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California's Safety-Net Clinics: A Primer

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by

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About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

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I. Introduction

California's health care "safety net" is composed of an array of providers committed to delivering a broad range of health care services to medically underserved and uninsured populations.

CALIFORNIA'S HEALTH CARE "SAFETY NET" IS COMPOSED of an array of providers committed to delivering a broad range of health care services to medically underserved and uninsured populations regardless of patients' ability to pay. The health care safety net is subject to varied definitions¹ because it lacks a formal structure and its components have diverse licensing, funding, missions, and relationships. Generally, though, the safety net includes public hospitals and health systems, health care districts, community health centers and clinics, and for-profit and nonprofit health care organizations that provide free or discounted care.

This report focuses on the outpatient clinic component of the safety net, which is essential to delivering both primary and specialty care to millions of low-income Californians. These safety-net clinics, whose categories sometimes overlap, include licensed primary care clinics, clinics operated by governmental entities such as counties and cities, and clinics operated by federally recognized Indian tribes or tribal organizations. The scope of services offered by a safety-net clinic depends in large part on its funding mandates and community need. Understanding the complex functions, structures, and operational environments of these clinics is critical to appreciating the overall nature and extent of California's health care safety net.

This report, which updates a report published by the California HealthCare Foundation in November 2005, serves as a primer on California's safety-net clinics. It includes discussion and analysis of:

- The character of safety-net clinics;
- Requirements for state licensure;
- The demographics of those served by safety-net clinics;
- The types of services provided;
- Key reimbursement and funding mechanisms;
- The various categories of safety-net clinics; and
- Some of the challenges faced by these clinics in the current operational environment.

II. What Is a Safety-Net Clinic?

California's safety-net clinics are defined largely by their mission to maintain an open-door policy, providing health care services to individuals and their families regardless of their ability to pay.

CALIFORNIA'S SAFETY-NET CLINICS ARE DEFINED NOT BY any specific legal terms or by their organizational structures or scope of practice but by their common mission: to provide health care services to individuals and their families regardless of a patient's ability to pay. Safety-net clinics may be operated by for-profit corporations, public agencies, or private, nonprofit organizations. The majority of these clinics in California are operated by public agencies, including public hospitals and health systems² and health care districts,³ and by private, nonprofit organizations. The clinics provide a spectrum of health services that includes primary, specialty, and urgent care.

Many safety-net clinics have specific legislative mandates to provide health care services to the medically indigent as a condition of federal or state funding and/or reimbursement from public health programs. For example, whether operated by public agencies or private nonprofit organizations, Federally Qualified Health Centers (FQHCs) and FQHC "look-alikes" (see Section VI) are required by federal law to provide certain services. Similarly, counties operate safety-net clinics to provide services pursuant to a mandate under Section 17000 of the California Welfare and Institutions Code.⁴

III. Licensing Requirement Overview

Primary care clinics operated by nonprofit corporations, including community clinics and free clinics, are the only safety-net clinics required to be licensed by the California Department of Public Health.

CALIFORNIA HAS RECOGNIZED DISTINCT CATEGORIES of clinics since the early 1930s. Through the 1930s and 1940s, “clinics and dispensaries,” including those operated by charitable organizations, teaching and research institutions, employers, private individuals, and governmental agencies, were required to obtain permits from the State Board of Public Health. Protection of the public health was a primary purpose of the clinic permit law; another was regulation of the corporate practice of medicine.

The predecessor to today’s licensed primary care clinic was once described in California statutes as a “charitable” clinic. Charitable clinics were those supported by charitable funding and providing health care services without charge. Charitable clinics, teaching and research clinics, and employer and employee clinics were required by state statute to be licensed beginning in 1953; state law did not require clinics run by public agencies to be licensed.

As the structure of California’s state health services agencies and funding streams evolved, so did clinic licensing laws. In 1971, “community clinic” was defined by statute for the first time as a clinic operated by a nonprofit corporation, supported in whole or in part by donations, bequests, gifts, grants, fees, or contributions. A community clinic provided services based on the patient’s ability to pay, or provided services without charge. A “free clinic,” defined by statute for the first time in 1976, was a clinic operated by a nonprofit corporation that did not charge or collect any fees for services directly from patients.

In 1978, California’s clinic licensing law underwent substantial revisions and the phrase “primary care clinic” was defined for the first time, in Section 1204(a) of the California Health and Safety Code. Under this new licensing statute, community clinics and free clinics were eligible for licensure as primary care clinics.

Many other types of clinics, however, did not require state licensure: private clinics, clinics operated by governmental entities (including primary care clinics operated by counties and cities), clinics maintained or operated by tribal organizations, clinics operated as outpatient departments of hospitals, intermittent clinics operated by

licensed primary care clinics, clinics run by teaching institutions, and student health services.

The basic definition of primary care clinic as it applies today was written into California law in 1985: The only safety-net clinics required to be licensed by the California Department of Public Health Licensing and Certification Division are primary care clinics, including community clinics and free clinics, operated by nonprofit corporations.⁵ These license-required primary care clinics include private, nonprofit, federally-funded clinics known as Federally Qualified Health Centers (FQHCs); FQHC “look-alikes” (FQHCLAs); free-standing nonprofit Rural Health Clinics (RHCs); family planning clinics; free clinics; and other types of nonprofit community clinics and clinics serving specific populations. (These and other categories of safety-net clinics are described in more detail in Section VI.) There are also clinics operated by counties and cities, health care districts, and private providers that are known in the areas they serve as “community” or “free” clinics, even though they are not statutorily defined or licensed as primary care clinics.

Licensed primary care clinics are subject to strict governmental oversight and must maintain certain quality standards as defined by law. If qualified, they may obtain enhanced reimbursement from certain government health programs and access to various funding sources to serve designated populations. (For an overview of key reimbursement and funding sources for safety-net clinics, see Section VII.)

Clinic administrators report that the procedure for licensing primary care clinics is lengthy and cumbersome. Although in recent years both legislative and administrative efforts have been made to streamline the application process and time frame for approval, it may still take a never-before-licensed

entity up to one year to obtain a primary care clinic license.⁶

The difficulties and delays in opening new safety-net clinics, due to inefficiencies in the licensing and certification process, not only present problems for clinic operators but also translate into delayed access to health care services for growing numbers of uninsured and underinsured patients in California.

IV. Who Is Served by Safety-Net Clinics

Data reveal that the licensed clinics providing primary care services reporting to the California Office of Statewide Health Planning and Development in 2006 served nearly 3.7 million people, providing more than 11.4 million patient encounters.

CALIFORNIA'S SAFETY-NET CLINICS — REGARDLESS OF type or affiliation — serve populations that are demographically similar: low-income, racially and ethnically diverse, and most often women and children. There is no single comprehensive set of utilization data for all safety-net clinics but, overall, about 7.6 million Californians rely on safety-net providers for regular health care services.⁷ Although safety-net clinics serve primarily those who are uninsured, underinsured, and publicly insured (i.e., beneficiaries of California's Medi-Cal and Healthy Families programs), nearly 3 million Californians with employer-based insurance also use safety-net providers, including public hospitals and clinics, as their main source of care.⁷ For example, licensed primary care clinics reported that private insurance paid for 686,000 patient encounters in 2006.⁸ Thus, safety-net clinics should be understood as a significant source of health care services for the uninsured and insured alike.

The demographic composition of people served by any one clinic depends on the scope of clinic services, the special populations served, and the clinic's location. A consistent variable, however, is family income: Nonprofit safety-net clinics, both public and private, by and large serve the poorest of the poor in California.

Public Clinics

It is difficult to draw a comprehensive picture of who uses California's public clinics. Though some utilization data are available from hospitals that report annually to the Office of Statewide Health Planning and Development (OSHPD),⁹ neither city and county clinics nor clinics operated by health care districts are required to make such reports. For clinics affiliated with county or health care district hospitals, clinic patient demographics are very likely to mirror those reported in hospital utilization data (though such data were not analyzed for this report). Some public clinics are designated as FQHCs, which are required to report utilization data to the federal Health Resources and Services Administration (HRSA). However, HRSA does not separately analyze data reported by public clinics.

Because the data are not reported, actual utilization demographics for public hospital clinics is not known. However, the California Association of Public Hospital and Health Systems estimates that 10 to 11 million patient visits are provided by approximately 100 public hospital outpatient clinics every year. Approximately 50 percent of the patients served by public hospitals do not speak English as their primary language; it is reasonably assumed that the same holds true for public hospital clinics. CAPH also reports that more than two-thirds of outpatient visits are provided to Medi-Cal recipients or the uninsured.¹⁰

Private, Nonprofit Clinics

Licensed primary care clinics are required to file annual utilization reports with OSHPD. While there are inherent weaknesses in the reliability of unverified, self-reported data, the OSHPD reports are nonetheless the best source of information about the services provided by private, nonprofit safety-net clinics in California and about the demographics of the people served. It should be noted that the data are probably underreported in several ways: The required data fields do not accurately capture patient utilization and coverage, and the services provided by intermittent clinics (open less than 20 hours per week) operated by primary care clinics, which are not subject to licensure, are not consistently reported, if at all. In addition, some licensed primary care clinics do not file required data reports.

OSHPD data from 2006 reveal that reporting licensed clinics providing primary care served nearly 3.7 million people, with more than 11.4 million patient encounters. These data indicate that licensed primary care clinics served over 800,000 more people in 2006 than in 2003, a 28 percent increase. Of these, approximately 84 percent had family incomes at or below 200 percent of the federal poverty level.⁸

Private, nonprofit licensed clinics primarily serve women and children. In 2006, approximately 13 percent of all women in California and 14 percent of all children sought services from private, nonprofit primary care clinics. Thirty-five percent of all patients served at nonprofit primary care clinics were age 19 and younger. Approximately 66 percent of the patient population were female; about 40 percent of female patients were of childbearing age.⁸

Of the licensed primary care clinics reporting language data in 2006, on average about 43 percent of their patients do not speak English as their primary language. The clinics serve a cross-section of races and ethnicities, with 54 percent of patients identified as Hispanic. More than 480,000 migrant workers were served in 2006, over 37 percent more than in 2003.¹¹

By comparison, California's federally funded health centers, for the most part a subset of the licensed primary care clinics but including some public clinics, reported providing services to more than 2.1 million patients in 2006. Of those:

- 83 percent had family income below 200 percent of the federal poverty level;
- 45 percent were uninsured;
- 38 percent had Medi-Cal coverage;
- 53.7 percent were considered to be best served in a language other than English;
- 62 percent were identified as Hispanic or Latino;
- 59.4 percent were female; and
- 36.7 percent were under age 19.¹²

V. Services Provided by Safety-Net Clinics

Many safety-net clinics focus on preventive and primary care, but a wide array of other services may be provided.

