWNTURN: PROSPECTS AND CHALLENGES 2 (2009), *available at* <http://www.kff.org/uninsured/upload/7876.pdf>. Conventionally, the term “health center” includes clinics that receive federal grants under § 330 of the Public Health Service Act and “look-alike” health centers that meet all requirements applicable to federally funded health centers. *Id.* Medicare, Medicaid, and State Children’s Health Insurance Program federally funded and “look-alike” health centers are classified as “federally qualified health centers.” *Id.*

10. *See* BONNIE LEFKOWITZ, COMMUNITY HEALTH CENTERS: A MOVEMENT AND THE PEOPLE WHO MADE IT HAPPEN 4 (2007).

11. ROSENBAUM, FINNEGAN & SHIN, *supra* note 9, at 1. “In 2007, more than 1,200 health center grantees working in nearly 7,200 delivery sites throughout the nation furnished care to more than 16 million patients They serve an estimated one in three low-income persons (those with family incomes less than twice the federal poverty level or \$44,100 for a family of four in 2009), one in seven rural Americans, and one in four low-income minority residents.” *Id.* (citing NAT’L ASS’N OF CMTY. HEALTH CTRS., A SKETCH OF COMMUNITY HEALTH CENTERS: CHART BOOK 2009 (2009) [hereinafter CHART BOOK], *available at* <http://www.nachc.com/client/documents/Chartbook%20FINAL%202009.pdf>).

12. NAT’L ASS’N OF CMTY. HEALTH CTRS., *America’s Health Centers* (Oct. 2009), http://www.nachc.org/client/documents/America’s_Health_Centers1.pdf [hereinafter *America’s Health Centers*].

13. KAISER FAMILY FOUND., *Community Health Centers* (Mar. 2009), <http://www.kff.org/uninsured/upload/7877.pdf> [hereinafter *Community Health Centers*]. *See also* ROSENBAUM,

provide many non-medical services that reduce barriers and improve access to health care, such as social outreach services, health education, and transportation services.¹⁴ Consequently, community health centers have played a crucial role in the United States health care safety net, especially given the decline in employer-sponsored coverage and increased number of uninsured in the United States.¹⁵

Since their inception in 1965, community health centers have embraced the new governance paradigm by decentralizing health care, establishing public-private partnerships, and allowing patients to actively participate in health center governance. New governance is further encapsulated by the legislation that regulates community health centers. Community health centers are required to comply with Section 330 of the Public Health Service Act in order to receive federal funding.¹⁶ Along with requiring community health centers to provide specified primary care services to medically underserved communities regardless of their patients' ability to pay,¹⁷ Section 330 mandates that community health centers have governing boards in which a majority of the members are health center patients.¹⁸

The funding mechanism of Section 330 gives community health centers an advantage over other health organizations that have failed to implement a consumer-majority governing board and has created a "feeding frenzy" among health institutions fighting to survive in the current economic downturn.¹⁹ Consequently, hospitals and other health organizations would like to see the consumer-governed board mandate provision repealed so

FINNEGAN & SHIN, *supra* note 9, at 3 (noting that in 2007, 39% of all community health center patients were uninsured, 35% were covered by Medicaid, and 16% had some level of private insurance that likely had limited coverage and high deductibles or cost sharing).

14. See *Community Health Centers*, *supra* note 13. See also 42 U.S.C. § 254b(b)(1) (2006) (detailed statutory language for all required primary health services and non-medical services provided by community health centers).

15. Irwin Redlener & Roy Grant, *America's Safety Net and Health Care Reform—What Lies Ahead?* 361 NEW ENG. J. MED. 2201, 2203 (2009) (noting that "[b]etween June 2008 and June 2009, visits to community health centers increased by 14%, and visits by uninsured patients by 21%"). See also KAISER FAMILY FOUND., THE UNINSURED: A PRIMER: KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 1, 17 (2010), available at <http://www.kff.org/uninsured/upload/7451-06.pdf>. Fifty million non-elderly Americans were uninsured in 2010. *Id.* Moreover, between 2007-2009, employer-sponsored coverage declined markedly as ten million people lost coverage through their employer as a result of the economic downturn and recession. *Id.*

16. See 42 U.S.C. § 254b. See also *Community Health Centers*, *supra* note 13.

17. 42 U.S.C. § 254b(a)(1)-(b)(1) (2006).

18. *Id.* § 254b(k)(3)(H)(i).

19. See generally LEFKOWITZ, *supra* note 10, at 15, 26, 140 (2007) (discussing how other health care organizations want the consumer-majority board requirements repealed so they can qualify for federal funding).

that they may receive Section 330 funding without having to create a consumer-majority governing board within their organization.²⁰

This article seeks to demonstrate how community health centers, meeting the federal regulations of Section 330 of the Public Health Service Act, have successfully embraced the new governance paradigm. It addresses the challenges community health centers face from other health care organizations that want federal funding, but prefer to be exempt from the consumer governed board requirement of Section 330 of the Public Health Service Act. Moreover, this article seeks to establish the importance of the consumer governed board requirement of Section 330 in maintaining a new governance framework within community health centers. Finally, it encourages legislators to consider creating similar federal requirements for other health organizations to receive federal funding by positing the idea that the new governance model—as exemplified by community health centers—will not only lead to improved health outcomes, but will further lead the nation in establishing a collaborative national health care system that provides cost-effective quality care to all Americans.

II. AN OVERVIEW OF NEW GOVERNANCE

Over the past several decades, commentators have noted that three theories of law have played a role in health care and shaping modern health care governance.²¹ One theory of law emphasizes self-regulation where physicians control all aspects of the health care delivery system, including fee-for-service arrangements, standards for licensing and enforcement, and patient selection.²² Another theory of law emphasizes command and control from the federal government and is often referred to as the “modestly egalitarian social contract model.”²³ This model is premised on the belief that patients and society, as a whole, possess legitimate rights and interests in a fair and equitable health care system.²⁴ A third theory of law emphasizes market competition and the notion that individuals choose health insurance and health services based on their own financial resources.²⁵ More recently, scholars have identified a fourth theory of law that is transformative of these older theories of law.²⁶ This fourth theory involves an emerging set of tools and practices that allow more

20. See *id.* at 26, 140.

21. See Trubek, *New Governance and Soft Law*, *supra* note 4, at 146.

22. Rosenblatt, *supra* note 3, at 162-63.

23. Trubek, *New Governance and Soft Law*, *supra* note 4, at 146.

24. See Rosenblatt, *supra* note 3, at 166-67.

25. *Id.* at 155.

26. See Trubek, *New Governance and Soft Law*, *supra* note 4, at 147.

people to participate in the work of government.²⁷ This fourth theory is called “new governance.”²⁸

New governance builds on a “history of past thinking, chang[es] emphases, and incorporat[es] new elements,” but does not completely replace the existing models of health law and administration.²⁹ Scholars of new governance seek to build a “conceptual bridge” between advocates of centralized regulatory structures and proponents of the market competition model.³⁰ New governance recognizes that although privatization may be partially effective in solving public problems, “private markets cannot be relied on to give appropriate weight to public interests over private ones without active public involvement.”³¹ In establishing its paradigm, new governance shifts policy analysis and public administration away from focusing on the operation of a public agency or program and towards focusing on the distinctive tools or instruments of public action that these agencies and programs embody.³² New governance scholars describe movements away from top-down regulation and towards a “collaborative, ‘softer’ model where a variety of stakeholders work together to create, implement, and continually renegotiate programmatic structure and implementation.”³³

The new governance paradigm “embrace[s] localization, competition, solutions derived from the particular needs and circumstances of those closest to the problem, solutions that cross over traditional boundaries between areas of law, and a kind of perpetual experimentation inherent in multiple, ongoing collaborations.”³⁴ New governance “offers a series of approaches to regulation [that are] less rigid than traditional models of administrative oversight, and allows for a ‘bottom up’ process” to solve problems.³⁵ It is a broad phenomenon that includes “[decentralization], public-private partnerships, new types of regulations and incentives, network

27. Lisa Blomgren Bingham, Tina Nabatchi & Rosemary O’Leary, *The New Governance: Practices and Processes for Stakeholder and Citizen Participation in the Work of Government*, 65 PUB. ADMIN. REV. 547, 548 (2005).

