California's Safety-Net Clinics: A Primer

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California's Safety-Net Clinics: A Primer

Prepared for
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About the Foundation

The **California HealthCare Foundation,** based in Oakland, is an independent philanthropy committed to improving California's healthcare delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at 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"[1] 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 difficult to pin down and define because of its loose structure and the diverse licensing, funding, mission, and relationships of its components. The safety net includes public hospitals and health systems, health care districts, community health centers and clinics, and for-profit and not-for-profit health care organizations that provide free or discounted care.

This report focuses on the outpatient clinic portion of the safety net, which is under strain but essential to delivering both primary and specialty care to millions of low-income Californians. These 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. These entities are collectively referred to in this report as safety-net clinics. The scope of services offered by a safety-net clinic depends in large part on its funding mandates and community need. Understanding the complex function, structure, and operational environment in which these clinics function is critical to understanding the underpinnings of California's health care safety net.

This report serves as a primer about California's safety-net clinics. It includes:

- A discussion of the character of safety-net clinics;
- An overview of the requirement for state licensure;
- A general description of the demographics of those served by safety-net clinics;
- A basic explanation of the types of services provided;
- An outline of key reimbursement and funding mechanisms;
- A description of the various categories of safety-net clinics; and
- A brief analysis 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 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. Safety-net clinics may be operated by for-profit corporations, public agencies, or private, nonprofit organizations. There is no legal definition of a safety-net clinic. The majority of safety-net clinics in California are operated by public agencies, including public hospitals and health systems,[2] health care districts,[3] or private, nonprofit corporations. These organizations 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 (described further in Section VI) are required by federal law to provide certain services. Similarly, counties operate clinics to provide services pursuant to the Section 17000 mandate under state law.[4]

Safety-net clinics that are operated by nonprofit corporations are eligible for state licensure as primary care clinics. Safety-net clinics may also be exempt from state licensing based on the category of clinic. An overview of the requirements for state licensure will help the reader better understand the genesis of safety-net clinics in California.

III. Licensing Requirement Overview

Protection of the public health was a primary imperative of the clinic permit law; another was the regulation of the corporate practice of medicine.

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, and governmental agencies, were required to obtain permits from the State Board of Public Health to operate. Protection of the public health was a primary imperative of the clinic permit law; another was the regulation of the corporate practice of medicine.

The predecessor to today's licensed primary care clinic was described in statute 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 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 agency and funding streams evolved, so did the clinic licensing law. In 1971 "community clinic" was defined in statue 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. "Free clinic," defined for the first time in 1976, was a clinic operated by a nonprofit corporation that did not charge or collect any fee directly from patients for services. However, while not statutorily defined as community clinics, clinics operated by counties and cities, health care districts, and private providers may be known in the communities they serve as "community" or "free" clinics.

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 & Safety Code to include community clinics and free clinics. These clinics were eligible for licensure as primary care clinics. 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 did not require a state license.

The basic definition of primary care clinic as it stands today has been written in state statute since 1985. Primary care clinics operated by nonprofit corporations are the only safety-net clinics required to be licensed by the California Department of Health Services (CDHS), Licensing and Certification Division. Licensed primary care clinics include private non-profit federally-funded clinics known as federally qualified health clinics (FQHCs), FQHC look-alikes, free-standing nonprofit 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.

Licensed primary care clinics are subject to strict governmental oversight and must maintain certain quality standards as defined by law. If qualified, they also may obtain enhanced reimbursement from some government health programs and have access to various funding sources for serving designated populations. An overview of key reimbursement and funding sources for safety-net clinics is presented in Section VII.

IV. Who Is Served by Safety-Net Clinics?

Data reveal that the 768 clinics reporting in 2003 served more than 3.2 million people, providing more than 10 million patient visits.

Safety-net clinics serve primarily those who are uninsured, underinsured, and publicly insured (i.e., the beneficiaries of California's Medi-Cal and Healthy Families programs). There is no one comprehensive data source that reports use for all safety-net clinics. The actual demographic composition of people served by any one clinic depends on the scope of clinic services, the special populations served, and where the clinic is located. One consistent variable is family income. Public clinics and private, nonprofit safety-net clinics by and large serve the poorest of the poor in California.

Public Clinics

It is difficult to draw a comprehensive picture of the individuals who use California's public clinics. Though some data are available from hospitals that report annual utilization information to the Office of Statewide Health Planning and Development (OSHPD),[5] city and county clinics and clinics operated by health care districts are not required to make such reports, leaving an incomplete picture. For those clinics affiliated with the county hospitals or hospitals operated by health care districts, clinic patient demographics may mirror those that are reported in hospital utilization data. (Hospital discharge data were not analyzed for this report.)