MANY SAFETY-NET CLINICS FOCUS ON PREVENTIVE AND primary care, but a wide array of other services may be provided, depending on community need, funding, and licensing limitations. Health services provided at clinics include dental care, optometry and ophthalmology, podiatric care, pediatric care, women's health services (including family planning and obstetric care), geriatric care, chiropractic care, alternative and complementary medicine, mental health and family counseling services, chronic disease case management, health education, alcohol and drug treatment, HIV care, pharmacy, laboratory, radiology, specialty care, and ancillary services. In addition, many safety-net clinics offer social support outreach, transportation, child care, translation services, and insurance eligibility and enrollment assistance.

Licensed primary care clinics are required to provide or arrange for a wide range of diagnostic and therapeutic services, such as radiology, clinical laboratory, and pharmacy services. FQHCs are also required to provide services, such as transportation and language assistance, to better enable target populations to access health center services.

Safety-net clinics are using innovative technologies and collaborative partnerships to expand access to a variety of health care services for their communities. In particular, clinics facilitate telemedicine visits to provide specialty care services in remote areas, operate mobile health units to bring services to patients, and provide on-site care at senior housing facilities. Clinics also implement cutting-edge models of care for quality improvement, such as chronic disease management and integration of behavioral health care into primary care services. Safety-net clinics are also active participants in California's emergency preparedness and response planning.

In summary, safety-net clinics provide a range of essential health care services to address communities' needs and to meet state and federal mandates. By focusing on the provision of primary care and preventive services, and by providing a regular source of care for the people they serve, safety-net clinics may play a role in reducing inappropriate emergency room visits and unnecessary hospitalizations, resulting in overall health care cost savings.¹³

VI. Safety-Net Clinic Categories

The network of California's safety-net clinics is made up of complex and sometimes overlapping categories.

THE NETWORK OF CALIFORNIA'S SAFETY-NET CLINICS is made up of complex and sometimes overlapping categories. This report focuses on clinics operated by government entities and by private, nonprofit organizations, although other types exist, including those run by private employers or other groups.

Public community-based clinics include those sponsored by cities, counties, and health care districts. They may be hospital-affiliated or freestanding and may also be designated as FQHCs, FQHCLAs, or RHCs. Private, nonprofit clinics include FQHCs, FQHCLAs, RHCs, free clinics, family planning clinics, and other types of community clinics serving specific populations.

Types of Safety-Net Clinics

- **Federally Qualified Health Centers**

Includes Public Health Services Act Section 330 grantees (113 in California)* and FQHCLAs (26 in California);†

- **Rural Health Clinics**

Established to help underserved rural communities (261 certified in California);‡

- **Free Clinics**

Prohibited from charging patients for services (40 licensed in California);§

- **County-Run Clinics**

Include facilities run at county hospitals, in freestanding clinics, or contracted out (exact number in California not available); and

- **Private and Other Types**

Includes Indian Health Service clinics, family planning clinics, school-based health centers, and some clinics run by university health systems, private hospitals, employers, and private individuals (exact number of facilities in California not available).

Sources:

*List provided by HRSA/BPHC as of November 2008.

†List provided by the BPHC, October 23, 2008 and November 13, 2008.

‡List of California RHCs certified by Centers for Medicare & Medicaid Services is available online at www.oshpd.ca.gov/RHPC/clinics.

§List of free clinics provided by California Department of Public Health, Licensing and Certification, on November 17, 2008.

Federally Qualified Health Centers

FQHC designation, for the purposes of participation in and reimbursement by Medicaid and Medicare, was defined by amendments to the Social Security Act in 1989 and 1991, respectively.¹⁴ By virtue of this federal designation, FQHCs receive enhanced reimbursement from Medicaid based on a prospective payment system rate that approximates the FQHC's reasonable cost-per-visit and from Medicare at a capped rate based on reasonable cost.

An FQHC may be a public or a private nonprofit entity that:

- Receives a grant under Section 330 of the Public Health Services (PHS) Act;
- Meets the requirements to receive a Section 330 grant and receives funding under a contract with a Section 330 grant recipient;
- Is determined by HRSA to meet the requirements for receiving a Section 330 grant (even if not actually receiving a grant);
- Was considered a comprehensive federally funded health center as of January 1, 1990;
- Is a program or facility operated by a tribe or tribal organization pursuant to the Indian Self-Determination and Education Assistance Act of 1975;¹⁵ or
- Is an urban Indian organization that receives funding for the provision of primary care services under Title V of the Indian Health Care Improvement Act.¹⁶

In addition to enhanced reimbursement by Medicaid and Medicare, FQHC designation authorizes eligibility for 1) free malpractice coverage through the Federal Tort Claims Act coverage program¹⁷; 2) federal loan guarantees through

HRSA;¹⁸ 3) participation in Section 340(b) federal drug pricing programs to purchase discounted pharmaceuticals;¹⁹ 4) automatic Health Professional Shortage Area (HPSA) designation, which may allow for assistance with recruitment and retention of medical, dental, and mental health providers;²⁰ and 5) special “safety harbors” protection under federal and state anti-kickback statutes.²¹ Eligibility for certain specific programs based on FQHC designation also depends on the safety-net clinic's status as a Section 330 grantee.

Generally, health centers designated as FQHCs must be community-based and patient-driven organizations that serve populations with limited access to health care. They are required to establish a governance structure that represents the people who will be served by the facility. Consumers or users of health center services must constitute the majority of an FQHC governing board. However, there is greater flexibility for county-run FQHCs within these governance requirements, and certain requirements may be waived for some Section 330 programs at the request of the applicant (see “County-Based Clinics,” below).

The FQHC designation application process requires the applicant to determine in advance its service or “catchment area,”²² whether the clinic will exist in a high poverty area or Medically Underserved Area (MUA)²³ or serve a Medically Underserved Population (MUP),²⁴ and its scope of services, staffing configuration, and governance structure. The applicant also must document the need for primary care services in its area, its specific plan for addressing these needs, the history and clinical capacity of its organization, and the geography and demographics of the communities it serves. In addition, it must provide a detailed budget and staffing information. Applicants must demonstrate compliance with all relevant program and federal and state requirements.

HRSA uses a numerical scoring process to review all applications and assess eligibility. The application requirements for FQHC can be found at <http://bphc.hrsa.gov>.

The types of FQHC designations are further described below.

Section 330 Grantees

All recipients of grants under PHS Act Section 330 are public or private, nonprofit or tax-exempt organizations, including tribal, faith-based, and community-based organizations.²⁵ As of November 2008, there were 113 Section 330 grantees in California.

In order to qualify as a Section 330 grantee, a safety-net clinic must include several elements that distinguish it from other types of providers. A Section 330 clinic is required by law to:

- Be located in or serve a high-need community, defined as a Medically Underserved Area, High Poverty Area, or Medically Underserved Population;²⁶
- Provide, either directly or through contracts or other cooperative arrangements, a broad range of primary care services, as well as support services such as translation and transportation services that promote access to health care;
- Make services available to all residents of its service or catchment area, with fees adjusted based upon an individual's ability to pay;
- Unless explicitly waived by HRSA, operate under the direction of a governing board with a majority of directors who are users of the center and who represent the diversity of individuals being served by the center; and

- Meet other performance and accountability standards regarding its administrative, clinical, and financial operations.

Designation as an FQHC by virtue of Section 330 status provides eligibility for other federal grants and programs. For example, Federal Tort Claims Act coverage, whereby certain health center employees are deemed to be federal employees for the purpose of malpractice coverage, is available to Section 330 grant recipients that meet specific Federal Tort Claims Act requirements.²⁷ Section 330 grantees also are allowed special protections under federal and state anti-kickback laws.²⁸

FQHC Look-Alikes

A public or private, nonprofit entity that otherwise meets Section 330 program requirements may be designated as an FQHC look-alike (FQHCLA) if it does not receive funding under Section 330 but is governed, operates, and provides services in the same way as Section 330 grantees. A public or private nonprofit organization may separately apply for FQHCLA status.²⁹

FQHCLA status allows for enhanced reimbursement under Medicare and Medicaid and may allow the health center to participate in other federal programs, such as the 340b drug pricing program. However, FQHCLAs are not eligible to participate in the Federal Tort Claims Act malpractice coverage program and are not protected under the anti-kickback safe harbors applicable to Section 330 grantees.

An entity applying for FQHCLA status must:

- Be operational at the time of application;
- Not be owned, controlled, or operated by another entity;³⁰ and

- Serve, in whole or in part, a federally-defined Medically Underserved Area or Medically Underserved Population.

As of November 2008, there were 96 FQHCLAs designated nationally, with 26 approved in California. Although the total number of FQHCLAs in California has decreased since 2006, this is due largely to conversion to FQHC status. HRSA reports that between 2006 and 2008, 17 FQHCLAs were “de-designated” due to conversion while seven new FQHCLAs were designated.³¹

HRSA is in the process of making significant changes to the requirements for securing and maintaining FQHCLA designation, in order to better align the look-alike program with the Health Center Program authorized under Section 330 of the PHS Act. HRSA proposes more stringent requirements for FQHCLA designation, including requirements for an annual recertification and the submission of a health care plan and business plan to be used to monitor progress in meeting clinical and financial goals. HRSA also proposes to open FQHCLA eligibility to organizations that serve special populations (e.g., migrant and seasonal farm-workers, homeless populations) rather than the general community, and to waive the governance requirements for a 51 percent consumer/patient majority on, and monthly meetings by, the oversight board. As of December 2008, the regulations implementing these changes had not become final.³² The application requirements for FQHCLA designation are found at <http://bphc.hrsa.gov>.

Clinics Operated by Tribes or Tribal Organizations

The Indian Health Service (IHS), an agency established by the Snyder Act of 1921 and functioning within the U.S. Department of Health

and Human Services, operates a comprehensive health care system that serves approximately half of the estimated 4 million American Indians and Alaska Natives in the United States. According to IHS, the system includes 46 hospitals and over 600 other facilities operated by the IHS, tribes, or Alaska Native corporations, or purchased through contracts with private providers.³³ IHS contracts with non-IHS providers, through the Contract Health Services program, for services not available within its network or through tribal programs. IHS and tribal facilities receive both Medicaid and Medicare reimbursement based on an “all-inclusive rate” negotiated between the Centers for Medicare and Medicaid Services and the IHS.

Under the Indian Self-Determination and Education Assistance Act,¹⁵ federally recognized tribes may administer and operate health care programs in their communities through contractual relationships with the IHS or its agencies, or may access services through the IHS system. The Indian Health Care Improvement Act (IHCA) of 1976¹⁶ was passed to support these options.³⁴ The IHCA directs the IHS to identify, plan, design, construct, and renovate hospitals, health centers, substance abuse treatment centers, and staff quarters; to establish joint venture demonstration projects under which an Indian tribe or tribal organization would acquire or construct a health facility and lease it; and to acquire health care delivery space through a variety of cooperative efforts with the tribes, including entering into joint ventures to make health services more accessible to Indians. The IHCA expired in 2001 but, pending reauthorization, Congress has continued to appropriate funds for IHCA programs under the Snyder Act.