28. Trubek, *New Governance and Soft Law*, *supra* note 4, at 147.

29. Lester M. Salamon, *The New Governance and the Tools of Public Action: An Introduction*, 28 FORDHAM URB. L.J. 1611, 1623-24 (2001).

30. Bach, *supra* note 5, at 303.

31. Salamon, *supra* note 29, at 1634-35.

32. *Id.* at 1627.

33. Bach, *supra* note 5, at 304.

34. *Id.* at 305.

35. John D. Blum, *New Governance and Health Care Regulation*, 2 ASIAN J. WTO & INT’L HEALTH L. & POL’Y 125, 135-36 (2007).

creation, coordinated data collection and dissemination, benchmarking, monitoring, and active [consumer] participation.”³⁶

The decentralization of government involves shifting power from federal government to state and local levels of government and places less emphasis on “nationally administered programs.”³⁷ It recognizes that “all government tasks are best carried out at the level closest to those affected by them.”³⁸ The role of government changes from controller to facilitator. The national government sets standards, provides funding, and maintains a collaborative relationship with state and local governments.³⁹ The government identifies a problem and then supports innovation and encourages best practices and experimentation among local entities.⁴⁰

Public-private partnerships are created to work on shared problems and utilize collaborative networks to achieve desired outcomes through negotiation.⁴¹ This is closely linked to network creation.⁴² Developing networks among different organizations and programs changes the government’s role because it no longer regulates organizations to achieve desired outcomes.⁴³ Public-private partnerships may utilize the collection of data to evaluate whether set goals and benchmarks are achieved.⁴⁴ The results are monitored through the collection and dissemination of data.⁴⁵ New governance enhances the synergies that exist among public and private actors, and such collaboration is a “desirable byproduct” of the complementarities that exist among different sectors that can be enhanced to solve public problems.⁴⁶

A distinctive and unique feature of new governance is the increasing role of the patient and consumer participating in the work of government.⁴⁷ New governance emphasizes the enhanced role of consumer participation

36. Trubek, *New Governance and Soft Law*, *supra* note 4, at 139.

37. *Id.* at 148.

38. Louise G. Trubek, *New Governance Practices in U.S. Health Care*, in *LAW AND NEW GOVERNANCE IN THE EU AND THE US* 245, 254 (Gráinne de Búrca & Joanne Scott eds., 2006) [hereinafter Trubek, *New Governance Practices*] (quoting Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 MINN. L. REV. 342, 382 (2004)).

39. Trubek, *New Governance and Soft Law*, *supra* note 4, at 148.

40. *Id.*

41. *Id.*

42. *Id.*

43. Trubek, *New Governance Practices*, *supra* note 38, at 255.

44. Trubek, *New Governance and Soft Law*, *supra* note 4, at 148-49.

45. *Id.* at 149.

46. Salamon, *supra* note 29, at 1633.

47. See Bingham, Nabatchi & O’Leary, *supra* note 27. See also Trubek, *New Governance and Soft Law*, *supra* note 4, at 156.

by hinging on the notion that the individual consumer may influence outcomes at the clinical and policy levels.⁴⁸

Consumers are considered essential for deliberation and the functioning of the health care improvement process. New governance seeks to “share power in decision-making, encourage citizen autonomy and independence, and provide a process for developing the common good through civic engagement.”⁴⁹ Moreover, the bottom-up approach of new governance facilitates consumers participation in decisions that affect their lives.⁵⁰ New governance emphasizes that the values of participation and transparency are essential for a democratic system and the process may lose legitimacy when affected groups are left out of the decision-making process due to outright exclusion or lack of information.⁵¹ Consumers “must play an important role in public policy and decision making . . . [and] have the right to decide what is important to them and how [to] best achieve their objectives.”⁵² Consumer participation allows those affected by public policies to play a decisive role in monitoring public action to ensure it meets the needs of the affected community.⁵³

Despite the fact that “new governance” contains the word “new,” the framework of new governance appeared in social action programs established during the War on Poverty.⁵⁴ An enduring War on Poverty program that built itself upon a new governance framework and has received increased recognition for its success in the United States health care system is the Community Health Center Program.

III. THE ORIGINS OF COMMUNITY HEALTH CENTERS

The Community Health Center Program became a part of the United States health care system during Lyndon B. Johnson’s War on Poverty and was funded as part of the Community Action Program established by the

48. Trubek, *New Governance and Soft Law*, *supra* note 4, at 156.

49. Bingham, Nabatchi & O’Leary, *supra* note 27.

50. *See id.* at 548-50.

51. *See id.* at 549-51.

52. Bingham, Nabatchi & O’Leary, *supra* note 27, at 555. *See also* Trubek, *New Governance and Soft Law*, *supra* note 4, at 168.

53. Melish, *supra* note 4, at 52.

54. A significant example of an enduring social action program from the War on Poverty that utilized new governance is the Head Start Program. Head Start targeted young children and channeled a significant proportion of funds through local school boards that had strong local parent involvement. *See generally* EDWARD ZIGLER & SUSAN MUENCHOW, *HEAD START: THE INSIDE STORY OF AMERICA’S MOST SUCCESSFUL EDUCATIONAL EXPERIMENT* (1992). *See also* Melish, *supra* note 4, at 30-31 (listing multiple arenas in which new governance is a dominant model, such as environmental law, occupational safety and health administration, prison and school administration, and health care).

Economic Opportunity Act of 1964.⁵⁵ The Economic Opportunity Act of 1964 provided for the development and administration of community action programs with “the maximum feasible participation of the residents of the areas and members of the groups served.”⁵⁶ President Johnson recognized that services would be utilized and more relevant to the poor’s needs if the poor, themselves, participated in the planning.⁵⁷ The War on Poverty was “not a struggle simply to support people, to make them dependent on the generosity of others,” but rather, “a struggle to give people a chance . . . an effort to allow them to develop and use their capacities, as we have been allowed to develop and use ours, so that they can share, as others share, in the promise of this nation.”⁵⁸ This concept was termed “maximum feasible participation.”⁵⁹ It was believed that such participatory engagement would serve as a lever for increasing individual responsibility and community ownership in developing sustainable solutions to poverty.⁶⁰

The 1964 legislation mandated that the Office of Economic Opportunity (OEO) work “toward elimination of poverty or a cause or causes of poverty through developing employment opportunities, improving human performance, motivation, and productivity, or bettering the conditions under which people live, learn, and work”⁶¹ Although the OEO did not include health in its initially funded projects, many participants of other programs (*i.e.* Job Corps and Head Start) had untreated medical conditions and local community agencies began submitting proposals for the purchase of private sector medical services.⁶² Eventually, OEO decided it would be less expensive and more efficient to fund health services directly, especially with projects aimed at changing health care delivery to the poor.⁶³

Dr. Jack Geiger and Dr. Count Gibson received the first grant to develop a health care delivery model aligned with the objectives of the War

55. LEFKOWITZ, *supra* note 10.

56. 42 U.S.C. § 2782(a)(3) (1964).

57. LEFKOWITZ, *supra* note 10. *See also* Lyndon B. Johnson, Special Message to the Congress Proposing a Nationwide War on the Sources of Poverty (March 16, 1964), in 1 PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES: LYNDON B. JOHNSON, 1963-64, at 375-80 (1965) [hereinafter Lyndon B. Johnson’s Special Message]. President Johnson declared, “local citizens best understand their own problems and know best how to deal with those problems.” *Id.* at 378.