The California Association of Public Hospital and Health Systems (CAPH) estimates that more that 11 million patient visits were provided in 1999 by clinics affiliated with public hospitals, representing almost half of all outpatient visits to hospitals by uninsured and publicly funded patients. Approximately 80 percent of the patients served were classified as Latino, African American, Asian/Pacific Islander, or Native American. Of the total patient population, approximately 42 percent were uninsured.[6]

Private, Not-for-Profit Clinics

Licensed primary care clinics are required to file annual utilization reports with OSHPD, and those data make up the best source of information about demographics of the people served by private not-for-profit safety-net clinics in California. Data reveal that the

768 clinics reporting in 2003 served more than 3.2 million people, providing more than 10 million patient visits. Of these individuals, approximately 81 percent had family incomes at or below 200 percent of the federal poverty level (FPL).[7]

The private, nonprofit licensed clinics primarily serve women and children. In 2003, 67 percent of the patients served were ages 19 and under. Sixty-six percent of the patient population was female; of those, about half were of childbearing age.[7]

Forty-seven percent of the people served did not use English as their primary language. Fifty-one percent of patients identified as Hispanic, although the clinics serve a cross-section of races and ethnicities. Nearly 350,000 migrant workers were served in 2003.[7]

California's federally funded health centers provided services to more than 1.8 million patients. Of those:

- 95 percent had family incomes below 200 percent of the FPL;
- 46 percent were uninsured;
- 38 percent had Medi-Cal coverage;
- 78 percent were racially/ethnically identified as "non-white";
- 52 percent were considered to be best served in a language other then English;
- 61 percent of patients were identified as Hispanic or Latino; and
- 61 percent of the services delivered were pediatric and women's health services.[8]

California's safety-net clinics — regardless of type or affiliation — serve populations that are demographically similar. Safety-net clinic patients are poor, racially and ethnically diverse, and are often women and children.

V. Services Provided

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

Many safety-net clinics focus on preventive and primary care services, but a wide array of other services may be provided, depending on community need, funding, and licensing limitations. Other services include dental care, optometry and ophthalmology, podiatric care, pediatric and women's health services (including obstetrical 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, and radiology, and other special services.

In addition, many safety-net clinics offer social support transportation, translation, and health education services. Licensed primary care clinics are required to provide or arrange for a whole range of diagnostic, therapeutic, radiology, laboratory, and other services for the care and treatment of patients.

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 private, nonprofit organizations, although other types exist, including some run by private employers or other groups.

Public clinics include those sponsored by cities, counties, and health care districts. They may be hospital-affiliated or freestanding, community-based clinics that may also be federally designated as FQHCs, FQHC look-alikes, or rural health centers (RHCs). Private, nonprofit clinics include FQHCs, FQHC "look-alikes," nonprofit 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 Section 330 grantees (87 in California; FQHC look-alikes (36 in California) and Indian Health Service clinics (29 in California).
- Rural Health Clinics
  Established to help underserved communities; 241 certified in California.
- Free Clinics
  May not charge patients for services; 32 in California.
- County-Run Clinics
  Include facilities run at county hospitals, in freestanding clinics or contracted out.
- Private and Other Types
  Includes family planning clinics, school-based clinics, and some run by university health systems, private hospitals, employers, and private individuals. Numbers of facilities not available.

Federally Qualified Health Centers

The FQHC designation for the purposes of Medicare and Medicaid was first defined by 1989 amendments to the Social Security Act.[9] FQHCs receive enhanced reimbursement from Medicare on the basis of reasonable cost and from Medicaid based on a prospective payment system rate that is required to approximate the FQHCs reasonable cost per visit. An FQHC may be a public or a private nonprofit entity that:

- Receives a grant under Section 330 of the Public Health Service (PHS) Act;
- Meets the requirement 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 (but does not receive 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 Act[10]; or
- Is an urban Indian organization that receives funding under Title V of the Indian Health Care Improvement Act[11] for the provision of primary care services.

Safety-net clinics that are designated as FQHCs are further described below.

Section 330 Grantees

All recipients of grants under section 330 are public or private, nonprofit, or tax-exempt organizations. Organizations eligible to compete for Section 330 funding include tribal, faith-based, and community-based organizations.[12]

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

- Be located in or serve a high need community, i.e., "medically underserved areas" or "medically underserved populations";
- Provide, either directly or through contracts or cooperative arrangements, a broad range of primary care services, as well as supportive 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 a individual's ability to pay;
- 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 receipt of a Section 330 grant provides eligibility for other federal grants and programs. For example, Federal Tort Claims Act (FTCA) 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 all specific FTCA requirements.[12] In addition, FQHCs and health centers designated as FQHC look-alikes may participate as covered entities in the drug pricing program established by Section 340(b) of the PHS Act.

FQHC Look-Alikes

A public or private, nonprofit entity that otherwise meets Section 330 program requirements may be certified as an FQHC look-alike if it does not receive funding under Section 330 but has established a governance structure, and operates, and provides services similarly to those centers that do receive Section 330 funding. A public or private, nonprofit organization may separately apply for FQHC look-alike status.[13]

Look-alike status allows for enhanced reimbursement under Medicare and Medicaid and may allow the health center to participate in other federal programs.

An entity applying for FQHC look-alike status must:

- Be operational at the time of application.
- Not be owned, controlled, or operated by another entity.[14]
- Serve, in whole or in part, a federally medically underserved area (MUA) or a medically underserved population (MUP).

As of July 2005, there were 111 FQHC look-alikes approved nationally with a total of 235 sites. In California 36 FQHC look-alikes have been approved by HRSA. These operate 84 sites.[15]

Operated by Tribes or Tribal Organizations

The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, operates a comprehensive health care system that serves just more than half of the estimated 2.6 million American and Alaska Natives in the United States. The system includes 36 hospitals, 61 health centers, 49 health stations, and five residential treatment centers.[16] IHS also contracts with non-IHS providers through the Contract Health Services (CHS) Program for services that are not available within its own network or through tribal programs. IHS and tribal facilities receive both Medicaid and Medicare reimbursement. Reimbursement is based on an "all-inclusive rate" negotiated between Centers for Medicare and Medicaid Services and the IHS. The legislative authority for IHS funding is provided by the Snyder Act of 1921.