The Urban Indian Health Program (UIHP) provides outpatient services to Native Americans living in urban areas. Started as clinics staffed by

volunteers that relied heavily on donated equipment and supplies, the UIHP now supports contracts and grants to approximately 34 urban health programs funded under Title V of the IHCA; 15 of these programs are designated as FQHCs.³⁵ Although 58 percent of the American Indian/Alaska Native population lives in urban areas served by UIHP, the program provides care to less than 7 percent of that population.³⁶

In the Omnibus Reconciliation Act of 1993, Title V and tribal 638 programs³⁷ were made automatically eligible for FQHC designation. Other programs and facilities operated by federally recognized tribes or tribal organizations may apply for and be designated as FQHCs or RHCs if they meet program guidelines. Approximately 45 percent of UIHP clinics receive Medicaid reimbursement as FQHCs, and others receive Medicaid fees for service.³⁵ In California, reimbursement for UIHP clinics and health centers is based on IHS negotiated rates, similar to FQHC and RHC reimbursement in the state.³⁸

The California Area Indian Health Service (CAIHS) supports tribal governments and urban Indian communities in the development and administration of comprehensive health care delivery systems that meet the needs of Indian people. The CAIHS reports that 31 tribal health programs in California are operating 57 ambulatory clinics under the authority of the Indian Self Determination Act. In addition, IHS funds eight urban health programs in California, although none of the tribal facilities and programs currently operating in the state originated as facilities previously operated by IHS.

The CAIHS reports that it is unlikely that hospital-based service programs will be developed by IHS in California; this means that tribal programs must rely on private and public hospitals to meet inpatient and emergency needs, and on Contract Health Service funding to purchase services through

the private sector.³⁹ In California, most tribally operated health programs have multiple funding sources. Many augment their IHS funding with grants from public and private sources, including funds generated from tribal enterprises; in some cases, the IHS is not even the primary funding source.

Rural Health Clinics

The Rural Health Clinic (also known as the “95-210 clinic”) designation was created by the Rural Health Clinic Services Act of 1977.⁴⁰ Its primary purpose was to address the inadequate supply of physicians to serve Medicare and Medicaid beneficiaries in rural areas.⁴¹ The model sought to improve access to primary care and emergency services in underserved, rural communities, and to promote structured collaboration between physicians and non-physician providers such as nurse practitioners and physician assistants. Like FQHCs, RHCs receive enhanced reimbursement by Medicaid and Medicare based on the reasonable cost of providing services. As of August 2008, 3,779 RHCs were certified in the United States, including 261 in California.⁴² The majority of California RHCs are for-profit, freestanding clinics.

To qualify as an RHC, an entity must:

- Be located in a non-urban area, as defined by the U.S. Census Bureau, and in a geographic or population-based Health Professional Shortage Area (HPSA) or an MUA/MUP as designated by HRSA, or in an area designated as an HPSA by the governor of the state and certified by the federal Department of Health and Human Services;
- Employ or contract with a nurse practitioner, a physician assistant, or a certified nurse midwife, who is available to furnish patient care services

at least 50 percent of the time that the clinic operates;

- Meet specific service requirements, including basic laboratory testing and diagnostic and therapeutic services commonly furnished in a physician's office; and
- Meet Medicare quality assessment and performance improvement requirements.⁴³

Certification as an RHC is site-specific. RHCs differ from FQHCs in several key ways. An RHC:

- May be operated by a for-profit or nonprofit entity;
- May not be simultaneously designated as an FQHC, but can move from RHC to FQHC status through the FQHC designation process;
- May be independent and freestanding, or provider-based, as a subordinate but integrated part of a Medicare participating hospital, skilled nursing facility, or home health agency;
- Is not mandated to provide care to everyone regardless of ability to pay;
- Is not mandated to provide the comprehensive set of preventive and primary care services required of FQHC-designated clinics; and
- Does not receive federal grant funds to support the cost of care for those who cannot afford to pay.

Because RHCs are not required to maintain an open-door policy and may be operated by for-profit entities, they do not fall within the technical definition of safety-net clinics. However, RHCs increasingly are viewed as safety-net providers in the rural communities they serve because their patients

tend to be self-paying and uninsured, Medicaid recipients, and other vulnerable populations. In addition, many RHCs are operated by independent practitioners as freestanding clinics that are the sole providers for the community, serving a high percentage of rural elderly and low-income patients. The majority of provider-based and freestanding RHCs report having policies in place to offer free or reduced-cost services to low-income patients.⁴⁴

Provider-based RHCs are generally owned and operated by a hospital; there are approximately 94 hospital-based RHCs in California.⁴⁵ The main difference between a provider-based RHC and a freestanding one is Medicare payment limits, depending on the size of the hospital. Provider-based RHCs owned and operated by hospitals with fewer than 50 acute care beds are exempt from the Medicare cost-per-visit limit. By comparison, freestanding RHCs and provider-based RHCs owned and operated by hospitals with 50 or more beds are generally paid by Medicare based on a per-visit limit as set out in Medicare regulations.⁴⁶ Provider-based RHCs must meet the same certification requirements as freestanding RHCs.

In California, many rural health care districts operate RHCs to provide a health care services safety net. In addition, RHCs increasingly participate in local collaboratives to ensure access to health care services in the community. However, there is little assistance in the form of federal or state grants or other outside funding for RHC operations to offset the cost of services to the uninsured.⁴⁷

The most recent available data indicate that Medicare and Medicaid account for 55 percent of RHC revenue. Commercial and private insurance represent 30 percent of revenue and private pay and free or reduced-cost care account for 15 percent.⁴⁴ RHCs are paid on a cost-based, all-inclusive rate for a visit. Medicare payments to RHCs are capped

and adjusted annually; Medicaid reimbursement is based on a prospective payment system similar to reimbursement for FQHCs.

Although the exact number is unclear, according to OSHPD sources there are a few freestanding RHCs in California that are not operated as private practices or provider-based entities and are licensed as primary care clinics.⁴⁸

Free Clinics

“Free clinic” is specifically defined by California statute as “a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services.”⁴⁹ A free clinic is not permitted to charge patients directly for services rendered or for drugs, equipment, or supplies furnished. Free clinics play a significant role in the local community health care safety net by creating additional capacity for those needing access to health care services. Free clinics rely on volunteer providers to deliver care services and private donations to support clinic operations.

There is no readily available national data source to describe the patient demographics of free clinics. The National Association of Free Clinics estimates that such clinics provide services to more than 3.5 million of the nation’s uninsured and underinsured individuals.⁵⁰ As of November 2008, the California Department of Public Health Licensing and Certification Division reported that 40 primary care clinics were licensed as free clinics in California.⁵¹ At least four of these have obtained FQHC or FQHCLA status. Approximately nine licensed free clinics operate exclusively for pregnancy-related care and counseling, with fewer than 5,000 patient encounters in 2007.

Free clinics may be eligible to participate in federal and state health care-related programs. For example, in 1996, Section 224 of the PHS Act was amended to extend Federal Tort Claims Act malpractice coverage for volunteer free clinic health professionals.⁵² Free clinics that are not designated as FQHCs do not receive enhanced reimbursement from government programs for the provision of services.

County-Based Clinics

Counties in California are key providers of safety-net primary care services, or “indigent health care,” due to their obligation under Section 17000 of the California Welfare and Institutions Code to provide services to all people regardless of their insurance status or ability to pay. Counties are not mandated to fulfill their Section 17000 obligation in any specific way and use various systems of care and levels of service to do so. County-owned and operated clinics may be eligible for FQHC designation if their governance structure meets FQHC program requirements. Four of the more common models for delivering care are outlined below.

County Hospital-Based Clinics

Public hospitals and health systems are significant safety-net providers. Seventeen counties own and operate 21 general acute care hospitals in California, some partnering with university-based health systems to provide safety-net services through their medical centers.⁵³ While public hospitals account for less than 6 percent of all hospitals statewide, they provide nearly half of all hospital care to California’s uninsured¹⁰ and an estimated 25 percent of all outpatient visits provided by California hospitals.⁵⁴

Increasingly, public hospitals and health systems are shifting their focus and investments from the inpatient to the outpatient setting. Between 1993

and 1998, outpatient services at California public hospitals increased in volume by 27 percent.¹⁰ This mirrored a national trend toward increasing outpatient visits and decreasing inpatient admissions.

Public hospital systems have three different governance models. The most common is a county-owned and operated health care delivery system governed by the county board of supervisors. Second, in some counties, such as Alameda and San Francisco, a health authority separate from the county board of supervisors governs the county hospital system. Finally, several counties contract with a University of California medical center or a nonprofit hospital system to fulfill the Section 17000 mandate.

County-Based Freestanding Clinics

Counties also operate publicly owned, freestanding clinics as community-based safety-net clinics. Some are part of a larger public hospital system, while others are separately operated by the county public health department.

County Contracted Clinics

Several counties contract out some or all of their outpatient clinical services to licensed primary clinics or other private providers to meet Section 17000 mandates. For instance, many licensed primary care clinics are County Medical Services Program providers. There is a growing trend for counties to seek efficiencies by contracting services out to existing safety-net providers rather than providing services directly.

County-Based FQHCs

Increasingly, counties are seeking FQHC or FQHCLA designation for new and existing hospital-based and freestanding clinics in order to access grant funding and enhanced reimbursement by Medicare

County Medical Services Program (CMSP)

The CMSP was established in January 1983, when responsibility for indigent care transferred from states to counties. Smaller rural counties (population 300,000 or less) did not have the infrastructure to support such care, so they contracted with California Department of Health Services to administer indigent care services for these counties. CMSP now provides health coverage to low-income indigent adults in 34 California counties.

In 1995, legislation established an 11-member CMSP governing board that:

- Provides policy direction for the program;
- Sets beneficiary eligibility requirements;
- Determines the scope of covered health care benefits;
- Sets payment rates for health care providers participating in CMSP; and
- Contracts to administer the program.

Beginning in October 2005, Anthem Blue Cross Life & Health Insurance Company assumed administrative responsibility for CMSP.

Source: County Medical Services Program (www.cmspcounties.org)

and Medi-Cal. As of November 2008, 11 counties are direct Section 330 grantees: Solano County Health and Social Services Department; Contra Costa County Health Services Department; Yuba County; Alameda County Health Care Services; Sacramento County Department of Health & Human Services; San Bernardino County; Santa Clara Valley Health & Hospital System; San Mateo County Department of Health Services; Santa Barbara County Public Health Department; County of Santa Cruz Health Services Agency; and Ventura County Healthcare Agency.⁵⁵ Other county agencies, such as the San Francisco County Department of Public Health, have obtained FQHC status by virtue of being a subgrantee of a Section 330 grantee. By and large, California counties obtain FQHC status by competing for funding under the Section 330

Health Care for the Homeless Program (discussed in more detail in Section VII). Some counties, such as Alameda County Health Care Services, run their programs in partnership with other Section 330 grantees.