58. Lyndon B. Johnson’s Special Message, *supra* note 57, at 376.

59. Melish, *supra* note 4, at 4 (quoting the Economic Opportunity Act of 1964, Pub. L. No. 88-452, § 202(a), 78 Stat. 508, 516 (repealed 1981)).

60. Melish, *supra* note 4, at 11.

61. Economic Opportunity Act of 1964 § 202(a).

62. ALICE SARDELL, THE U.S. EXPERIMENT IN SOCIAL MEDICINE: THE COMMUNITY HEALTH CENTER PROGRAM, 1965-1986 51 (1988).

63. *Id.*

on Poverty.⁶⁴ They developed a community health center model that provided comprehensive personal health care delivered by teams of physicians and other health professionals assigned to specific communities, community outreach, attention to environmental and economic contributors to poor health, and patient involvement in the setup and delivery of health programs.⁶⁵ The first funded OEO-neighborhood health center opened in 1965 in the Columbia Point neighborhood in Boston.⁶⁶ The passage of an amendment to the 1964 Economic Opportunity Act, which specified funding for the planning and operation of comprehensive health service programs in medically underserved rural and urban areas, resulted in an expansion of many other health centers in poor and predominately minority neighborhoods.⁶⁷ Moreover, this amendment emphasized the importance of consumer participation in health services.⁶⁸

Since their inception, community health centers have been firmly committed to a model of health care that is comprehensive and community-focused. The original "neighborhood health centers" sought to embody the concepts of social medicine, comprehensive health care, and community participation.⁶⁹ Community health centers were intended to complement the social insurance programs of Medicare and Medicaid and offer a model of health care reform that included social services, job training, community outreach and empowerment, mental health services, nutrition, and other public health and community organizing initiatives.⁷⁰ The community-based elements of the community health center model included community health services, community economic development, and community participation.⁷¹ This model was intended to involve patients themselves in the creation and administration of the programs.⁷² The first community health centers implemented community health services by helping community members collaborate on economic and environmental issues, such as sanitation and

64. LEFKOWITZ, *supra* note 10, at 8-9.

65. *Id.* at 8.

66. *See id.* at 9.

67. SARDELL, *supra* note 62, at 52.

68. *Id.* Section 222(a)(4) of the Economic Opportunity Amendments of 1967 stipulated that the program was to "assure that these services are made readily accessible to low-income residents . . . are furnished in a manner most responsive to their needs and with their participation" Economic Opportunity Amendments of 1967, Pub. L. No. 90-222, § 222(a)(4), 81 Stat. 672, 699, 42 U.S.C. § 2701 (1968).

69. SARDELL, *supra* note 62, at 3.

70. A.H. Strelnick, *Increasing Access to Health Care and Reducing Minority Health Disparities: A Brief History and the Impact of Community Health Centers*, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 63, 65-66 (2004).

71. SARDELL, *supra* note 62, at 53.

72. LEFKOWITZ, *supra* note 10, at 8.

housing conditions.⁷³ Beyond providing health services, community health centers provided community members with employment, job training, and skills that improved the economic well-being of poor communities.⁷⁴ The model of care delivered through community health centers has addressed health as part of a community's mission.⁷⁵ This community-oriented model of care is further facilitated and supported by the laws governing community health centers, specifically Section 330 of the Public Health Service Act.

The Public Health Service Act of 1975 originated from controversies over the authoritative role of community members within the governance structure of community health centers.⁷⁶ Despite the early success of community health centers in creating a collaborative and decentralized framework, the role of community members and the delegation of control of community health centers to the local community received opposition from those who felt other institutions possessed better administrative capabilities.⁷⁷ Representatives of health institutions and community representatives had different perspectives on health center purposes and consumers demanded greater authority in health center decision making.⁷⁸ Some argued that health care system improvement could only be accomplished by top-down funding to hospitals and institutions.⁷⁹ Others argued that community organizations offered the greatest likelihood of structural change in the system.⁸⁰ As a result of these controversies, guidelines issued in 1970 specified two ways to assure consumer input: (1) a center could have an "advisory board, half of whose members were eligible to receive services," or (2) a center could have a "fully empowered governing board" with one-third of it comprised of members eligible to receive its services.⁸¹

The first group of health centers implemented consumer advisory boards, but the responsibility and authority of the boards was vague since there were no other existing models of consumer participation in health

73. SARDELL, *supra* note 62, at 53.

74. *Id.* at 55. Additionally, health center staff helped initiate community development in areas outside of health care, such as housing and water conservation. *Id.*

75. Juniper Lesnik, *Community Health Centers: Health Care as It Could Be*, 19 J.L. & HEALTH 1, 9 (2004-05).

76. See Alice Sardell, *Neighborhood Health Centers and Community-Based Care: Federal Policy from 1965 to 1982*, 4 J. PUB. HEALTH POL'Y 484, 488 (1983) [hereinafter Sardell, *Neighborhood Health Centers*].

77. *Id.*

78. *Id.*

79. LEFKOWITZ, *supra* note 10, at 12.

80. *Id.*

81. *Id.*

delivery that the centers could look toward for guidance.⁸² Congressional leaders began visiting health centers and recognized that advisory boards were “unworkable” and that while legislation, by itself, could not guarantee the efficacy of the consumer’s role on such governing boards, they believed “at least [legislation could] ‘prevent paternalism’ at health centers.”⁸³ The continued opposition to a top-down bureaucratic structure and the relentless advocacy of community health center consumers, program administrators, and Congressional leaders for greater consumer authority in health center governance led to the ultimate passage of the Public Health Service Act in 1975.⁸⁴

The Public Health Service Act was viewed as a “turning point” for the health center program since it created a separate legislative authority for community health centers that would be administered by the Health Resources Services Administration of the United States Department of Health and Human Services.⁸⁵ Moreover, Section 330 of the Public Health Service Act officially adopted the term “community health center” and further described the organization and funding mechanisms of the health centers.⁸⁶ This legislative authority authorized direct federal grants to public and private not-for-profit organizations to operate community health centers and continues to regulate the administration and funding mechanisms of community health centers today.⁸⁷

To qualify for Section 330 federal funding, community health centers must comply with several statutory requirements. First, community health centers must be located in medically underserved areas in either rural or urban settings, or serve a federally designated medically underserved population.⁸⁸ These areas typically have higher rates of poverty, higher rates of infant mortality, or a shortage of physicians.⁸⁹ Second, community health centers must have nonprofit, public, or tax exempt status.⁹⁰ Third, community health centers must provide comprehensive primary care, dental

82. Sardell, *Neighborhood Health Centers*, *supra* note 76.

83. SARDELL, *supra* note 62, at 102-03.

84. Sardell, *Neighborhood Health Centers*, *supra* note 76, at 494-95.

85. *Id.* at 490. *See also* 42 U.S.C. § 254b(o) (2006).

86. Sardell, *Neighborhood Health Centers*, *supra* note 76, at 490.

87. Sidney D. Watson, *Affordable Health Care*, in BUILDING HEALTHY COMMUNITIES: A GUIDE TO COMMUNITY ECONOMIC DEVELOPMENT FOR ADVOCATES, LAWYERS AND POLICYMAKERS 289, 292 (Roger A. Clay, Jr. & Susan Jones eds., 2009).

88. 42 U.S.C. § 254b(b)(3) (2006).