Federally recognized tribes are provided the option under the Indian Self-Determination and Education Assistance Act[17] to administer and operate health care programs in their communities through contractual relationships with the IHS or its agencies, or to continue to access services through the IHS system. The Indian Health Care Improvement Act (IHCIA) of 1976[18] was passed to support the options of the Indian Self-Determination and Education Assistance Act. Although the IHCIA expired in 2001, Congress has continued to appropriate funds for IHCIA programs under the Snyder Act.

The Urban Indian Health Programs (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 is now supported through grants and contracts from the IHS, under Title V of the IHCIA. Although 25 percent of the Native American population lives in urban areas that are served by UIHP, the program serves only about 6 percent of the Native American population.

UIHP facilities are automatically qualified to receive 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. Reimbursement for clinics and health centers is based on FQHC or RHC guidelines rather than the IHS negotiated rates.

Rural Health Clinics

The rural health clinic (RHC) designation was created by enactment of the Rural Health Clinic Services Act of 1977.[19] The primary purpose was to address the inadequate supply of physicians to serve Medicare and Medicaid beneficiaries in rural areas.[20] The model sought to improve access to primary care and emergency services in underserved, rural communities, and to promote use of a collaborative model between physicians and non-physician providers, such as nurse practitioners and physician's assistants, to provide health care services. There are nearly 3,500 RHCs certified in the United States.[21] As of February 2005, there were 241 RHCs certified in California.[22]

To qualify as an RHC, an entity must:

- Be located in a non-urbanized area as defined by the U.S. Census Bureau and in a geographic or population-based Health Professional Shortage Area (HPSA), a MUA as designated by HRSA, or an area designated as a health professions shortage area by the governor of the state;
- Employ or contract with a nurse practitioner, a physician assistant, or a certified nurse midwife available to furnish patient care services at least 50 percent of the time that the RHC 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.

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

- May be operated by a for-profit entity.
- May not be simultaneously designated as an FQHC, but can move from RHC to FQHC status.
- May be independent or free-standing or provider-based, as an integral and subordinate part of a Medicare participating hospital, skilled nursing facility, or home health agency.
- Are not mandated to provide care to everyone regardless of ability to pay.
- Are not mandated to provide the comprehensive set of preventive and primary services required of FQHC-designated clinics.

Because RHCs are not required to maintain an open door policy and may be operated by for-profit entities, these types of entities are not considered to be safety-net clinics in the most traditional sense. However, increasingly RHCs are viewed as safety-net providers in the rural communities they serve because their patient mix tends to include self-pay, uninsured, Medicaid, and other vulnerable populations. RHCs are frequently operated by independent practitioners as freestanding clinics that are often 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 covering the provision of free or reduced cost services to low-income patients.[21] 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.

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.

Medicare and Medi-Cal account for 55 percent of RHC revenues. Commercial and private insurance represent 30 percent of revenue and private pay and free/reduced cost care account for 15 percent. RHCs are paid on a cost-based, all-inclusive rate for a visit. Medicare payments to RHCs are capped and adjusted annually; Medi-Cal reimbursement is based on a prospective payment system similar to reimbursement for FQHCs.[21]

In California, a few free-standing RHCs, which are not operated as private practices, are licensed as primary care clinics.[7] The exact number is unclear but is believed to be few.[23]

Free Clinics

"Free clinic" is specifically defined in 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." A free clinic is not permitted to charge patients directly for services rendered or for drugs, medicines, or equipment or supplies furnished.[24] 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 on private donations to support clinic operations.

There is no readily available national data source to describe the patient demographic of free clinics. The National Association of Free Clinics estimates that the nation's free clinics provide services to more than 3.5 million of the nation's uninsured and underinsured individuals.[25] As of December 31, 2004, OSHPD reported that 32 primary care clinics were licensed as free clinics in California.[7] At least four of these free clinics have obtained FQHC or FQHC look-alike status. Six licensed free clinics operate exclusively for pregnancy-related care and counseling and served a total of less than 250 patients in 2003.[7] California's free clinics provided a range of primary care services for nearly 126,400 patients in 2003.[7]

Free clinics may be eligible to participate in federal and state health programs. For example, in 1996, Section 224 of the PHS Act was amended to extend Federal Tort Claims Act coverage for volunteer free clinic health professionals. 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; they use various systems of care and levels of service to fulfill this mandate. County-owned and operated clinics may be eligible for FQHC designation status if the governance structure of the FQHC meets program requirements. Three 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. Currently 15 counties own and operate hospitals in the state, with an additional three counties contracting with the University of California, and one with the nonprofit Community Medical Centers in Fresno, to provide safety-net services through their medical centers. While public hospitals account for only 6 percent of all hospitals statewide, they provide almost 25 percent of all outpatient visits.[6]

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 by 27 percent.[6] This mirrors a national trend toward increasing outpatient visits and decreasing inpatient charges.

Public hospital systems have three different models of governance. 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 that is separate from the county board of supervisors governs the county hospital system. Finally, Fresno, San Diego, Orange, and Sacramento 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 may also operate publicly owned, freestanding clinics as community-based safety-net clinics. They may be part of a larger public hospital system, or separately operated by the county public health department.