Generally, in applying for FQHC designation under the Health Center Program, counties face two major hurdles. The first is to avoid service area overlap with existing Section 330 grantees.⁵⁶ Second, and more significant, is being able to meet the stringent health center governance requirements under Section 330.⁵⁷

According to HRSA, county agencies and other public entities that operate health center programs may meet the FQHC governance requirement in one of two ways. The public entity's board, such as a county board of supervisors, may be composed of a patient/consumer majority. In most counties in California, however, this is unlikely.

Alternatively, the public entity may establish a separate health center governing board composed of health center users. This separate board must meet all the membership requirements and perform all the responsibilities expected of governing boards except that the public entity itself may retain fiscal and personnel policy responsibilities. When a health center operates with two boards, each board's separate responsibilities must be clearly specified in writing.⁵⁸ Several counties, such as Alameda and Contra Costa, maintain advisory boards appointed by the board of supervisors to help the county comply with HRSA governance requirements.

HRSA has the authority to waive certain FQHC governance requirements upon the request of an applicant, including a public entity, for specific Section 330 programs. These include the Migrant Health, Health Care for the Homeless, and Health Services to Residents of Public Housing programs. A waiver of governance requirements may also be made

when funds are requested to implement a health center program in a sparsely populated rural area.⁵⁷

In addition, four public entities in California—Stanislaus County Health Services Agency, Tulare County Health Services, County of Riverside, and Monterey County Health Department—have obtained FQHCLA designation. These counties have established separate governance boards to meet the FQHCLA designation requirements.

School-Based Health Centers

California law defines a school health center as a center or program that provides age-appropriate health care services at the program site or through referral, and may be located on or at a local educational agency (which means a school, school district facility, charter school, or county office of education). A school health center may conduct routine physical, mental health, and oral health assessments, and provide referrals for any services not offered on site.⁵⁹ California has more than 140 school health centers located in elementary, middle, and high schools, primarily in low-income areas; of these, approximately 30 are school-linked clinics or mobile vans that serve the school community. To maintain campus health centers, schools contribute financially or through in-kind support of space, utilities, and custodial services. School health centers are operated by the school districts or in partnership with organizations such as FQHCs, community clinics, hospitals, and county health departments.⁶⁰

In the past, HRSA has provided funding for a School-Based Health Center (SBHC) program even though there was no explicit legislative mandate for it; the SBHC program was administered by the Bureau of Primary Health Care within the general authority for the Section 330 programs. HRSA no longer identifies SBHCs as a separate health center program or type of health center. However,

it continues to recognize school-aged children as an underserved population to be served by health centers. Organizations receiving Section 330 funding specifically to support an SBHC must comply with the requirements of the Community Health Center Program (discussed in more detail in Section VII).⁶¹ In 2006, California Section 330 grantees served a total of 32,607 SBHC patients.¹²

In 2008, Gov. Arnold Schwarzenegger signed S.B. 564 to expand the school health centers program by requiring the California Department of Public Health to implement the Public School Health Centers Support Program and to establish a grant program to provide technical assistance and funding for the expansion, renovation, and retrofitting of existing school health centers, and the development of new school health centers. To date, however, no state funds have been appropriated for this purpose.

The federal Health Care Safety Net Act of 2008 authorized the study of the economic cost and benefits of school-based health centers and the impact of these centers on student health, including the impact that federal funding would have on these centers.⁶²

Other Safety-Net Clinics

There are many licensed primary care and specialty care clinics operating in California that do not fit any of the categories described above. These include clinics offering family planning and women's health services, such as Planned Parenthood clinics, mobile clinics operated by licensed hospitals or primary care clinics under California's Mobile Health Care Services Act,⁶³ and others. These clinics offer a host of health care and health education services to underserved and vulnerable, low-income populations. They rely on reimbursement from an array of public health programs such as Medi-Cal; Family Planning, Access, Care, and Treatment (Family PACT); the

Child Health and Disability Prevention program; Healthy Families; and Title X funding, plus sliding scale fees, private third-party payments, and private donations.

In addition, there are safety-net clinics operated by university health systems, private hospitals and private individuals that are not required to obtain state licensure. There is no readily available data to support an accurate overview of these clinic operations.

VII. Reimbursement and Funding for Safety-Net Clinics

Safety-net clinic operations are supported by various federal and state entitlement and grant programs, private foundation grants, charitable donations, sliding scale fees, and third-party reimbursement.

SAFETY-NET CLINIC OPERATIONS ARE SUPPORTED BY MONEY from various federal and state entitlement programs, discretionary and competitive federal and state grant programs, private foundation grants, charitable donations, sliding scale fees, and third-party reimbursement. This section provides an overview of the key revenue sources for safety-net clinics.

Government Health Programs

Medi-Cal

Medi-Cal, California's Medicaid program, accounts for approximately 46 percent of total clinic revenue.⁸ States that participate in Medicaid, a federal program authorized by Title XIX of the Social Security Act, pay for medical assistance for certain individuals and families with low incomes, according to federal rules. Each participating state maintains its own eligibility standards, scope of benefits, and provider reimbursement standards within federal guidelines. The federal government matches expenditures by the state program based on the state's participation agreement, called the State Plan for Medical Assistance. The federal matching rate varies by state from 50 to 77 percent;⁶⁴ California receives a 50 percent match.

Reimbursement for services furnished to Medi-Cal beneficiaries is made either directly to the clinics on a cost-based or fee-for-service basis or through Medi-Cal managed care subcontracts. Medi-Cal fee-for-service rates to providers are capped as set out in state Medi-Cal regulations. The Medi-Cal program is required by federal and state law to reimburse licensed primary care clinics that are designated as FQHCs or certified as RHCs at a prospective per-visit rate based on the clinic's reasonable cost.

California licensed primary care clinics reporting to OSHPD in 2006 stated net patient revenue derived from Medi-Cal to be \$787 million, accounting for about 68 percent of total net patient revenue from various payer sources. This includes the traditional fee-for-service Medi-Cal program, Medi-Cal managed care, and such separate Medi-Cal sources as the Family PACT waiver program,

Children’s Health and Disability Program, and the Breast Cancer Early Detections and Breast and Cervical Cancer Treatment programs.⁸ This amount for licensed primary care clinics represents less than 2.3 percent of the state’s total Medi-Cal budget in 2006–07.⁶⁵

There are no readily available comparable data on Medi-Cal reimbursement for public safety-net clinics. However, like licensed primary care clinics, the primary payer source for county-based safety-net clinics is Medi-Cal.

Medicare

Medicare, a federal program for the elderly and disabled authorized by Title XVIII of the Social Security Act, consists of distinct but interrelated parts providing funding for health care services. The Medicare Part B program accounts for approximately 10 percent of total net patient revenue for licensed primary care clinics in California.⁸ Comparable data for RHCs and public safety-net clinics are not readily available. Safety-net clinics enroll in Medicare as providers and are paid for Medicare services through regional fiscal intermediaries. Although not normally a covered benefit, the Medicare Part B program pays for some preventive care services for Medicare beneficiaries when these are delivered to FQHC or RHC patients.

Clinic services to Medicare beneficiaries are paid on a fee-for-service basis, or on a reasonable-cost basis if the clinic is designated as an FQHC or certified as an RHC. Medicare payments to providers are capped, even if the rate is based on reasonable cost. The cap is updated annually in the Federal Register.

State Children’s Health Insurance Program

The State Children’s Health Insurance Program (SCHIP) is authorized under Title XXI of the

Social Security Act. The program provides health insurance for low-income children through a joint federal/state program. California’s SCHIP program is administered by the Managed Risk Medical Insurance Board as the Healthy Families program, for which the federal government provides an annual allotment.⁶⁶ Safety-net clinics participate as Healthy Families providers through subcontracts with managed care organizations that are program contractors. In counties where managed care organizations do not operate, safety-net clinics participate as direct contractors with the state. A little more than 1 percent of the total operating revenue for California licensed primary care clinics is derived from contracts for services provided to Healthy Families enrollees.⁸

Other Government Health Programs and Funding Sources

Other government health programs, including city-, county-, and state-funded programs, provide funding for limited services or services for specific populations in California. These include the County Health Care for Indigents program, the County Medical Services program, the Medically Indigent Services program, and the Health Care Coverage Initiative. They are operated as separate health programs and account for less than 6 percent of total revenue from all payer sources for licensed primary care clinics.⁸

Federal Safety Net Care Pool

Twenty-one public hospitals access funding through the Medi-Cal Hospital/Uninsured Care Demonstration Project, also known as the Safety Net Care Pool (SNCP), to provide services to uninsured patients.⁶⁷ This funding pool is designed to maximize the use of federal funds for care to the uninsured. However, in order for the public hospitals to access

federal funds, the counties must provide the state's share of the match.

Operating as a five-year Medicaid waiver demonstration project beginning in 2005, the SNCP is designed to draw approximately \$3.8 billion in federal financial participation for reimbursement to public hospitals, including those that are university-based and county-run, for provision of medical care services to the uninsured. The primary features of the demonstration are:

- Counties must provide a 50 percent state match to draw down federal dollars;
- Hospitals contracting with SNCP receive preferential or exclusive referrals of Medicaid patients in their areas;
- Payment to the hospitals is based on Medicaid cost;
- Continued federal funding is contingent upon expansion of health care coverage to the uninsured;
- California is prohibited from implementing a provider tax to be used as the non-federal portion of the funds; and
- Total SNCP funding is capped annually (in 2007, at \$766 million with no growth factor).⁶⁸

Federal Disproportionate Share Hospital Funding

Public hospital systems and private hospitals that serve a particularly large number of uninsured and Medi-Cal patients are considered disproportionate share hospitals (DSH) and receive supplemental reimbursement by Medi-Cal. DSH funding for hospital-based clinics is available to the extent that hospitals choose to allocate funds to their outpatient clinic services.

Government Grant Programs

Several key federal and state grant programs provide important operating revenue for California's safety-net clinics.

Health Resources and Services Administration Programs

The Health Centers Consolidation Act of 1996 authorized the U.S. Department of Health and Human Services to consolidate the administration of various community-based health programs authorized under Section 330 of the Public Health Service Act.⁶⁹ The Consolidated Health Center Programs law is designed to promote the development and operation of community-based primary health care services in Medically Underserved Areas and to improve the health status of Medically Underserved Populations. Section 330 funding is intended to help defray the cost of health care services to the uninsured.

The Health Resources and Services Administration (HRSA) administers the Section 330 programs. The grant application process is competitive on a national basis. If the HRSA awards Section 330 funding to a clinic, that clinic is designated as an FQHC. Open funding opportunities are published cyclically at www.hrsa.gov/grants and in the Federal Register.