89. Watson, *supra* note 87, at 292. Over 70% of all health center patients had family incomes at or below 100% of the federal poverty level, and over 90% had family incomes at or below 200% of the federal poverty level. *See id.*

90. *See* 42 U.S.C. § 254b(c) (2006).

care, x-ray, lab, and pharmacy services.⁹¹ They must also provide services that reduce barriers to health care such as transportation, translation services, health education, home visits, and specialty care referrals.⁹² Fourth, community health centers must be open to all residents of the neighborhood or target population they serve, regardless of income level or insurance status.⁹³ They are prohibited from turning away patients due to inability to pay and operate on a sliding-fee income subsidy scale.⁹⁴ Finally, community health centers must be governed by a board of directors, more than half of whom must be patients of the community health center.⁹⁵

IV. EMBRACING THE NEW GOVERNANCE PARADIGM: COMMUNITY HEALTH CENTERS & SECTION 330 OF THE PUBLIC HEALTH SERVICE ACT

Section 330 of the Public Health Service Act established legislation that embraces the new governance tenets of decentralization, public-private partnerships, and active patient participation within community health centers. Through its requirements of where community health centers must be located,⁹⁶ who they must serve,⁹⁷ and the integration of a consumer-majority governing board,⁹⁸ Section 330 ensures that community health centers remain firmly rooted in the local context and accountable to the communities in which they operate. The decentralization and community focus of community health centers "naturally translates to public-private partnerships within community health centers."⁹⁹ Moreover, decentralization and public-private partnerships are further facilitated by active patient involvement through the consumer-majority governing boards of community health centers. The breakdown of the core tenets of new governance that are inherent within community health centers demonstrates how Section 330 of the Public Health Service Act embraces a new governance framework.

A. *Decentralization*

Decentralization is a foundational concept of new governance that is embodied within community health centers. The most conspicuous aspect

91. *Id.* § 254b(b)(1)(A)(i).

92. *Id.* § 254b(b)(1)(A)(iii)-(v).

93. *Id.* § 254b(a)(1).

94. *Id.* § 254b(k)(3)(G).

95. 42 U.S.C. § 254b(k)(3)(H)(i) (2006).

96. *Id.* § 254b(b)(3).

97. *Id.* § 254b(a)(1).

98. *Id.* § 254b(k)(3)(H)(i).

99. Leiyu Shi & Patricia B. Collins, *Public-Private Partnerships in Community Health Centers: Addressing the Needs of Underserved Populations*, 4 ORGANIZATIONAL ETHICS 35, 36 (2007).

of new governance is the movement of authority “downward and outward” with decision-making control transferred away from centralized federal bureaucracies and toward localities and the private sector.¹⁰⁰ As such, new governance proceeds under the conviction that decisions are better made at the local level and decision-making authority should take place at the level closest to the individuals affected by them.¹⁰¹ This approach is based on the “instrumental fact that information quality and responsive flexibility is generally highest at the level closest to the problem”¹⁰² Moreover, there exists an “intrinsic value benefit to individual dignity and agency that comes from solving problems locally.”¹⁰³ Community health centers closely follow this decentralized approach of new governance.

Community health centers decentralize health care by involving community residents in the center’s operations and by bringing them “closer to the people.”¹⁰⁴ Since their inception, community health centers brought health care “closer to the people” by employing residents to visit patient homes to act as liaisons between medical professionals and patients.¹⁰⁵ The underlying justification for this decentralization was that community members were capable of providing information about the community’s needs that would otherwise be inaccessible by professionals not within the trenches of the community.¹⁰⁶ Today, community health centers continue to employ local community residents and stimulate community development and economic growth.¹⁰⁷

Moreover, Section 330 of the Public Health Service Act has allowed the control of the community health center to remain in the hands of the local community.¹⁰⁸ Local community ownership and control ensures that each health center is responsive to the health needs of the community being

100. See Melish, *supra* note 4, at 35 (quoting Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 MINN. L. REV. 342, 345 (2004)).

101. *Id.*

102. *Id.* at n.143.

103. *Id.*

104. SARDELL, *supra* note 62, at 54.

105. *Id.*

106. *Id.*

107. *America’s Health Centers*, *supra* note 12. Community health centers have produced 143,000 jobs in the United States’ most economically deprived neighborhoods. *Id.* See also ROSENBAUM, FINNEGAN & SHIN, *supra* note 9, at 9 (noting that “[a] 2008 estimate of health centers’ impact on local economies concluded that [for every] \$1 million invested in health centers . . . [there is] a \$6 million rate of return . . .”).

108. Lewis D. Solomon & Tricia Asaro, *Community-Based Health Care: A Legal and Policy Analysis*, 24 FORDHAM URB. L.J. 235, 266 (1996-97).

served.¹⁰⁹ Section 330 of the Public Health Service Act facilitates the localization of community health centers by defining a health center as “an entity that serves a population that is medically underserved . . . by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements – required primary health services . . . for all residents of the area served by the center.”¹¹⁰ As a result, community health centers remain “localized” by providing services in a central location that is close to the homes of the patients being served.¹¹¹

Consistent with the new governance tenet of decentralization, federal funding for community health centers bypasses state governments and flows directly to the non-profit, community-level organizations.¹¹² In order to receive federal funding, Section 330 requires that the “primary health services of the center will be available and accessible in the catchment area of the center”¹¹³ Additionally, community health centers are required to periodically review their catchment areas to “ensure that the size of such area is such that the services to be provided through the center . . . are available and accessible to the residents of the area promptly and as appropriate.”¹¹⁴ They must also review the catchment areas to ensure the boundaries conform to relevant boundaries of “political subdivisions, school districts, and Federal and State health and social service programs,”¹¹⁵ and ensure the boundaries eliminate access barriers to the services resulting from “the area’s physical characteristics, its residential patterns, its economic and social grouping, and available transportation.”¹¹⁶ These Section 330 funding requirements provide an incentive for community health centers to remain local and continue to provide the required primary care services to the community members within their catchment area.

The most unique provision of Section 330 of the Public Health Service Act that further facilitates decentralization is the consumer-governing board provision that requires health centers to have a governing board of which at least fifty-one percent of its members are clinic patients.¹¹⁷ Allowing patients

109. Dan Hawkins & Sara Rosenbaum, *Health Centers at 40: Implications for Future Public Policy*, 28 J. AMBULATORY CARE MGMT. 357, 360 (2005).

110. 42 U.S.C. § 254b(a)(1) (2006).

111. Sardell, *Neighborhood Health Centers*, *supra* note 76, at 487.

112. JESSAMY TAYLOR, NAT’L HEALTH POL’Y FORUM, THE FUNDAMENTALS OF COMMUNITY HEALTH CENTERS 3 (2004), *available at* http://www.nhpf.org/library/background-papers/BP_CHC_08-31-04.pdf.

113. 42 U.S.C. § 254b(k)(3)(A) (2006).

114. *Id.* § 254b(k)(3)(J)(i).

115. *Id.* § 254b(k)(3)(J)(ii).

116. *Id.* § 254b(k)(3)(J)(iii).

117. *See id.* § 254b(k)(3)(H)(i). *See infra* Part IV.C (discussing consumer-majority governed board requirement and new governance tenet of active patient participation).

to participate in the governing of the health center further ensures that community needs are adequately addressed and met by the community health center.¹¹⁸ Overall, the provisions of Section 330 of the Public Health Service Act stem from the premise that communities respond favorably to ideas generated by their members and are more accepting of a clinic with community representation.¹¹⁹

B. Public-Private Partnerships

Decentralization and patient participation facilitates the development of public-private partnerships within the community health center network.¹²⁰ The model of care adopted by community health centers is grounded in the community's needs, resources, and partnerships.¹²¹ Community health centers coordinate closely with other community resources and make use of all existing funds, including those of other health programs and Medicaid.¹²² Additionally, community health centers maintain their non-medical and cross-sectoral activities through collaboration with other programs in their community.¹²³ Community health centers have always collaborated with other service providers to address health issues affecting health status, such as access to care, substance abuse, and environmental conditions.¹²⁴

Section 330 of the Public Health Service Act gives the Secretary authority to allocate grants to public and nonprofit entities for projects to plan and develop health centers that offer "proposed linkages between the center and other appropriate provider entities, such as health departments, local hospitals, and rural health clinics, to provide better coordinated, higher quality, and more cost-effective health care services."¹²⁵ Moreover, in order to receive federal funding, the community health center must make and "continue to make every reasonable effort to establish and maintain

118. Solomon & Asaro, *supra* note 108, at 266-67.

119. *Id.* at 266.