County Medical Services Program (CMSP)

- Established in January 1983, when responsibility for indigent care transferred from states to counties.
- Smaller rural counties (300,000 or fewer) did not have infrastructure to support a system, so they contracted with California Department of Health Services (DHS) to provide services.
- Established by DHS to administer indigent care services for these counties.
- Now provides health coverage to low-income indigent adults in 34 California counties.
- 11-member governing board provides policy direction for the program; sets beneficiary eligibility requirements; determines scope of covered health care benefits; and sets payment rates paid to health care providers participating in CMSP.

Source: County Medical Services Program, (www.cmspcounties.org/about/about.htm).

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 CMSP providers. There is a growing trend for counties to create efficiencies by contracting services out to other existing safety-net providers rather than providing services directly. Increasingly counties are also seeking FQHC or FQHC-look alike designations for freestanding clinics in order to access enhanced reimbursement under Medicare and Medi-Cal. For example, Los Angeles County has several FQHC applications pending.

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; school-based clinics operated by community organizations; and others. These clinics offer a host of health care and health education services to underserved and vulnerable, low-income populations, and rely on reimbursement from an array of public health programs, such as Family PACT, CHDP, and Healthy Families, and Title X funding, sliding scale fees, reimbursement from private third-parties, and private donations to remain operational.

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

VII. Reimbursement and Funding for Safety-Net Clinics

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.

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. For more details about the programs described below, see Appendix A.

Government Health Programs

Medi-Cal

Medi-Cal, California's Medicaid program, accounts for nearly one-third of the total revenue for private, nonprofit licensed primary care clinics (and approximately one-quarter of the revenue for public clinics, which are not discussed in detail here).[6,7] Medicaid is a federal program, authorized by Title XIX of the Social Security Act, entitling eligible beneficiaries to specific basic health care services. States that elect to participate in federal programs 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 government matches state spending for Medicaid services at a rate that varies by state from 50 to 77 percent.[26] California receives a 50 percent match.

The amount of patient revenue derived from Medi-Cal for licensed primary care clinics reporting to OSHPD in 2003 was $480.8 million, representing 38 percent of gross revenues from various payer sources but less than 2 percent of the state's total Medi-Cal budget.[7]

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

Medicare

The Medicare Part B program accounts for approximately 8 to10 percent of total gross revenues for safety-net clinics.[6,7,8] Medicare, a program for the elderly and disabled, is authorized by Title XVIII of the Social Security Act. Safety-net clinics enroll in the Medicare program as providers and are paid for Medicare services through regional fiscal intermediaries. Although not normally covered as a benefit, the Medicare Part B program pays for preventive care service to Medicare beneficiaries when these are delivered to FQHC or RHC patients.

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. The federal government provides a medical assistance match of 65 percent and California pays 35 percent of Healthy Families expenditures.[26] Less than 2 percent of the total gross revenues for licensed primary care clinics are derived from contracts for services provided to Healthy Families enrollees.[7]

Other Government Health Programs and Funding Sources

Other government health programs provide limited services or services for specific populations. These programs include:

- County Health Care for Indigents Program, including the County Medical Services Program and the Medically Indigent Services program;
- Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program;
- Comprehensive Perinatal Services Program;
- Breast and Cervical Cancer Control Program; and
- Children's Health and Disability Screening Program (CHDP).

These are operated as separate health programs in California and account for nearly one-third of the patient-based revenues from various payer sources for licensed primary care clinics.

Government Grant Programs

There are several key federal and state grant programs that provide important operating revenue for California's safety-net clinics.

Federal Bureau of Primary Health Care (BPHC) Programs

Federal grant programs administered by the BPHC within the Health Services Resource Administration (HRSA) fund clinic operations and/or services provided by safety-net clinics in the United States and its territories. Clinics that qualify to receive this funding are designated as federally qualified health centers.

The BPHC also sets aside funding to encourage existing health centers to establish new access points (clinic sites). Organizations seeking funding to establish new access points to serve specific areas and/or populations that are not served by existing grantees must also compete for funding on a national basis.

In 2004, the Consolidated Health Center Programs provided funding to 914 grantees nationally, awarding a total of more than $1.4 billion.[27] California is home to more Section 330 grantees than any other state. However, the total award to California grantees is disproportionate based on its proportion of the U.S. population.While California's population represents 12 percent of the total U.S. population,[28] California grantees receive approximately 10 percent of the Section 330 funding. Eighty-seven California grantees, representing 9.5 percent of the total number of grantees nationwide, received $141.6 million in 2004 to provide services to more than 1.8 million people.[8,27]

Consolidated Health Center Programs Timeline

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, and transitional and permanent housing and health services for the homeless.

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

The Consolidated Health Center Programs include four key programs administered by BPHC as described below. A brief overview of the SBHC program and HCAP, both of which were later added to the organization's purview, is also provided.

Community Health Center (CHC) Programs

The primary goal of the 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 2004, the CHC program accounted for 80.8 percent of the total funding for the Consolidated Health Center Programs.[27] Almost 83 percent of California Section 330 grantees received CHC program grants. As a whole, California clinics drew down approximately $98.8 million in CHC funds, less than 8.5 percent of the total available program dollars.[8]

Migrant Health Center (MHC) Program

The MHC program[29,24] provides grants to community nonprofit organizations for a broad array of culturally and linguistically competent medical and support services to meet the special need of migratory and seasonal farmworkers and their families.