Grant amounts depend on the scope of the project and may be made on a multiyear cycle or for a project period. The amount of the grant may not exceed the operational costs of the health center in a particular fiscal year, minus operational funding from state and local sources and fees, premiums, and third-party reimbursements that the center may reasonably expect to receive for its operations. A single clinic may receive funds from more than one Section 330 program.

Health Center Program Timeline:

The HRSA's Health Center Program has developed and expanded in significant ways over more than 40 years.

1960s: Federal Office of Economic Opportunity funds first community health centers to provide health and social services to poor, medically underserved communities.

1962: Migrant Health Act (P.L. 87-692) added Section 310 of the PHS Act to provide a broad array of medical and support services to migrant and seasonal farmworkers and their families.

1987: The Stewart B. McKinney Homeless Assistance Act (P.L. 100-77) added Section 340 to the PHS Act to provide emergency food, shelter, education, transitional and permanent housing, and health services for the homeless.

1990: The Disadvantaged Minority Health Improvement Act authorized the Public Housing Primary Care program under Section 330(i) of the PHS Act.

1994: HRSA established the Healthy Schools, Healthy Communities initiative to encourage development of comprehensive, full-time, school-based primary care programs.

1996: The Health Centers Consolidation Act (P.L. 104-299) consolidated four existing federal health center grant programs into a single program under Section 330 of the PHS Act.

2002: The Health Care Safety Net Amendments of 2002 (P.L. 107-251) expanded the Health Center Program.

2008: The Health Care Safety Net Act of 2008 (P.L. 110-355) reauthorized the Health Center Program and increased funding through 2012.

HRSA provides funding for public and private non-profit health care organizations for four major project categories:

- **New Access Points Grants.** Support new service delivery sites that will provide comprehensive primary health care and access to oral and mental health services. Applicants may be existing grantees or organizations that do not currently receive Section 330 grant funds.

- **Expanded Medical Capacity Grants.** Support expansion of access to primary care health services in an existing grantee's current service area (e.g., by adding new medical providers or services, or expanding hours of operation).
- **Service Expansion Grants.** Support the addition of new, or expansion of existing, mental health/substance abuse and oral health services at Section 330 grantee health centers.
- **Service Area Competition Grants.** Provide ongoing continuation funding for service areas currently served by health center grantees. The competitive application process is open to Section 330 grantees whose project periods (typically three years) are about to expire, and to organizations proposing to serve the same areas or populations that are served by existing Section 330 grantees.

In 2007, the most recent year for which data is published by HRSA on Section 330 health centers, HRSA's Health Center Program provided funding to 1,067 grantees nationally, awarding a total of more than \$1.68 billion.⁷⁰ California is home to more Section 330 grantees (110 in 2007) than any other state. However, the total award to California grantees is somewhat lower than its proportion of the U.S. population: California's population is more than 12 percent of the total U.S. population,⁷¹ but California grantees receive only approximately 10 percent of Section 330 funding. In 2007, California grantees, representing 10.3 percent of the national total, received \$184.7 million to provide services to more than 2.3 million people.⁷²

HRSA's Health Center Program includes four key primary care programs, while other programs are administered by HRSA:

Community Health Center Program

The primary goal of the Community Health Center (CHC) program is to maintain access to comprehensive primary and preventive care and improve the health status of underserved and vulnerable populations. Grant applicants must ensure the availability and accessibility of essential primary care and preventive health services, including oral health, mental health, and substance abuse services, to all people in the area served by the health center. Applicants may be private, nonprofit, or public entities.

In 2007, the CHC program accounted for 81.3 percent of the total funding for the Health Center Program nationally,⁷⁰ with 84 percent of California Section 330 grantees receiving CHC program grants. As a whole, California clinics drew down approximately \$120 million in CHC funds, less than 9 percent of the total available program dollars.⁷²

Migrant Health Center Program

The Migrant Health Center (MHC) program⁷³ provides grants to community nonprofit organizations for a broad array of culturally and linguistically competent medical and support services to meet the special needs of migratory and seasonal farmworkers and their families.

In 2007, the MHC program accounted for about 7.4 percent of total national Section 330 funding. California safety-net clinics drew down nearly \$36 million, accounting for about 25.7 percent of the total dollars spent for the program nationally. Approximately 19.5 percent of Section 330 grantees in California received MHC funding, a total of 26 MHC program grantees. In 2007, HRSA reported that 345,671 migrant workers and their family members across the United States received services from health centers paid in part by the MCH program.^{70,72}

Health Care for the Homeless Program

The Health Care for the Homeless (HCH) program is a major source of health care for homeless people. The program's goals are to provide access to comprehensive primary and preventive care and to improve the health status of the underserved homeless population by combining aggressive street outreach with integrated primary care, mental health, and substance abuse services. The program also coordinates efforts with other community agencies serving the homeless population.

In 2007, the HCH program accounted for 8.5 percent of total Section 330 funding nationally. Twenty-five California public and nonprofit agencies, including safety-net clinics, received HCH funding; the vast majority of California counties that are Section 330 grantees received HCH funds. The program spent about \$24.8 million in California in 2007, representing a little more than 17 percent of the national total; HCH funds helped provide services to 154,742 Californians.^{70,72}

Public Housing Primary Care Program

The Public Housing Primary Care (PHPC) program provides public housing residents with access to comprehensive, affordable health care through the direct provision of primary health care services, health promotion, and disease prevention activities. Health centers may be on the premises of public housing developments or at other locations immediately accessible to public housing residents. The PHPC program accounts for 1.2 percent of total Section 330 funding nationally.⁷⁰ In 2007, five California safety-net clinics received PHPC funding totaling \$3.34 million, equal to 16.6 percent of the total funding nationally.^{70,72}

Native Hawaiian Health Care Program

A relatively recent program funded by HRSA within the health center appropriation, the Native Hawaiian Health Care (NHHHC) program aims to improve the health status of Native Hawaiians by making health education, health promotion, and disease prevention services available through the support of Native Hawaiian Health Care Systems. The program also supports a health professions scholarship program for Native Hawaiians and administrative costs for Papa Ola Lokahi, an organization that coordinates and assists health care programs provided to Native Hawaiians.⁷⁴

Ryan White HIV Early Intervention Services (Title III)

Ryan White program funding provides early intervention and major care services to people with HIV infection. Ryan White grantees are required to provide HIV counseling and testing; counseling and education on living with HIV; appropriate medical evaluation and clinical care; and other essential services such as oral health care, outpatient mental health services, outpatient substance abuse and nutritional services, and referrals for specialty services. A major emphasis is on increasing access to HIV primary care and support services for communities of color. Grantees are required to spend at least 75 percent of funds on core medical services.⁷⁵

The program is authorized under Title III of the PHS Act and is administered by HRSA. Grantees must be public or private nonprofit agencies. The average size of multi-year grant awards is approximately \$358,000.⁷⁶ Ryan White funding is a significant source of grant revenue nationally (in 2007, approximately \$183 million in Title III funding was distributed; \$70 million to Section 330 clinics); California safety-net clinics received nearly \$19.5 million from Title III in 2007.⁷⁷

Family Planning Services Program (Title X)

Another key federal grant source for safety-net clinics is the Family Planning Services Program authorized under Title X of the PHS Act and administered through HRSA's Office of Family Planning. Created in 1970, the Title X program is the only federal program dedicated solely to family planning and reproductive health, with a mandate to provide a broad range of approved family planning methods and services. Under the Title X program, services are provided through 88 service delivery grants that support a nationwide network of more than 4,400 community-based clinics, including state and local health departments, hospitals, university health centers, independent clinics, and public and nonprofit agencies. In 2008, approximately \$300 million was appropriated to fund the Title X program.⁷⁸

The primary Title X grantee in California, the nonprofit California Family Health Council, Inc. (CFHC), administers sub-grants to safety-net clinics. Nearly 75 public and nonprofit agencies, which operate more than 311 safety-net clinics in California, receive funding through a competitive grant process. Total funding dispersed through CFHC in 2008 is estimated at \$17 million.⁷⁹

State-Based Grant Programs for Safety-Net Clinics

In California, a few state-based grant programs are available to help offset the cost of care to the uninsured or to provide other financial assistance to safety-net clinics. The Primary and Rural Health Care Systems Branch, within the Primary Care and Family Health Division of the California Department of Health Care Services, administers five funding programs:

- Rural Health Services Development (RHSD);

- Seasonal Agricultural and Migratory Workers (SAMW);
- Grants-In-Aid;
- Expanded Access to Primary Care (EAPC); and
- Indian Health Program.

The EAPC program, in particular, is a key source of funding to offset the cost of services to the uninsured. EAPC funds are available to safety-net clinics that are licensed primary care clinics or clinics operated by tribal organizations and meet EAPC program requirements. Funds for this program are appropriated from a combination of the state's General Fund and the Cigarette and Tobacco Products Surtax Fund under Proposition 99. Clinics that meet program requirements are provided multi-year awards to pay for care for uninsured individuals whose family income is at or below 200 percent of the federal poverty level, on a per-visit basis.

The state budget allocation for the EAPC program in 2007–08 was approximately \$30 million: \$13.5 million from the General Fund and the remainder from the Proposition 99 fund. This represents a significant reduction in General Fund spending since fiscal year 2005–06.⁸⁰ For fiscal year 2008–09, the General Fund appropriation remained stable but the overall EAPC appropriation was reduced by nearly \$3 million. By contrast, the combined annual General Fund allocation for the RHSD and the SAMW programs was a little more than \$15 million for fiscal years 2007–08 and 2008–09.

The Indian Health Program (IHP) is another small source of safety-net clinic funding derived from the state General Fund. The IHP administers a grant program to provide financial and technical assistance to Indian health programs. Grantees, who must meet specific program guidelines, provide a combination

of community health, medical, and dental care to American Indians and Alaska Natives in both rural and urban areas of California. According to IHP's program description, 627,562 Californians identify as American Indian or Alaska Native based on 2000 U.S. Census data. The total budget for the IHP in fiscal years 2007–08 and 2008–09 was \$6.46 million to fund 32 American Indian clinics and two traditional Indian health education projects.⁸¹

Other Revenue Sources

Safety-net clinics derive other revenue from grants and contracts from counties and cities, private foundations, charitable donations, sliding-scale fees paid by patients, and payments from private insurers. These revenue sources account for roughly 20 percent of total gross revenue for licensed primary care clinics.⁸

VIII. Issues Facing Safety-Net Clinics

As the number of uninsured in California rises and funding levels from most sources remain stable or decrease because of budgetary constraints, the burden on safety-net clinics to meet their open-door mandates probably will increase.

BASED ON RESULTS FROM THE 2007 CALIFORNIA HEALTH Interviews Survey, 6.4 million people in California were uninsured for some part of the year.⁸² As the number of uninsured in California begins to rise again due, in part, to the economic downturn, and funding levels from most sources decrease or remain stagnant because of budgetary constraints, the burden on safety-net clinics to meet their open-door mandates probably will increase.