120. See Shi & Collins, *supra* note 99.

121. *Id.* at 38.

122. NAT'L ASS'N OF CMTY. HEALTH CTRS., HEALTH CENTERS AND THE MEDICALLY UNDERSERVED: BUILDING A RESEARCH AGENDA 3, 7 (2005), available at http://www.nachc.com/client/Background_Paper_on_CHC_Model_FINAL.pdf [hereinafter HEALTH CENTERS]. See also LEFKOWITZ, *supra* note 10, at 12.

123. HEALTH CENTERS, *supra* note 122, at 3. The non-medical and cross-sectoral activities of community health centers include transportation, social support services, health education, outreach services, and translation services. 42 U.S.C. § 254b(b)(1)(A)(iii)-(v) (2006). Further, community health centers provide additional health services such as environmental health services that include sewage treatment, housing, and other environmental factors. 42 U.S.C. § 254b(b)(2)(C).

124. Lesnik, *supra* note 75, at 7.

125. 42 U.S.C. § 254b(c)(1)(A)(v) (2006).

collaborative relationships with other health care providers in the catchment area of the center.”¹²⁶ As a result, community health centers create networks and form partnerships with hospitals to provide management of care outside the health center walls.¹²⁷

Today, all community health centers have at least one relationship with hospitals or academic medical centers.¹²⁸ The extent of these relationships range from providing a referral for needed specialty care to the development of a highly integrated system.¹²⁹ Moreover, a number of community health centers participate in networks with other health centers and safety-net providers to negotiate contracts with managed care organizations, pool resources, and centralize clinical or administrative support services.¹³⁰ Health centers also partner with other health providers to utilize community and federal resources to provide specialty care to uninsured patients.¹³¹

The most significant example of community health center public-private partnerships is the Health Disparities Collaborative.¹³² The Health Disparities Collaborative was launched in 1998 and is participated in by over 800 community health centers.¹³³ The chronic care model of the Health Disparities Collaborative fosters public-private partnerships at all different levels.¹³⁴ It involves working closely with the federal Bureau of Primary Healthcare, state primary care associations, leaders of local community health centers, and the Institute of Health Care Improvement.¹³⁵ Implementation of the Health Disparities Collaborative involves close collaboration between the clinical and administrative staff within health centers, and requires partnerships between community health centers and local organizations that support patients with chronic diseases.¹³⁶ The Health Disparities Collaborative creates a network within the larger community to better serve patients and many community health centers have

126. *Id.* § 254b(k)(3)(B).

127. LEFKOWITZ, *supra* note 10, at 20.

128. HEALTH CENTERS, *supra* note 122, at 7.

129. *Id.*

130. *Id.*

131. *Id.* For example, health centers may collaborate with free clinics to take advantage of referral networks. *Id.* Additionally, some health centers have established networks of specialty care providers willing to see uninsured patients so that they may apply to the Health Resources and Services Administration (HRSA) for a Healthy Communities Access Program grant. *Id.*

132. Shi & Collins, *supra* note 99, at 38 (This article also describes other private-public partnerships within community health centers, such as the Healthy Communities Access Program, Medicare Part D outreach and enrollment, and the response to Hurricane Katrina.).

133. *Id.*

134. *Id.* at 39.

135. *Id.*

136. *Id.*

extended their networks to include community organizations, schools, and local and state public health departments.¹³⁷

The success of community health centers in establishing private-public partnerships serves as a model for other health care sectors in providing quality health care. Many health centers perceive public-private partnerships to be fundamental in delivering health care to the underserved.¹³⁸ Moreover, another tenet of new governance that is vital to the endurance and growth of community health centers is active patient participation.

C. Active Patient Participation

A central challenge within the new governance framework is in understanding how collaborative environments with active consumer participation can produce equitable results when vast imbalances of power may exist between affected groups.¹³⁹ Accountability problems may arise when any particular entity or interest group does not have the political power to affect the outcome or process.¹⁴⁰ As such, special efforts must be made to ensure consumer participation, especially among unorganized and underrepresented groups.¹⁴¹ Arguably, community health centers have devised a way that effectively embraces this new governance element of active patient participation by eliminating imbalances of power and ensuring consumer participation through their consumer-majority governed board requirement.

The role of the patient in the governance of community health centers is the most notable and unique aspect of community health centers that distinguishes them from other safety-net providers and health care institutions. Section 330 of the Public Health Service Act mandates a consumer-majority governing board within community health centers in order for them to receive federal funding.¹⁴² This consumer-majority governing board provision was the most advanced form of consumer

137. Louise G. Trubek & Maya Das, *Achieving Equality: Healthcare Governance in Transition*, 7 DEPAUL J. HEALTH CARE L. 245, 259 (2003-04).

138. Shi & Collins, *supra* note 99, at 41. In order to be sustainable, community health centers often rely on their community's resources and support from the private sector. Community health centers have shown that five essential ingredients are required to establish successful public private partnerships: (1) a shared vision to expand care, (2) shared governance, (3) designated time and resources by partnership members, (4) ongoing assessment, and (5) transformed community attitudes to promote health. *Id.*

139. See Trubek, *New Governance and Soft Law*, *supra* note 4, at 150, 168-69.

140. Bach, *supra* note 5, at 309.

141. See *id.* at 308-09.

142. 42 U.S.C. § 254b(k)(3)(H)(i) (2006).

participation in health services at the time.¹⁴³ Section 330 requires that each health center establish a governing board which

(i) is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center; [and] (ii) meets at least once a month, selects the services to be provided by the center, schedules the hours during which such services will be provided, approves the center's annual budget, approves the selection of a director for the center, and, except in the case of a governing board of a public center . . . establishes general policies for the center¹⁴⁴

It must be noted that the statutory language suggests that board members are not just randomly selected community members, but are actually patients being served by the health center and who represent the people and community served. Community health center board members represent the different races, ethnicities, and backgrounds of the community served by the health center and are thus able to better address the community's needs.¹⁴⁵ The functioning of the board is important in maintaining community control over health center operations, including planning and policy development.¹⁴⁶ Additionally, community board members make decisions on the primary care services offered by the health center and monitor finances.¹⁴⁷ Most notably, the board members are given the authority to hire and fire the health center's director.¹⁴⁸ As such, the consumer-majority governing board "has fiduciary responsibility and is not merely an advisory committee."¹⁴⁹ These Section 330 provisions ensure that community health centers remain responsive to community needs and prevents them from merging into larger enterprises, such as hospitals.¹⁵⁰

The active role of patients on the governing board of community health centers provides a feeling of ownership over the centers and has been considered a fundamental characteristic to the overall success and endurance of community health centers.¹⁵¹ Moreover, it is believed that community participation benefits the organization and delivery of health services by lowering costs and adding resources by promoting greater

143. Sardell, *Neighborhood Health Centers*, *supra* note 76, at 494.

144. 42 U.S.C. § 254b(k)(3)(H) (2006).

145. NAT'L ASS'N OF CMTY. HEALTH CTRS., *The Importance of Community Governance* (2007) [hereinafter *Community Governance*], available at www.nachc.com/client/documents/Governing_Board_12_17.pdf.

146. *Id.*

147. *Id.* See also 42 U.S.C. § 254b(k)(3)(H)(ii).