In 2004, the MHC program accounted for about 7.4 percent of total Section 330 funding.[27] California safety-net clinics drew down nearly $20.3 million, accounting for about 19 percent of the total dollars spent for that program nationally. Approximately 14.3 percent of California Section 330 grantees received MHC program funding, representing 19 safety-net clinics. In California 280,295 migrant workers and their family members receive services paid in part by the MHC program.[8,27]

Health Care for the Homeless (HCH) Program

The HCH program is the sole federal program addressing the primary health care needs of homeless people. The program's goals are to maintain access to comprehensive primary and preventive care and 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 2004, the HCH program accounted for approximately 8 percent of total Section 330 funding.[27] Twenty California public and nonprofit agencies, including safety-net clinics, received HCH funding. The total program dollars spent in California for that year were about $18.5 million, representing a

little more than 16 percent of the total HCH dollars nationally. Services were provided to 135,839 Californians with HCH funds.[8,27]

Public Housing Primary Care (PHPC) Program
The PHPC program provides residents of public housing access to comprehensive, consistent, and affordable health care services through the direct provision of primary health care services, health promotion, and disease prevention activities. The PHPC program accounts for 1.2 percent of the total Section 330 funding.[27] In 2004, five California safety-net clinics received PHPC funding totaling $2.26 million, equal to 13 percent of the total funding nationally. Services were provided to more than 25,000 people.[8,27]

School-Based Health Center (SBHC) Program
Although there is no legislative mandate explicitly authorizing the SBHC program, it is administered by the BPHC within the general authority for the Section 330 program. Organizations that received SBHC funding must maintain access to comprehensive primary and preventive health care services, including referral and follow-up for students and others in the community where the SBHC is located. The SBHC program accounts for 1.4 percent of total Consolidated Health Center Programs funding and is not a significant source of grant revenue for California safety-net clinics. While there are approximately 121 school-based health centers in California[30] that operate on a mixed revenue stream, seven California safety-net providers received SBHC program funding in 2004 of $1.6 million. These seven grantees provided services to 12,417 students and community members.[8]

Healthy Communities Access Program (HCAP)
HCAP provides grant funding and technical assistance to consortia including public and private health care providers, social service agencies, local government and other community-based organizations that work together to coordinate and strengthen health services and expand access to care for the uninsured and underinsured in their communities. HCAP is modeled after the Community Access Program (CAP), which began operating as a demonstration grant program beginning in 2000.

In 2004, HCAP provided approximately $103.7 million in grants nationwide to safety-net consortia. There are about 20 CAP/HCAP grantees in California, including a few individual safety-net clinics. Only one new California grantee received an award in 2004.[31]

In 2005, approximately $35 million will be available for up to 35 new HCAP grantees with the possibility of funding for one additional year, and $4.8 million is expected to be available for existing HCAP grantees.[32] Safety-net clinics that do not directly access this federal grant source may receive subawards or contracts for particular grant projects from the consortia of HCAP grantees.

Ryan White Title III HIV Early Intervention
Ryan White funding provides early intervention and primary care services to individuals 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 services and nutritional services, and referrals for specialty services. A primary emphasis is on increasing access to HIV primary care and support services for communities of color. The program is administered by HRSA and authorized under Title III of the PHS Act. Grantees must be public or private non-profit agencies. The average size of multi-year grant awards is approximately $400,000.[33] While Ryan White funding is a significant source of grant revenue nationally (in 2003 approximately $185.4 million in Title III funding was distributed), California safety-net clinics received approximately $19.5 million from Title III in 2003.[34]

Family Planning Services Title XX Program
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 solely dedicated to family planning and reproductive health with a mandate to provide a broad range of acceptable and effective family planning methods and services. The primary grantee in California, the California Family Health Council, Inc. (CFHC), a nonprofit organization, administers subawards to safety-net providers. Nearly 65 public and non-profit agencies, which operate more than 260 safety-net clinics in California, receive funding through a competitive grant process. Total funding dispersed through CFHC in 2005 is estimated at $16.6 million.[35]

State-Based Grant Programs

In California, there are a few state-based grant programs available to 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 (PRHCSB) with the Primary Care and Family Health Division of the CDHS, 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
- The Indian Health Program.

One key source of funding to offset the cost of services to the uninsured, the EAPC program is available to safety-net clinics that are licensed primary care clinics or clinics operated by tribal organizations and that meet 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 the cost of care for the uninsured individuals, whose family income is at or below 200 percent of the FPL, on a per visit basis. In 2003, safety-net clinics provided 522,950 EAPC encounters that brought in approximately $50.6 million for licensed primary care clinics.[7] The state budget allocation for this program in 2005–06 is $30.2 million; $20 million from the General Fund and the remainder from the Proposition 99 fund, unchanged from prior years.[36] By contrast, the combined annual General Fund allocation for the RHSD and the SAMW programs is less than $15 million for fiscal years 2004–07.