Unlike many for-profit health care entities, the funding for safety-net providers is heavily weighted toward reimbursement from governmental health care programs, which are subject to budget cuts. These clinics also rely on a patchwork of public and private discretionary funding to support direct services and operations. With such a small number of payer sources and unstable base funding, clinics have limited ability to shift costs to pay for uncompensated care.

Challenges Facing Safety-Net Clinics

Within the wider problem of the overall economic downturn, safety-net clinics face a number of specific challenges.

State and County Budget Crises

The current economic downturn has forced virtually all states to reduce program budgets. California is facing an unprecedented General Fund budget deficit for fiscal year 2009–10 if no action is taken to reduce spending and/or increase revenue. In addition, the California Legislative Analyst's Office is predicting annual shortfalls in the range of \$22 billion through fiscal year 2013–14. At the same time, the state's health expenditures are expected to rise, largely due to increased caseload, greater utilization of services, and rising costs for services.⁸³ Funding for programs for the uninsured probably will decrease or remain flat. Further, county budget shortfalls resulting in program cuts also affect safety-net clinics that are county-based or county contractors.

Medi-Cal Program Cuts

In 2008–09, the California Legislature opted to decrease provider reimbursement, limit the number of Medi-Cal beneficiaries through changes to the eligibility determination process, and limit or eliminate reimbursement for some services. Reinstating quarterly eligibility redeterminations will cause more people to be dropped from the eligibility rolls, resulting in even greater numbers of uninsured. Limiting reimbursement for services—such as dental care, which safety-net clinics are required to provide—results in a greater level of uncompensated care for these providers.

Credit Crisis

The current restricted credit market is making it increasingly difficult for safety-net clinics to access loans for capital improvements and lines of credit to cover shortfalls when program payments are delayed. Without access to financing, clinics may be forced to delay expansion projects and even to reduce staff and limit services.

Beneficiary Citizenship Verification and Residency Requirements

The federal Deficit Reduction Act of 2005 requires states to obtain satisfactory documentation of citizenship or nationality for each person who seeks Medicaid eligibility.⁸⁴ California must comply with this requirement in order to receive federal financial support for the Medi-Cal program. California law also requires citizenship and identity verification as a condition of receiving certain Medi-Cal benefits. Citizenship verification also applies to Medicaid waiver programs, such as Family PACT. People without proper documentation of citizenship and identity will not be eligible for Medi-Cal coverage, further straining the resources of safety-net clinics

that provide health care services regardless of a patient's ability to pay.

Increasing Uninsured Population

Although in recent years there have been modest gains in insurance status for Californians under age 65, it is expected that the number of uninsured will begin to trend upward again, in part because of a global economic recession causing many to lose employer-based health insurance. Safety-net clinics serve a disproportionate number of uninsured patients relative to other types of providers of outpatient services, and California has one of the highest uninsured rates in the nation, with 15 to 19.5 percent of all residents lacking health insurance.⁸⁵ A growing number of uninsured puts additional strains on safety-net clinics that by mission or mandate maintain an open-door policy.

Technologically Driven Changes in the Health Care Market

A major federal initiative has been implemented to standardize and encourage electronic claims processing to third-party payers. Also, electronic storage and transfer of medical records is the industry standard. Safety-net clinics are striving to keep pace with these and other technology changes. Although there has been support in the form of technical assistance and funding from government and nonprofit sources, the availability of resources has not kept up with the demand. The long-term viability of safety-net providers in the health care marketplace will depend, in part, on their technological sophistication.

Lack of Public Awareness

There is a general lack of public awareness about the mission, value, and quality of safety-net clinics, including the ways in which safety-net clinics support

local employment and economic growth in many low-income communities. For example, HRSA reported that in 2005, the “total direct, indirect, and induced economic impact of health centers generated \$12.6 billion in economic activity and 143,000 jobs” nationally.⁸⁶ Minimal resources for public outreach and marketing and media campaigns to help the general public understand the overall value of safety-net clinics for their communities places safety-net clinics at a distinct political disadvantage.

Supports for Safety-Net Clinics

In the face of the challenges described above, safety-net clinics are supported by the following strengths.

Proven Track Record in Their Communities

Safety-net clinics have adhered to the mission of serving vulnerable and underserved populations in their communities. Many have demonstrated their ability to carry out this mission, and communities accept and rely on them to provide needed services.⁸⁶

Local and National Political Support

Bipartisan support on the local, state, and national levels has increased over the years as health centers have come to be recognized as essential safety-net providers in their communities.

Federal Funding Commitments

In 2001, President Bush made a five-year commitment to substantially increase the number and scope of health centers through the president’s Health Centers Initiative. The initiative successfully met its goal to strengthen the health care safety net for all Americans by funding 1,236 new and expanded access points nationwide through the Consolidated Health Center Programs.⁸⁶ Many of these new sites are in California. Sustainability for newly established health centers and expanded

services will be an ongoing issue in light of unprecedented federal and state budget deficits. The American Recovery and Reinvestment Act of 2009, signed by President Obama on February 17, 2009, earmarked an additional \$2 billion in funding for nonprofit community health centers nationwide.

External Resources

California community health centers and clinics are supported by many external organizations and initiatives. These include clinic coalitions, external disease management initiatives, and substantial philanthropic efforts, all of which lend resources and expertise to strengthen the health care safety net. (For a discussion and list of such resources, see Appendix A.)

IX. Conclusion

In the current operational climate, safety-net clinics face major challenges to long-term sustainability and expansion in order to meet the needs of growing numbers of uninsured, underinsured, and other underserved populations.

SAFETY-NET CLINICS SERVE AS THE MEDICAL HOME for millions of Californians, most of whom are low-income and uninsured. These clinics, including licensed primary care clinics, clinics operated by governmental entities such as counties and cities, and clinics operated by federally recognized Indian tribes or tribal organizations, have become indispensable components of the health care system for vulnerable and underserved populations. They not only contribute needed preventive and primary health care and an array of complementary services but also serve as local economic drivers in low-income communities.

As explained in detail in this primer, safety-net clinics rely on a patchwork of governmental and private funding sources. While safety-net clinics have a proven track record as resourceful innovators in providing quality, comprehensive health care services, in the current economic climate these clinics face major challenges to long-term sustainability, and to their ability to meet the needs of growing numbers of uninsured, underinsured, and underserved populations. The viability of safety-net clinics, and the vitality of the people they serve, depends on a serious commitment by both federal and state policymakers to support the existing safety-net infrastructure and to increase funding for expansion in response to growing need.

Appendix A: Resources for Safety-Net Clinics

Clinic associations and consortia, some of which receive federal funding, provide technical assistance, policy information, training, and advocacy for safety-net clinics, and sometimes act as funding conduits. Many safety-net clinic associations are also supported by private foundation grants and special initiatives, which provide assistance not only for direct operational costs but also with policy initiatives and technical aspects of clinic operations.

The Health Resources and Services Administration funds state and regional primary care associations and primary care offices, which are typically state agencies. Technical assistance cooperative agreements between the primary care associations and primary care offices are also supported with this money. In California, the primary care office is the Office of Statewide Health Planning and Development. The primary care association is the California Primary Care Association (www.cPCA.org), a statewide trade association representing more than 600 nonprofit rural and urban clinics and health centers, including federally funded, federally designated, community, and free clinics.

Also contributing to support of safety-net clinics are the California Association of Public Hospitals and Health Systems (CAPH) and the California Health Care Safety Net Institute (SNI). CAPH (www.caph.org) is a trade association representing 29 public and nonprofit hospitals, academic medical centers, and comprehensive health care systems, operating in 15 counties throughout the state. SNI (www.safetynetinstitute.org) is a nonprofit organization that promotes quality improvement and systems innovation in California's public hospital systems to advance community health in the state, particularly for low-income and uninsured individuals.

Regional consortia that support collaboration between clinics, or between clinics and other types of health care providers in the same geographic area, play a critical role in safety-net operations in California. While these consortia vary in size, history, and sophistication, they all serve as a foundation of support and assistance for their member clinics and health centers. The associations and consortia are not direct service providers but offer a high level of support and expertise in such areas as information technology, quality improvement, data collection, and public policy advocacy. Coalitions may also provide economies of scale for negotiating shared purchase agreements or obtaining grant funding. Contact information for key regional organizations supporting safety-net clinics is included in the table on the next page.

California's Regional Consortia

| NAME | COUNTIES SERVED | MEMBERS/SITES | PATIENTS SERVED |
|---|---|------------------|-----------------|
| Alameda Health Consortium/ Community Health Center Network www.alamedahealthconsortium.org | Alameda | 8/35 | 112,000 |
| Alliance for Rural Community Health www.ruralcommunityhealth.org | Lake, Mendocino | 6/11 | 37,000 |
| Capitol Community Health Network www.capitolhealthnetwork.org | Sacramento | 8/13 | 50,000 |
| Central Valley Health Network www.cvhclinics.org | San Joaquin Valley counties | 13/116 | 530,000 |
| Coalition of Orange County Community Clinics www.coccc.org | Orange | 18/44 | 186,200 |
| Community Clinic Association of Los Angeles County www.ccalac.org | Los Angeles | 42/123 | 944,741 |
| Community Clinic Consortium of Contra Costa and Solano www.clinicconsortium.org | Contra Costa, Solano | 4/20 | 53,000 |
| Community Health Partnership www.chpscc.org | Santa Clara | 9/25 | 100,000 |
| Council of Community Clinics www.ccc-sd.org | San Diego, Riverside, Imperial | 17/100 | Not available |
| Merced County Health Care Consortium www.mercedcountyhealthcare.org | Merced | 7/36+ | Not available |
| North Coast Clinics Network www.northcoastclinics.org | Humboldt, Trinity, Del Norte | 13/13 | 50,000 |
| Northern Sierra Rural Health Network www.nsrhn.org | Northeastern California (9 counties) | 51/Not available | Not available |
| Planned Parenthood Affiliates of California www.ppacca.org | state (33 counties) | 8/108 | Not available |
| Redwood Community Health Coalition www.rchc.net | Sonoma, Marin, Yolo, Napa | 14/Not available | 147,000 |
| San Francisco Community Clinic Consortium www.sfccc.org | San Francisco | 10/16 | 70,000 |
| Shasta Consortium of Community Health Centers www.shastaconsortium.org | Shasta, Lassen, Siskiyou | Not available | Not available |

Source: Consortia Web sites, as of December 15, 2008.