148. Ann Zuvekas, *Community and Migrant Health Centers: An Overview*, 13 J. AMBULATORY CARE MGMT. 1, 3 (1990).

149. *Id.*

150. TAYLOR, *supra* note 112, at 4.

151. Hawkins & Rosenbaum, *supra* note 109.

access and volunteerism.¹⁵² The need for health facilities, services, and expectations are better addressed through the active voice of the participating consumer,¹⁵³ and community participation in health decision making makes providers more responsive to community-defined needs.¹⁵⁴ Scholars also believe that community participation leads to resources being directed to the needs felt by the community, and that health activities are carried out more appropriately when consumers have greater control.¹⁵⁵

Community governance allows the patients to take control of their health system and empowers them to be actively involved in solving their community's health problems.¹⁵⁶ The board "creates a forum for bringing real and immediate problems to the table for action, for gaining real-time feedback from the people who receive care, and for generating action to meet pressing community needs such as affordable housing, improved water supply and sewer systems, or better consumer information"¹⁵⁷ Consequently, community health center governing boards "care for and nurture their clinics and fight like hell to keep them going."¹⁵⁸

Although the consumer governance requirement appears to provide many benefits to communities by addressing their health needs and creating a sense of empowerment, it has faced opposition by other health institutions that would prefer to receive Section 330 funding without establishing a consumer-majority board.¹⁵⁹ This opposition threatens the new governance framework within community health centers, and advocates have justifiably "fought like hell" to prevent legislators from repealing the consumer-majority governing board requirement of Section 330 of the Public Health Service Act.

V. A FIGHT FOR FEDERAL FUNDING: OPPOSITION TO THE CONSUMER-MAJORITY GOVERNING BOARD REQUIREMENT

The requirement of a consumer majority governing board to receive federal funding challenges the existing notions of professional dominance by

152. J. David L. Zakus & Catherine L. Lysack, *Revisiting Community Participation*, 13 HEALTH POL'Y & PLANNING 1, 2-3 (1998).

153. *Id.* at 3.

154. See Peter Crampton et al., *Does Community-Governed Nonprofit Primary Care Improve Access to Services?* 35 INT'L J. HEALTH SERVS. 465, 468 (2005).

155. See *id.*

156. Hawkins & Rosenbaum, *supra* note 109, at 361.

157. *Id.* at 362.

158. *Id.* at 361.

159. See *infra* Part V (explaining the history of opposition faced by community health centers with regards to the consumer-majority governed board requirement of Section 330 of the Public Health Service Act).

allowing consumers to participate in health care governance.¹⁶⁰ As a result, community health centers face opposition by other health institutions that seek to receive authorized funding without creating consumer-majority governing boards.¹⁶¹

The first opposition to the consumer governing board requirement occurred in 1978 when Senator Jacob Javits introduced a bill that authorized funds for the planning and operation of "primary care centers" without the consumer-majority governing board requirement.¹⁶² Rather, a hospital could establish an advisory board with a consumer-majority drawn from the population of its catchment area.¹⁶³ The National Association of Community Health Centers (NACHC), Senator Edward Kennedy, and the Carter administration opposed the Javits Bill's elimination of consumer governing requirement.¹⁶⁴

The NACHC, a trade organization, believed the Javits Bill was a "hospital giveaway program" in that it provided more money with "no strings attached."¹⁶⁵ The key issue for NACHC was the provision that the hospital programs would only have an advisory board and not a governing board.¹⁶⁶ The NACHC argued that in order to be responsive to the needs of the community, there needed to be a consumer governing board.¹⁶⁷ Additionally, others argued that the governing board requirement was essential to the community health center model because it had demonstrated consumer acceptance and increased the use of the program by having patients participate in the program governance.¹⁶⁸ Community health centers were "a way of giving communities resources and developing independent systems which [were] dedicated to *ambulatory care* and not simply filling hospital beds."¹⁶⁹ Moreover, Senator Kennedy felt "hospitals 'ought to go an extra mile' and meet the governing board requirements if they wanted to participate in the community health program."¹⁷⁰ In the end, the Javits primary care bill was unsuccessful since most health policy actors were committed to maintaining the governing board provision established in 1975.¹⁷¹

160. See LEFKOWITZ, *supra* note 10, at 140.

161. *Id.*

162. Sardell, *Neighborhood Health Centers*, *supra* note 76, at 495.

163. SARDELL, *supra* note 62, at 153.

164. *Id.* at 155-56.

165. *Id.* at 155.

166. *Id.*

167. *Id.* at 155-56.

168. SARDELL, *supra* note 62, at 156.

169. *Id.*

170. *Id.*

171. *Id.* at 162.

Today, the consumer-majority governing board mandate of Section 330 of the Public Health Service Act has remained under fire by other health institutions and organizations that would like to receive federal funding.¹⁷² Concerns have been raised that federal support for primary care services fails to adequately address the contribution of provider groups who do not utilize a community health center model.¹⁷³ Primary care facilities run by hospitals, religious organizations, and local governments who lack the governance requirements of Section 330 are ineligible for Section 330 funding.¹⁷⁴ As such, some communities that lack community health centers, but have other non-profit safety net providers, have experienced difficulty securing additional funds.¹⁷⁵

Consequently, in May 2004, the Senate Republican Task Force on Health Care Costs and the Uninsured proposed the removal of the Section 330 governing board provision to allow religious-sponsored health systems to qualify for Section 330 funding.¹⁷⁶ Moreover, others believed an exemption to the Section 330 governing board provision should be expanded to include other non-eligible organizations.¹⁷⁷ However, like the Javits bill, this proposal received opposition by those who maintain that the consumer-governing board requirement is a central element to the health center program and such an exemption would undermine the defining characteristics of community health centers.¹⁷⁸

Opponents of the consumer governing board exemption have questioned the priorities of non-eligible providers and argue that “[w]hile health centers seek to provide a true medical home and an ongoing relationship with a clinician, other types of safety net providers. . . may be more focused on training a rotating roster of medical students or providing inpatient care than creating a medical home and arranging enabling services.”¹⁷⁹ Moreover, others have toyed with the idea of creating a funding stream separate from Section 330 that would support non-eligible primary care models.¹⁸⁰ However, health center advocates argue that many of these other safety net institutions receive high levels of federal funding through Medicaid Disproportionate Share Hospital (DSH) payments, and

172. LEFKOWITZ, *supra* note 10, at 140.

173. TAYLOR, *supra* note 112, at 27.

174. *Id.*

175. *Id.*

176. *Id.*

177. *Id.*

178. TAYLOR, *supra* note 112, at 27.

179. *Id.* (noting that the validity of this concern is not well documented).

180. *Id.*

that shifting the Section 330 funding stream to such facilities would ultimately compromise the funding for community health centers.¹⁸¹

Today, the United States is in the midst of an economic downturn and its health care system is trying to manage care for the increasing number of uninsured while simultaneously trying to reduce the burden of uncompensated care costs.¹⁸² The fiscal budgets of states are being hampered by Medicaid and the federal budget is experiencing greater deficit in providing eligible Medicare beneficiaries with their health benefits and services.¹⁸³ Hospitals have been forced to cutback as many find Medicaid reimbursement rates too low to cover care.¹⁸⁴ Smaller community hospitals are struggling from the weakened economy, unemployment, and charity care losses.¹⁸⁵ Many medical centers have been hurt by the cost of charity care and unpaid bills.¹⁸⁶ According to the American Hospital Association, one-third of 5,010 community hospitals had operating losses in 2008.¹⁸⁷ The struggle of these hospitals may be attributed to a reduction in their access to capital that was a consequence of hospital's agreeing with the federal government to accept nearly \$155 billion in cost cuts that are largely from government payments.¹⁸⁸ Community hospitals and medical centers are facing the threat of hospital mergers as the for-profit hospital chains are looking for significant opportunities to capitalize on these struggling health care institutions.¹⁸⁹ This fiscal strain on hospitals and other

181. *Id.* Although other health care institutions that do not qualify for Section 330 funding may receive high levels of Medicaid DSH payments, the recently enacted Patient Protection and Affordable Care Act calls for a gradual and significant reduction in Medicaid DSH payments. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 2551(a), 124 Stat. 119 (2010). These Medicaid DSH reductions may ultimately diminish the arguments made by health center advocates that, since non-eligible providers have access to higher DSH payments, they should remain outside the Section 330 funding stream.