Another small source of funding, derived from the state general fund, is the Indian Health Program (IHP). The IHP administers a grant program to provide financial and technical assistance to Indian health programs, including safety-net clinics. Grantees provide a combination of community health, medical, and dental care to American Indians in rural or urban areas of California grantees and must meet specific program guidelines. According to IHP's program description, 627,562 Californians identify as American Indian and Alaska Native based on 2000 U.S. Census data. The total budget for the IHP in fiscal year 2004–05 was $6.46 million with more than $6 million distributed to 29 primary care clinics.[37]

Other Revenue Sources

Safety-net clinics derive other revenues 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 less than 23 percent of total gross revenues for licensed primary care clinics.[7]

Table 1. Most Common Funding Sources for Section 330 Grantees in 2003

Category	Type	U.S.	CA
Federal Grant	§330 Grants	22.2%	14.6%
	Other Federal	3.3%	2.0%
Non-Federal Grant	State & Local	9.4%	14.3%
	Foundation/Private	3.2%	4.5%
Patient Services	Patient Self-Pay	5.9%	4.6%
	Medicaid	35.5%	39.0%
	Medicare	5.5%	4.7%
	Other	8.7%	8.9%
Other Revenue	Indigent Care Programs	3.9%	5.3%
	Other	2.5%	1.9%

VIII. Issues Facing Safety-Net Clinics

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

BASED ON RESULTS OF THE 2003 CALIFORNIA HEALTH Interviews Survey, 6.6 million people in California were uninsured for some part of the year.[38] As the number of uninsured in California rises and funding levels from most sources decrease because of budgetary constraints, the burden on safety-net clinics to meet their open-door mandates will likely increase.

Unlike many for-profit health care entities, the funding for safety-net providers is heavily weighted toward reimbursement from governmental health care entitlement programs. In addition, these clinics rely on a patchwork of public and private discretionary funding to support direct services and operations. With such a small number of payer sources, clinics have limited ability to shift costs to pay for uncompensated care. There is no stable base of non-discretionary funding for safety-net clinics.

Other factors that weigh on safety-net clinics:

Medi-Cal Managed Care. Intense competition in the health care marketplace for Medi-Cal enrollees under managed care cuts into the safety-net clinics' largest payer source. This is a significant problem for safety-net clinics that rely on enhanced reimbursement from Medi-Cal to offset the cost of care to the uninsured.

Medi-Cal redesign. Safety-net clinics are further strained by the initiative to move more people eligible for Medi-Cal into managed care, to limit the number of Medi-Cal eligible through altered eligibility determinations, and to limit benefits for those Medi-Cal beneficiaries. Limiting eligibility will result in even greater numbers of uninsured. Limiting reimbursement for benefits — such as dental services, which safety-net clinics are required to provide — results in a greater level of uncompensated care for these providers.

State/county budget crises. The economic downturn has forced virtually all states to reduce program budgets. While California's overall Medi-Cal budget for fiscal years 2005–06 has increased, most of the increases will support the Medi-Cal redesign proposals. Funding for programs for the uninsured has remained flat. County budget shortfalls resulting in program cutbacks also affect

safety-net clinics that are county-based or county contracted.

Increasing uninsured population. Safety-net clinics serve a disproportionate number of uninsured patients relative to other types of providers of outpatient services. California has one of the highest uninsured rates in the nation, with 18 percent of all residents lacking health insurance.[39] Growing numbers of uninsured put additional strain on safety-net clinics that by mission or mandate maintain an open door policy.

Increasing immigration. The foreign-born population in the United States has increased from 7.9 percent in 1990 to 11.8 percent in 2003. The foreign-born population in California was approximately 26.2 percent in 2000 and was estimated at 26.5 percent in 2003.[40] In California, this means even greater pressure to communicate with patients in a language other than English. Although the increasing emphasis on culturally appropriate services cuts across all health care sectors, until this is incorporated as a service mandate for all providers who are reimbursed by public health programs, patients will rely on safety-net clinics that have a proven track record in the delivery of services to non-English speaking clients. Because these patients tend to be uninsured, safety-net clinics will bear much of the cost of their care.

Federal budget deficits. The federal government is undergoing a major budget overhaul, with many social services programs, including Medi-Cal and the Consolidated Health Care Programs, subjected to significant cuts. The proposed budget includes plans to reduce Medicaid costs, posing major challenges to safety-net clinics that rely heavily on Medicaid revenues.

Technologically Driven Changes in the Health Care Market. During the last five years, the federal government has undertaken a major initiative to standardize and encourage electronic claims processing to third-party payers. Electronic storage and transfer of medical records is rapidly becoming the norm. Safety-net providers are striving to keep pace with technology changes. Although there has been support in the form of technical assistance and funding from government and nonprofit sources to assist these providers, the availability of resources has not kept up with the demand. Long-term viability of safety-net providers in the health care marketplace will depend, in part, on their technologic sophistication.

In the face of these challenges, clinics are supported by the following strengths:

Mission-driven clinics have a proven track record in the communities they serve. 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.

Local and national political support. Bipartisan support on the local and national levels has increased over the years as health centers have become 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 with the president's Health Centers Initiative. The initiative's goal was to strengthen the health care safety-net for all Americans. Nearly 500 new and expanded health center sites nationwide were funded from 2001 to 2004 through the Consolidated Health Center Programs, many of which are located in California. The original proposed 2005–06 budgets included funds to expand the number of people served at health centers to 16 million. However, the president's recently submitted budget has called for a sizable decrease in funding for the initiative. Sustainability for newly established health centers will be an issue.

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.