Appendix B: Key Safety-Net Clinic Support Organizations

Alameda Health Consortium/Community Health

Center Network (AHC/CHCN): Clinic consortium serving Alameda County.

www.alamedahealthconsortium.org

Alliance for Rural Community Health (ARCH): Clinic consortium serving Lake and Mendocino Counties.

www.ruralcommunityhealth.org

Association of California Healthcare Districts (ACHD):

Statewide association of health care districts.

www.achd.org

California Area Indian Health Service(CAIHS): Area office of the federal Indian Health Service, overseeing Indian health programs in California.

www.ihs.gov/FacilitiesServices/AreaOffices/California

California Association of Public Hospitals and

Health Systems (CAPH): Statewide trade association representing 29 public and nonprofit hospitals, academic medical centers, and comprehensive health care systems in California. Association members make up the core group of providers in the state's medical safety net, operating in 15 counties throughout the state.

www.caph.org

California Family Health Council, Inc. (CFHC):

Nonprofit organization that coordinates and supports the delivery of health services in community-based organizations throughout California. It directs funding for providers of family health services; performs advanced research in reproductive health care and contraception; conducts education, training, and community outreach efforts; and tests, implements, and monitors programs.

www.cfhc.org

California Health Care Safety Net Institute (SNI):

Nonprofit organization that promotes quality improvement and systems innovation in California's public hospital systems to advance community health in California, particularly for low-income and uninsured individuals within the state's racially and ethnically diverse populations.

www.safetynetinstitute.org

California Hospital Association (CHA):

The largest state health care trade association in California, with nearly 450 hospital and health system members, as well as other health care providers, including entities that operate outpatient departments and rural health clinics.

www.calhealth.org

California Primary Care Association (CPCA):

Statewide trade association representing more than 600 nonprofit community clinics and health centers that provide comprehensive health care services, particularly for low-income, uninsured, and underserved Californians. Membership includes community and free clinics, federally funded and federally designated clinics, rural and urban clinics, and large and small clinic corporations. The association is designated by the federal Bureau of Primary Health Care as the state primary care association and receives federal program support to develop and enhance services for member clinics.

www.cPCA.org

California Rural Health Policy Council (RHPC):

Public agency that formulates and establishes rural health policy for California and provides a focal point for discussion of rural health issues within the state Health and Human Services Agency.

www.oshpd.ca.gov/rhpc/clinics

California Rural Indian Health Board (CRIHB):

Formed to enable the provision of health care to member tribes in California. Focusing on the needs and interests of the Indians of rural California, it is a network of tribal health programs controlled and sanctioned by Indian people and their tribal governments.

www.crihb.org

California School Health Centers Association (CSHCA):

Nonprofit advocacy organization representing school health centers.

www.schoolhealthcenters.org

California State Rural Health Association (CSRHA):

Statewide trade association of rural health providers, it represents public and private nonprofit rural health clinics.

www.csrha.org

Capitol Community Health Network (CCHN):

Nonprofit partnership of community clinics, health centers, and health education agencies supporting the primary health care safety net in Sacramento County.

www.capitolhealthnetwork.org

Central Valley Health Network (CVHN): Clinic consortium serving San Joaquin, Kern, Inyo, Colusa, Calaveras, Solano, Butte, Glenn, Sutter, Yolo, Tulare, Stanislaus, Merced, Kings, Yuba, Fresno, San Bernardino, and Madera counties.

www.cvhnclinics.org

Coalition of Orange County Community Clinics (COCCC): Clinic consortium serving Orange County.

www.coccc.org

Community Clinic Association of Los Angeles County (CCALAC): Clinic consortium serving Los Angeles County.

www.ccalac.org

Community Clinic Consortium of Contra Costa and Solano Counties (CCC): Clinic consortium serving Contra Costa and Solano Counties.

www.clinicconsortium.org

Community Clinics Initiative (CCI): Collaboration between the Tides Foundation and the California Endowment, which began in 1999 to provide resources, evidence-based programming and evaluation, education, and training to support community health centers and clinics.

www.communityclinics.org

Community Health Partnership (CHP): Clinic consortium serving Santa Clara County.

www.chpscc.org

Council of Community Clinics (CCC): Clinic consortium serving San Diego, Riverside, and Imperial Counties.

www.ccc-sd.org

County Health Executives Association of California (CHEAC): Statewide association of administrators from county health agencies that operate provider-based and freestanding clinics, including FQHCs, affiliated with public entities.

www.cheac.org

Health Resources and Services Administration (HRSA): Federal agency that administers Section 330 funding.

www.hrsa.gov

Indian Health Service (IHS): Division of the U.S. Department of Health and Human Services that works to ensure that comprehensive, culturally competent personal and public health services are available and accessible to American Indian and Alaska Native people.

www.ihs.gov

Merced County Health Care Consortium (MCHCC): Consortium of community clinics, private practice physicians, hospitals, and the county health department serving Merced County.

www.mercedcountyhealthcare.org

National Assembly on School-Based Health Care (NASBHC): National trade association of school-based health centers.

www.nasbhc.org

National Association of Community Health Centers, Inc. (NACHC): National trade association representing the interests of community health centers. It serves community, migrant, and homeless health centers, and FQHCLAs in all 50 states.
www.nachc.com

National Association of Free Clinics (NAFC): Nonprofit professional association composed of free clinics and state and regional free clinic associations, working together to support free clinics and the people they serve.
www.freeclinics.us

National Association of Rural Health Clinics (NARHC): National organization dedicated exclusively to improving the delivery of quality, cost-effective health care in rural underserved areas through the Rural Health Clinics Program.
www.narhc.org

National Center for Farmworker Health (NCFH): Nonprofit organization that provides information services and products to a network of more than 500 migrant health center service sites in the United States, as well as organizations, universities, researchers, and individuals involved in farmworker health.
www.ncfh.org

National Rural Health Association (NRHA): National nonprofit membership organization with more than 18,000 members. The association's mission is to provide leadership on rural health issues.
www.ruralhealthweb.org

North Coast Clinics Network (NCCN): Clinic consortium serving Humboldt, Trinity, and Del Norte counties.
www.northcoastclinics.org

Northern Sierra Rural Health Network (NSRHN): Clinic consortium serving Lassen, Modoc, Siskiyou, Shasta, Sierra, Nevada, Plumas, Tehama, and Trinity counties.
www.nsrhn.org

Office of Statewide Health Planning and Development (OSHPD): California governmental agency that oversees Health Professional Shortage Area designations and collects data on licensed primary care clinics. It is designated by HRSA as the primary care organization for California.
www.oshps.ca.gov

Planned Parenthood Affiliates of California (PPAC): Represents nine separately incorporated Planned Parenthood affiliates serving 33 counties throughout California and addressing statewide governmental issues.
www.ppacca.org

Redwood Community Health Coalition (RCHC): Clinic consortium serving Marin, Napa, Sonoma and Yolo counties.
www.rchc.net

Rural Assistance Center (RAC): Established in 2002 by the U.S. Department of Health and Human Services' Rural Initiative as a rural health and human services information portal. RAC helps rural communities and other rural stakeholders access the full range of programs, funding, and research that can enable them to provide quality health and human services to rural residents.
www.raconline.org

San Francisco Community Clinic Consortium (SFCCC): Clinic consortium serving San Francisco County.
www.sfccc.org

Shasta Consortium of Community Health Centers (SCCHC): Clinic consortium serving Shasta, Lassen, and Siskiyou counties.
www.shastaconsortium.org

Endnotes

1. There is no one commonly used definition of the term “safety net” in the health care sector. The definition of “safety-net providers” created by the Institute of Medicine most closely aligns with the population and providers described in this report. According to the Institute of Medicine, safety-net providers are “providers that deliver a significant level of health care to uninsured, Medicaid and other vulnerable populations.” See *America’s Health Care Safety Net: Intact But Endangered*, Institute of Medicine, June 2000. According to the Health Resources and Services Administration (HRSA), core safety-net providers typically include federal, state, and locally supported community health centers or clinics, many of which are deemed Federally Qualified Health Centers (FQHCs), public hospital systems, and local health departments, and in some communities include mission-driven teaching hospitals, community hospitals and ambulatory care clinics (which are often located in central city areas or serve as the sole provider of health care in the community). HRSA states that Rural Health Clinics (RHCs), small rural hospitals, critical access hospitals, clinics that receive Ryan White HIV/AIDS grant funding, and nurse-managed clinics also are important safety-net components. See HRSA, “Information for Part D Sponsors on Contracting with Safety Net Pharmacy Providers” (www.hrsa.gov/medicare/forpartdsponsors.htm).
2. “Public hospitals and health systems” are defined as county-owned facilities and state university-based medical centers that fulfill Section 17000 obligations in their respective counties. See *California’s Public Hospital and Health Systems: An Inside Look at Outpatient Services*, California Association of Public Hospital and Health Systems, 2001.
3. Health care district powers are statutorily defined in *California Health and Safety Code* §32000, et seq.
4. *California Welfare and Institutions Code* §17000 states: “Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.”
5. The *California Health and Safety Code* also requires specialty clinics and psychology clinics to be licensed. Those categories of clinics are not included in this report’s discussion of safety-net clinics.
6. The California Performance Review, launched in 2004, found that the backlog for new license applicants for clinics and other health facilities was 9 to 12 months. California Performance Review, “HHS22-Issue Fee-Supported Licenses Without Delay,” in *Report of the California Performance Review, Issues and Recommendations: Health & Human Services*, 417–424, (http://cpr.ca.gov/about_cpr).
7. *7.6 Million Californians Rely on the Safety Net of Health Care Providers for Regular Care*, University of California, Los Angeles, Center for Health Policy Research, September 2007.
8. *California Community Clinics: A Financial Profile*. Analysis of 2003–06 Annual Utilization Data compiled by OSHPD. Capital Link, in collaboration with California Healthcare Foundation, November 2008.
9. OSHPD collects hospital and clinic utilization data. It also publishes demographic data and mapping by county for urban and rural Medical Service Study Areas (MSSAs) in the state, (see www.oshpd.ca.gov/rhpc/resources/demographics.html). MSSAs are defined geographical analysis units. The U.S. Public Health Service recognizes MSSAs as “rational service areas” for purposes of determining Health Professional Shortage Areas, Medically Underserved Areas, and Medically Underserved Populations.
10. “Fast Facts: California’s Essential Public Hospitals.” California Association of Public Hospitals and Health Systems (CAPH), February 2008 (www.caph.org/fastfacts.htm); see also “California Public Hospitals’ Outpatient Care: Value for Patients and Our State’s Health Care System,” CAPH, November 2008.