182. See Redlener & Grant, *supra* note 15, at 2201-03.

183. See *id.* at 2202-03.

184. *Id.* at 2203. See also AM. HOSP. ASS'N, *The Economic Crisis: The Toll on the Patients and Communities Hospitals Serve* (Apr. 27, 2009), available at <http://www.aha.org/aha/content/2009/pdf/090427econcrisisreport.pdf> (reporting that nine out of ten hospitals reduced services due to economic conditions, and one-fifth had reduced community health services such as patient education and community clinics).

185. David Olmos, *Hospital Mergers Loom as U.S. Overhaul Fails Centers (Update 2)*, BLOOMBERG (Feb. 2, 2010), www.bloomberg.com/apps/news?pid=newsarchive&sid=ank46EncnDSrM.

186. *Id.*

187. *Id.*

188. *Id.* Hospitals agreed with these budget cuts in anticipation of the passage of health reform that would have allowed them to gain \$171 billion over ten years from reimbursements for newly insured patients. *Id.*

189. *Id.*

health care institutions likely makes Section 330 grant funding even more appealing and desirable.

Moreover, a recently published *Health Affairs* article highlights the advantages that community health centers have in receiving increased funding from federal grants.¹⁹⁰ The results suggest that grant dollars affect both the service provision and the provision of uncompensated care.¹⁹¹ An additional \$1 million in federal grant funding led to a one-percentage point increase in 24-hour coverage by health centers, or could lead to approximately eight more full-time employees, five of whom are medical providers.¹⁹² Most astonishingly, for uncompensated care, a \$500,000 increase in federal funding is predicated to increase uncompensated care by \$135,000.¹⁹³ This translates into treating 540 more uninsured patients.¹⁹⁴ Further, the study suggested that “federally qualified health centers might be able to leverage their federal grant support to gain additional state, local, and private grant dollars,” thereby leading to higher levels of service and uncompensated care.¹⁹⁵ These findings are likely to make federal grant funding appear even more lucrative to other health providers, especially at a time when they are facing increased Medicaid cuts, lower Medicare reimbursement rates, and the economy is too weak to adequately cover uncompensated care.

Even with the advantage of receiving Section 330 funding, community health centers continually face challenges to their financial survival, especially given the increasing number of uninsured these centers serve.¹⁹⁶ Since community health centers target low-income neighborhoods and serve all patients regardless of ability to pay, they are much more sensitive to cuts in public insurance and the diminution of public coverage.¹⁹⁷ Whereas many other care providers may be able to capitalize on profits obtained from privately insured patients, most of the revenue obtained by community

190. See Anthony T. Lo Sasso & Gayle R. Byck, *Funding Growth Drives Community Health Center Services*, 29 HEALTH AFF. 289, 292-95 (2010).

191. *Id.* at 294.

192. *Id.*

193. *Id.* at 294-95.

194. *Id.* at 295.

195. Lo Sasso & Byck, *supra* note 190, at 295.

196. *Community Health Centers*, *supra* note 13. See generally John S. McAlearney, *The Financial Performance of Community Health Centers, 1996-1999*, HEALTH AFF., Mar.-Apr. 2002, at 219, 219-25 (discussing financial challenges and near financial insolvency faced by community health centers).

197. Watson, *supra* note 87, at 295.

health centers is derived from Medicaid and the federal grant subsidies.¹⁹⁸ Health centers rely heavily on grant revenues, Medicaid payments, and other sources of payment to support their operations.¹⁹⁹ Health centers receive over twenty-two percent of their revenue from Section 330 grants and about thirty-six percent of their revenue from Medicaid payments.²⁰⁰ Medicaid reimbursement has a profound effect on the financial strength of community health centers.²⁰¹ The current economic downturn has led to increased cuts in Medicaid and as a result community health centers' ability to serve the uninsured is threatened.²⁰² Moreover, due to insufficient funding, health center patients have difficulty obtaining specialty care and mental health services that are not provided at the community health center.²⁰³ Grant funding provides a means for health centers to address these challenges.²⁰⁴ As such, it is important that health centers continue to receive direct operational subsidies through federal grants to ensure their financial viability.

Recognizing the unique role that health centers play in providing comprehensive primary care services to low-income communities, Congress has maintained the statutory requirements for federal funding of community health centers and has passed legislation that further supports and expands community health centers.²⁰⁵ In October 2008, the Health Care Safety Net Act of 2008 was enacted and it reauthorized the health center program through fiscal year 2012.²⁰⁶ Moreover, it anticipates a fifty percent growth "through funds to develop new health centers and expand the reach of existing [Section 330] grantees."²⁰⁷ This growth is expected to increase the number of patients served by health centers to 25 million.²⁰⁸

More recently, the American Recovery and Reinvestment Act of 2009 (ARRA), provided over \$2 billion to expand the number of sites, increase services at existing community health centers, and provide supplemental payments for spikes in the number of uninsured that community health

198. TAYLOR, *supra* note 112, at 12. Private providers receive 61% of their revenue from private insurers, whereas health centers receive only 13% of their revenue from private insurers. *Id.* at 16. See also CHART BOOK, *supra* note 11.

199. TAYLOR, *supra* note 112, at 13.

200. *Id.*

201. Watson, *supra* note 87, at 295.

202. *Id.*

203. Lo Sasso & Byck, *supra* note 190, at 290.

204. *Id.*

205. See ROSENBAUM, FINNEGAN & SHIN, *supra* note 9, at 9-11.

206. *Id.* at 9.

207. *Id.*

208. *Id.*

centers serve as a result of the recession.²⁰⁹ Additionally, President Obama announced in December 2009 that he would allocate \$600 million of the \$787 billion economic stimulus plan to pay for construction and renovation projects at 85 community health centers across the country and to help provide care for more than 500,000 additional patients in underserved communities.²¹⁰ Moreover, the Patient Protection and Affordable Care Act (PPACA) increased federal funding for establishing and maintaining a greater community health center network.²¹¹ With increased allocation of federal grant funds to community health centers from ARRA, the economic stimulus plan, and PPACA, it may be likely that providers not eligible for Section 330 funding will encourage legislators to reconsider creating an exception to the consumer-governed board requirement, or remove it entirely, to open up these funding streams.

However, as suggested earlier, removing the consumer-majority governed board requirement of Section 330 will not only undermine the defining characteristics of health centers, but will disintegrate the new governance framework in which community health centers have been built upon. By failing to include patients on the governing boards, the feelings of control and ownership will be effectively yanked out of the hands of the local communities and the needs of the communities may not be adequately addressed. Community health centers would become indistinguishable from any other health care organization and may be more vulnerable to mergers with for-profit health care institutions who seek to capitalize on the weakened governing structure of community health centers.

VI. CAUSE AND EFFECT: THE SURVIVAL AND SUCCESS OF COMMUNITY HEALTH CENTERS

Community health centers have created a unique health services infrastructure that provides quality care to many patients within the safety net. They have tailored their services to communities and have overcome economic, geographic, and cultural barriers to health care.²¹² Community health centers have exceeded many quality and outcome measures of other medical providers, including Medicaid managed care providers.²¹³ Health center patients are more likely to receive preventative counseling on lifestyle

209. *See id.* at 10.