California Consortia and the Counties They Serve

Alameda Health Consortium/Community Health Center Network (AHC/CHCN)
Alameda County
(www.chcn-eb.org)

Alliance for Rural Community Health (ARCH)
Sonoma, Lake, and Mendocino Counties
(www.ruralcommunityhealth.org)

Central Valley Health Network (CVHN)
San Joaquin, Kern, Inyo, Colusa, Calaveras, Solano, Del Norte, 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)
Orange County
(www.coccc.org)

Community Clinic Association of Los Angeles County (CCALAC)
Los Angeles County
(www.ccalac.org)

Community Clinic Consortium of Contra Costa
Contra Costa County
(www.clinicconsortium.org)

Community Health Partnership (CHP)
Santa Clara County (www.chpscc.org)

Council of Community Clinics (CCC)
San Diego and Imperial Counties
(www.ccc-sd.org)

North Coast Clinics Network (NCCN)
Humboldt, Trinity, and Del Norte Counties
(www.northcoastclinics.org)

Northern Sierra Rural Health Network (NSRHN)
Lassen, Modoc, Siskiyou, Shasta, Sierra, Nevada, Plumas, Tehama, and Trinity Counties
(www.nsrhn.org)

Redwood Community Health Coalition (RCHC)
Marin, Napa, Sonoma, and Yolo Counties
(www.rchc.net)

Sacramento Community Clinic Consortium (SCCC)
Sacramento County
(www.sacconsortium.org)

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

Shasta Consortium of Community Health Centers (SCCHC)
Shasta, Lassen, and Siskiyou Counties
(www.shastaconsortium.org)

IX. Resources for Safety-Net Clinics

Clinic associations and consortia provide technical assistance, policy information, training, advocacy, and sometimes act as funding conduits for safety-net clinics.

Clinic associations and consortia provide technical assistance, policy information, training, and advocacy, and sometimes act as funding conduits for safety-net clinics. Some of these organizations receive federal funding. The BPHC funds state and regional primary care associations (PCAs) and primary care offices (PCOs), which are generally state agencies. Technical assistance cooperative agreements between the PCAs and PCOs are also supported with this money. In California the PCA is the California Primary Care Association; OSHPD is the PCO.

In addition, the BPHC funds clinic consortia through the HCAP program. Regional consortia — which support the collaboration between clinics and health centers, or between clinics and other types of health care providers, located 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 do 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 national and state-based organizations supporting safety-net clinics, including California clinic consortia, is available in Appendix C.

In addition to funding from BPHC and other federal programs, many safety-net clinic associations are supported by private foundation grants to carry out their operations and special initiates to benefit safety-net clinics. For more information see Appendix A.

Table 2. California's Regional Consortia (December 31, 2003)

Name	Counties Served	Members/Sites	Patients Served
Alameda Health Consortium/ Community Health Center Network	Alameda	7/37	150,000
Alliance for Rural Community Health	Lake, Mendocino, Sonoma	6/9	37,000
Central Valley Health Network (CVHN)	Sacramento, San Joaquin Valley	13/98	445,000
Coalition of Orange County Community Clinics	Orange	17/38	506,000
Community Clinic Association of Los Angeles County (CCALAC)	Los Angeles	42/114	536,000
Community Clinic Consortium of Contra Costa	Contra Costa	3/11	45,000
Community Health Partnership	Santa Clara	8/25	Not available
Council of Community Clinics	San Diego	17/70	Not available
North Coast Clinics Network	Humboldt, Trinity, Del Norte	5/12	47,000
Northern Sierra Rural Health Network	Northeastern California (9 counties)	14/28	81,000
Planned Parenthood Affiliates of California	State (33 counties)	9/102	Not available
Redwood Community Health Coalition	Sonoma, Marin, Yolo, Napa	15/35	147,000
San Francisco Community Clinic Consortium	San Francisco	10/13	67,000
Shasta Consortium of Community Health Centers	Shasta, Lassen, Siskiyou	5/17	Not available

X. Conclusion

In the current operational climate these clinics face major challenges to long-term sustainability and expansion to meet the needs of growing numbers of uninsured.

Safety-net clinics have become indispensable components of the health care system for vulnerable and underserved populations. However, these clinics rely on a patchwork of funding sources to provide comprehensive primary care and preventive services in the communities they serve. In the current operational climate these clinics face major challenges to long-term sustainability and expansion to meet the needs of growing numbers of uninsured.

Appendix A: Detail on Reimbursement and Funding Programs

Medi-Cal

Medi-Cal is authorized by the California Welfare and Institutions Code and implementing regulations. The federal Medicaid program provides a 50 percent match to the state toward California's expenditures for Medi-Cal services.[27] The Medi-Cal program includes a specific scope of federally mandated and optional benefits that must be available to all eligible beneficiaries under the program. FQHC and RHC services are included as mandatory Medi-Cal benefits under both state and federal law.[41]

Safety-net clinics participate in the Medi-Cal program as direct service providers or as managed care subcontractors. Licensed primary care clinics elect to be certified and enrolled to participate in the Medi-Cal program through the state's clinic licensing process. Safety-net clinics that are not required to obtain a state licensure are nonetheless required to apply for Medi-Cal certification and enrollment.

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.

Medicare

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

State Children's Health Insurance Program

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. Less than 2 percent of the total gross revenues for licensed primary care clinics are derived from contracts for services provided to Healthy Families enrollees.[7] Safety-net clinics are not reimbursed at an enhanced rate for these services.

Other Government Health Programs and Funding Sources

The Family PACT program is administered by the California's Office of Family Planning within the CDHS, Primary Care and Family Health Branch. As a Medicaid waiver program, the Family PACT services are included under the Medi-Cal schedule of benefits in California Welfare & Institutions Code §14132(aa). The state's expenditures for the program are matched by the federal government at 90 percent. The program accounts for about 12 percent of the gross revenue for licensed primary care clinics.[7]

There are also additional funding streams for some county-operated clinics. These include:

Realignment funds. In 1991, the California legislature realigned sales tax and vehicle license fees revenue to compensate for some health programs being shifted from the state to the counties. While the counties are mandated to establish specific health and mental health accounts, county officials are given discretion as to how the funds are spent. Neither account is earmarked especially for clinics. Vulnerable to changes in the state economy and political mandates (such as the reduction in the vehicle license fee in 2002), realignment funding is not a stable source of health care funding for counties.