11. OSHPD. *2006 Annual Utilization Data for Primary Care Clinics* (www.oshpd.ca.gov/hid/products/hospitals/utilization/pc_sc_utilization.html).
12. HRSA/BPHC. *Bureau of Primary Health Care Section 330 Grantees Uniform Data System, Calendar Year 2006 Data, California Rollup Report*. July 2007.
13. Schacht, J. *The Vital Role of Community Clinics and Health Centers: Assuring Access for All Californians*. California Primary Care Association. March 2008. (Citing Falik, M., J. Needleman, B.L. Wells, et al. 2001. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." *Medical Care* 39[6]: 551–61; and Falik, et al. 2006. "Comparative Effectiveness of Health Centers as Regular Source of Care," *Journal of Ambulatory Care Management* 29[1]: 24–35.
14. Social Security Act §§1905(l)(2)(B) and 1861(aa)(4); 42 U.S.C.A. §§1396d(l)(2)(B) and 1395x(aa)(4).
15. Public Law 93-638.
16. Public Law 94-437; 25 U.S.C.A. §1651, et seq.
17. Federally Supported Health Centers Assistance Act (FSHCAA) of 1992, Public Law 102-501, and FSHCAA of 1995, Public Law 104-73.
18. "Guidance for the Loan Guarantee Program." HRSA/BPHC Program Information Notice (PIN), 2003-20.
19. Veteran Health Care Act of 1992, Public Law 102-585; 42 U.S.C. §256b.
20. Health Professional Shortage Area designation qualifies a clinic for certain types of government funding and benefits. HPSAs may have shortages of primary medical care, dental, or mental health providers and may be urban or rural areas, population groups, or medical or other public facilities. According to HRSA, as of September 2008, nationally there were 6,033 primary care HPSAs, 4,048 dental HPSAs, and 3,059 mental health HPSAs. Health Care Safety Net Amendments of 2002 (Public Law 107-251); also see HRSA/BPHC. "Benefits of the Automatic Health Professional Shortage Area Designation." Program Assistance Letter 2005-04.
21. Medicare Prescriptions Drug, Improvement, and Modernization Act of 2003, §461, Public Law 108-173; 42 U.S.C.A. §1320a–7b(b)(3)(H).
22. 42 U.S.C. §245b(a).
23. A Medically Underserved Area (MUA) may be a county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services. Designation is based on a calculation that considers: (1) ratio of primary care physicians per 1,000 population; (2) infant mortality rate; (3) percentage of population with income below the poverty level; and (4) percentage of the population age 65 and over. Communities are assigned a score based on the weighting of each of these variables. If the score falls below a specific threshold, they are designated as an MUA.
24. Medically Underserved Population (MUP) designation is calculated in the same manner as for MUAs (*see* note 23). However, the specific population for which the MUP is calculated represents only a portion of an area's population. The specific MUP population encounters barriers to primary care access, which may be economic (e.g., low-income or Medicaid-eligible populations) or social (cultural, linguistic).
25. Authorized by the Federally Supported Health Centers Assistance Act of 1992 (Public Law 102-501).
26. Recognition and definition of "high poverty area," effective January 1, 2009, was added by the Health Care Safety Net Act of 2008, HR 1343 (Public Law 110-335), which reauthorized Section 330 health center funding through the 2012 fiscal year, and the rural health clinic program.
27. HRSA/BPHC Program Assistance Letter 2008-05.
28. 72 Fed. Reg. 56632, October 4, 2007; *California Business and Professions Code* §650(c).
29. HRSA/BPHC. "Program Information Notice (PIN), 2003-21: Federally Qualified Health Center Look-Alike Guidelines and Application"; "PIN 2005-17: Revisions to Policy Information Notice 2003-21, Federally Qualified Health Center Look-Alike Guidelines and Application"; and "PIN 06-06: Revisions to Policy Information Notice

- 2003-21, Federally Qualified Health Center Look-Alike Guidelines and Application.”
30. The Balanced Budget Act of 1997 (Public Law 105-33) changed the rule about who may own or operate an FQHCLA.
 31. Information provided by the BPHC, October 23, 2008 and November 13, 2008.
 32. HRSA/BPHC. “Draft PIN for Comment: Federally Qualified Health Center (FQHC) Look-Alike Guidelines and Application, PIN 2008.” September 23, 2008.
 33. See www.ihs.gov.
 34. Indian health programs supported under the Indian Self-Determination and Education Assistance Act are called “638 programs.”
 35. See www.ihs.gov/nonmedicalprograms/urban/uihp.asp.
 36. See www.ihs.gov/nonmedicalprograms/urban/overview.asp.
 37. See endnote 34.
 38. Medi-Cal. “Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics.” *Medi-Cal Outpatient Services Manual*, pp. 1–5, as updated January 2008.
 39. See www.ihs.gov/facilitieservices/areaoffices/california/universal/pagemain.cfm?p=50.
 40. Public Law 95-210.
 41. House Report 95-548(I).
 42. A list of RHCs generated by the Centers for Medicare and Medicaid Services is available at www.cms.hhs.gov/MLNProducts/downloads/rhclistbyprovidername.pdf. A list of California RHCs is available at www.oshpd.ca.gov/rhpc/clinics. Also see 73 Fed. Reg. 36696, “Medicare Program: Changes in Conditions of Participation Requirements and Payment Provisions for Rural Health Clinics and Federally Qualified Health Centers,” June 27, 2008.
 43. 42 U.S.C.A. §1395x(aa). Also see 42 C.F.R. §§491 and 405(X).
 44. Gale, J.A., and A.F. Coburn. *The Characteristics and Roles of Rural Health Clinics in the United States*. Edward S. Muskie School of Public Health, University of Southern Maine, January 2003.
 45. List of hospital-based RHCs from 2003–04 from California Rural Health Policy Council personnel on December 16, 2008. There is no readily available recent data that delineates provider-based from freestanding RHCs.
 46. 42 C.F.R. §413.65.
 47. See www.oshpd.ca.gov/rhpc/funding/index.html for funding opportunities available to RHCs.
 48. The OSHPD 2007 Annual Utilization Report Data and the list of Medicare-certified Rural Health Clinics as reported by OSHPD in August 2008, report inconsistent data. Some licensed primary care clinics self-report as being 95-210 clinics when in fact they are not so certified. A few licensed primary care clinics that report to OSHPD are also listed as being Medicare-certified by OSHPD. Several clinics report as 95-210 clinics and as designated FQHCs or FQHCLAs. Technically, a clinic may not be designated as both a 95-210 clinic and an FQHC.
 49. *California Health and Safety Code* §1204(a)(1)(B).
 50. See www.freeclinics.us.
 51. List of free clinics provided by CDPH, Licensing and Certification, on November 17, 2008.
 52. Public Law 104-191, Sec. 194.
 53. OSHPD. *2007 Hospital Annual Utilization Data Notes, Pivot Profile* (www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/Hospital_Utilization.html).
 54. *California's Public Hospital and Health Systems: An Inside Look at Outpatient Services*. California Association of Public Hospital and Health Systems. 2001.
 55. List provided by HRSA, Nov. 13, 2008. Also see HRSA/BPHC. “Bureau of Primary Health Care Section 330 Grantees Uniform Data System, Calendar Year 2007 Data, California Rollup Report,” July 8, 2008.
 56. HRSA/BPHC. “Policy Information Notice 2007-09: Service Area Overlap: Policy and Process.”
 57. 42 U.S.C. §245b(k)(3)(H); also see 42 C.F.R. §51c.304.
 58. HRSA/BPHC. “PIN 98-12: Implementation of the Section 330 Governance Requirements.”

59. *California Health and Safety Code* §124174, as amended by Ch. 381, Statutes 2008 (SB 564), effective January 1, 2009.
60. *An Overview of California's School Health Centers*. California School Health Centers Association. December 2007 (www.schoolhealthcenters.org). Also see Senate Floor Analysis on SB 564, August 29, 2008.
61. 42 U.S.C. §245b(e).
62. Public Law 110-355.
63. *California Health and Safety Code* §1765.101, et seq.
64. For brief discussion of Federal Medical Assistance Percentage rate for states, see Office of the Actuary, Centers for Medicare & Medicaid Services. "Brief Summaries of Medicare & Medicaid, Title XVIII and Title XIX of the Social Security Act as of November 1, 2008."
65. California Department of Finance. "State Budget Highlights 2006–2007" (www.dof.ca.gov). California's total Medi-Cal expenditure for 2006–07 was budgeted at approximately \$35 billion.
66. See Centers for Medicare and Medicaid Services. "State Children's Health Insurance Program (SCHIP) Title XXI Federal Funds: Total Healthy Families Spending Projections (Children) and Summary of FY 2008 SCHIP Funding." January 10, 2008 (www.mrmib.ca.gov/mrmib/schipbackground.html).
67. *California Welfare and Institutions Code* §14166, et seq.
68. Centers for Medicare & Medicaid Services. "California Demonstration Fact Sheet: Medi-Cal Hospital/Uninsured Care." October 24, 2007 (www.cms.hhs.gov/medicaidstwaiverprogdemopgi).
69. Public Law 104-299.
70. HRSA/BPHC. "Bureau of Primary Health Care Section 330 Grantees Uniform Data System, Calendar Year 2007 Data, National Rollup Report." July 1, 2008.
71. U.S. Census Bureau population estimates for July 2007 (<http://factfinder.census.gov>).
72. HRSA/BPHC. "Bureau of Primary Health Care Section 330 Grantees Uniform Data System, Calendar Year 2007 Data, California Rollup Report." July 8, 2008.
73. The Migrant Health Act, signed into law in 1962 (Public Law 87-692), added Section 310 to the Public Health Service Act to establish the MHC program.
74. See <http://bphc.hrsa.gov/about/specialpopulations.htm>.
75. Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Public Law 109-415).
76. HRSA-09-100, Part C EIS: Categorical Grant Program to Provide Outpatient Early Intervention Services with Respect to HIV Disease; Application Guidance, CFDA Number: 93.918.
77. *Distribution of Ryan White Program Funding by Part, FY 2007*. Kaiser Family Foundation (www.statehealthfacts.kff.org). Also see *HIV/AIDS Policy Fact Sheet*. Kaiser Family Foundation. June 2008.
78. HRSA. "HRSA 2009 FY Budget Justification, Family Planning" (www.hrsa.gov/about/budgetjustification09/familyplanning.htm).
79. Data verified by Policy Department, California Family Health Council Inc., December 17, 2008.
80. The discrepancy between the annual appropriation and the reported revenue stream totals may be explained by program operations and administration of awards that allow clinics to bill against multiyear awards on an as-needed basis.
81. See www.dhcs.ca.gov/services/rural/pages/indianhealthprogram.aspx.
82. Brown, E. Richard, S.A. Lavarreda, E. Peckham, and Y.J. Chia. *Nearly 6.4 Million Californians Lacked Health Insurance in 2007—Recession Likely to Reverse Small Gains in Coverage*. University of California, Los Angeles, Center for Health Policy, December 2008.
83. Taylor, Mac. *California's Fiscal Outlook, OAL Projections 2008–09 Through 2013–14*. California Legislative Analyst's Office. November 2008.
84. Public Law 109-171.

85. *California: Health Insurance Coverage of the Total Population*, states (2006–2007), U.S. (2007) (www.statehealthfacts.kff.org).
86. U.S. Department of Health and Human Services, HRSA/BPHC. “Health Centers: America’s Primary Care Safety Net: Reflections on Success, 2002–2007.” June 2008.



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