210. Steve Holland & Patricia Zengerle, *Obama to Give \$600 Million to Health Centers*, REUTERS (Dec. 9, 2009), <http://www.reuters.com/article/idUSTRE5B81H920091209>.

211. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10503, 124 Stat. 119, 1004 (2010) (to be codified at 42 U.S.C. § 254b-2).

212. *America's Health Centers*, *supra* note 12.

213. Watson, *supra* note 87, at 294.

factors such as diet, smoking, and drinking.²¹⁴ They are also less likely to use hospitals and emergency rooms.²¹⁵ Moreover, socioeconomic, racial, and ethnic disparities have been reduced among health center patients.²¹⁶

In addition to better health outcomes, greater access to care, and increased equality in health care, community health centers have also provided better economic outcomes.²¹⁷ Community health centers save nearly \$3 billion annually in combined federal and state Medicaid expenditures.²¹⁸ Community health centers have also provided entry-level jobs, training, and career-building opportunities to the communities they serve.²¹⁹ Overall, when comparing health centers head-to-head with the best health care systems, community health centers do better with respect to costs, quality, and value.²²⁰

As mentioned earlier, community health center advocates, such as the National Association of Community Health Centers, attribute the success of community health centers to their unique consumer governance structure.²²¹ Such advocates argue that consumer governed boards are able to respond directly to the needs expressed by patients, thereby producing higher patient satisfaction.²²² They assert that the health center consumer-controlled boards assure that community health centers deliver community-specific care and preventative programs tailored to their patients' articulated needs.²²³ Moreover, they believe that community participation provides a mechanism for individuals to participate in activities that may positively impact their health, allows individuals to develop a heightened sense of responsibility, and allows consumers to educate themselves and attain greater health knowledge.²²⁴

214. *Id.* See also *Community Health Centers*, *supra* note 13.

215. Watson, *supra* note 87, at 294 (citing LEFKOWITZ, *supra* note 10, at 140).

216. Watson, *supra* note 87, at 294. See also *America's Health Centers*, *supra* note 12 (providing further information on health center key accomplishments in improving patient quality care and health outcomes).

217. See *Community Health Centers*, *supra* note 13.

218. JENNIE SCHACHT, THE VITAL ROLE OF COMMUNITY CLINICS AND HEALTH CENTERS 6 (Mar. 2008), available at [http://www.sfccc.org/news/FINAL%20%20VR%20Publication%20\(2\).pdf](http://www.sfccc.org/news/FINAL%20%20VR%20Publication%20(2).pdf).

219. Watson, *supra* note 87, at 295-96. In 2009, community health centers employed over 123,000 medical and administrative staff. See HEALTH RESOURCES & SERVS. ADMIN., U.S. DEPT. OF HEALTH & HUMAN SERVS., *Staffing and Utilization: National Summary for 2009*, http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009_national_staffing.html (last visited Apr. 3, 2011).

220. LEFKOWITZ, *supra* note 10, at 140.

221. *Community Governance*, *supra* note 146.

222. Lesnik, *supra* note 75, at 18.

223. *Community Governance*, *supra* note 146.

224. See *id.*

Although there is plentiful research supporting the success of community health centers in providing quality, cost-effective health care with good health outcomes,²²⁵ there has been no empirical research analyzing the actual cause and effect relationship of consumer governance on the success of health centers. To date, there are no published empirical studies that demonstrate the actual role and overall impact of patients on the governing boards of community health centers or how their work on the governing boards translates into the successful health outcomes that community health centers have achieved.

Undoubtedly, the current economic downturn has created increased financial pressures on health centers and other health organizations, thereby making access to federal funding even more appealing and desirable. As suggested earlier, hospitals and other health institutions burdened by Medicaid cuts may further push for legislation that repeals the governing board requirement of Section 330 to allow them access to this funding opportunity. However, such legislation would remove control from the communities and place it in the hands of large corporate providers. The lack of empirical research supporting a positive cause and effect relationship between consumer governance and the success of community health centers in achieving quality, cost-effective health care services and delivery may eventually make it easier for the legislation mandating the governing board requirement to be overturned, especially if other hospitals and health organizations are able to provide the same outcomes.

VII. CONCLUSION AND RECOMMENDATIONS

As the United States continues to strive for comprehensive health reform, the role of the consumer in health care governance may become more important, especially since community health centers are receiving additional federal funding to provide more services and expand their network throughout the country. The current success of community health centers may very well be attributed to their unique consumer governance structure despite the fact that little empirical research has been performed to measure its actual efficacy on the system. On the other hand, the success of community health centers may not be solely from their unique consumer-

225. See, e.g., INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE 112 (Brian D. Smedley, Adrienne Y. Smith & Alan R. Nelson eds., 2003) (asserting that the community health center model "has proven effective not only in increasing access to care, but also in improving health outcomes for the often higher-risk populations they serve"); Robert M. Politzer et al., *Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care*, 58 MED. CARE RES. & REV. 234, 237-44 (2001) (providing a comprehensive literature review of community health center services and outcomes). See also *supra* notes 213-16 and accompanying text.

majority governing board, but rather from their ability to embrace the new governance tenets of decentralization, public-private partnerships, and active participation.

Section 330 of the Public Health Service Act has de facto created a funding mechanism that supports a new governance paradigm. The very fact that Section 330 mandates that more than half of the board members be patients of the health center facilitates the process of decentralization, creation of public-private partnerships, and active patient participation inherent within the new governance paradigm of community health centers. The "bottom-up" approach of new governance theory and its emphasis on active consumer participation seem to provide a much more amenable environment for effective consumer governance in health organizations, but it appears that more research needs to be performed to determine the true impact of consumer governance on health care administration.

Despite the lack in empirical research, community health centers have provided an exemplary model of how new governance may work in health law and administration. They provide anecdotal evidence that decentralization, public-private partnerships, and active patient participation leads to improved health outcomes and cost-effective care by placing the control of health services in the hands of the patients seeking the necessary health care. Moreover, the reputed benefits of community health centers following a new governance framework seem to transcend far beyond improved health outcomes and quality of care. Decentralization, public-private partnerships, and consumer participation on governing boards promotes economic development, community empowerment, and social and political accountability.²²⁶ Moreover, community health center patients develop a sense of strength and participation in the political process and outstanding leaders for the community have emerged.²²⁷

Although hospitals, other non-profit health organizations, and religious organizations may advocate for the government's removal of the requirement of a consumer-majority board to receive Section 330 funding, Congress should hold their ground in refusing to expand the funding to organizations that fail to "go the extra mile" in establishing consumer-majority governed boards. Rather, Congress should seriously consider imposing such federal regulations on other health organizations, so as to encourage them to adopt a new governance framework within their existing governing structures.

226. See Ezekiel J. Emanuel & Linda L. Emanuel, *Preserving Community in Health Care*, 22 J. HEALTH POL. POL'Y & L. 147, 161 (1997) (discussing the role political accountability has played in modern health care, especially among community health centers).

227. *Id.*

Now is the time for Congress and other health reform leaders in the United States to restructure the governance of the American health care system and capitalize on the theory of new governance. Community health centers provide an exemplary model of a working new governance framework for all other health organizations to adopt and expand upon. As consumers become more involved in the political and administrative processes of the United States health care system, they may become more accountable to their health and the health of their communities. Legislators should work toward drafting legislation, similar to Section 330 of the Public Health Service Act, which facilitates the adoption of new governance in other health care organizations that is comparable to the framework inherent in community health centers today. By bringing more health care organizations “closer to the people” through decentralization, public-private partnerships, and consumer governance, the existing highly fragmented and expensive United States health care system may be unified into a more cost-effective, collaborative network of health providers that adequately addresses and meets the health care needs of all Americans.

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