County general funds. Local governments may choose to use county general fund dollars to support local health care programs. This funding is discretionary and vulnerable to changes in the county budget and local priorities.

Federal Disproportionate Share Hospital (DSH) funding. Public hospital systems and private disproportionate share hospitals that serve a particularly large number of uninsured and Medi-Cal patients receive supplemental reimbursement in Medi-Cal. Technically,

this funding is intended to cover provision of inpatient services. DHS funding for clinics is available only to the extent that hospitals choose to shift funds from the hospital to outpatient clinic services. There is currently a move to freeze DSH funding as part of California's Medi-Cal redesign proposal. In theory this will amount to a cut in funding given rising health care costs nationally and statewide.

Federal Bureau of Primary Health Care Programs

The Health Centers Consolidation Act of 1996[42] authorized the U.S. Department of Health and Human Services to consolidate administration of various community-based health programs authorized under Section 330 of the Public Health Service Act. 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 improve health status of medically underserved populations."[43] Section 330 funding is intended to help to defray the cost of health care services to the uninsured.

The Health Care Safety-Net Amendments of 2002 reauthorized the Consolidated Health Center Programs through 2006 and established the Healthy Communities Access Program (HCAP).[44] In addition, in 1994, HRSA established the School-Based Health Centers program, which is also administered by BPHC as part of the Consolidated Health Center Programs. Total funding levels for the Consolidated Health Center Programs are based on an annual appropriation from Congress.

Grant awards vary depending on the scope of the project and may be made on a multi-year cycle, or project period. The amount of a Section 330 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 centers must compete for funding at the end of their project periods with new organizations proposing to serve the same area and/or populations currently served by the existing health centers.[43]

Appendix B: Glossary

95-210 Clinics. Public Law 95-210 was enacted by Congress to provide certain incentives for health care organizations and hospitals to build, maintain, and staff rural health clinics. To alleviate the shortage of physicians, the federal government mandated the use of mid-level health care providers to extend the practice of qualified physicians.

Consolidated Health Center Program. Also known as the Section 330 grants program, this program is administered by the Bureau of Primary Health Care (BPHC). The BPHC distributes federal funds appropriate pursuant to §330 of the Public Health Service Act (PHSA) to qualified health care entities, including safety-net clinics. Section 330 grantees are designated as Federally Qualified Health Centers (FQHCs) and are entitled to several benefits, including enhanced Medicaid and Medicare reimbursement.

Federally Qualified Health Center (FQHC). A designation awarded under federal law to qualified public and non-profit health care entities, including safety-net clinics, which entitles these providers to enhanced Medicaid and Medicare reimbursement as well as participation in other federal programs.

FQHC Look-Alike. A clinic that meets all of the requirements for receiving §330 funds, but does not actually receive a grant. Clinic is eligible to apply for Look-Alike status in order to obtain many of the same benefits as CHCP funded entities, including enhanced Medicaid reimbursement.

Health Professional Shortage Area (HPSA). A designation that entitles a clinic to 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. More than 34 federal programs depend on the shortage designation to determine eligibility or as a funding preference. About 20 percent of the U.S. population resides in primary medical care HPSAs.

Medically Underserved Area (MUA). A designation that entitles a clinic to certain types of government funding and benefits. Designation is based on a calculation that considers: (1) ratio of primary care physicians per 1000 population; (2) infant mortality rate; (3) percentage of population with incomes 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/MUP.

Medically Underserved Population (MUP). MUP designation is calculated in the same manner as for MUAs. However, the specific population for whom the MUP is calculated represents only a portion of the area's population. These specific populations encounter barriers to primary care access. The barriers may be economic (e.g., low income or Medicaid-eligible populations) or social (cultural, linguistic).

Prospective Payment System (PPS). Method for calculating enhanced Medicaid and Medicare reimbursement for FQHCs. Calculation for reimbursement uses clinics' allowable costs for fiscal years 1999 and 2000 as baseline, and then adjusts reimbursement for inflation in each subsequent reimbursement year.

Rural Health Clinic. Clinic in a rural area offering services that rely largely on providers such as nurse practitioners and physician assistants.

Section 330. The section of the Public Health Service Act (PHSA) that defines required services and process for awarding grants to entities under the CHCP authority.

Appendix C: Key Organizations

Alameda Health Consortium/Community Health Center Network (AHC/CHCN): A clinic consortium serving Alameda County (www.chcn-eb.org).

Alliance for Rural Community Health (ARCH): A clinic consortium serving Sonoma, Lake, and Mendocino Counties (www.ruralcommunityhealth.org).

Association of California Healthcare Districts (ACHD): Statewide association of health care districts that operates provider-based clinics and rural health clinics (www.achd.org).

Bureau of Primary Health Care (BPHC): Division of Health Resources and Services Administration that oversees Consolidated Health Center Program (bphc.hrsa.gov).

California Association of Public Hospitals and Health Systems (CAPH): Statewide trade association representing 30 public and not-for-profit hospitals, academic medical centers, and comprehensive health care systems in California. CAPH members make up the core group of providers in the state's medical safety net, operating in 17 counties throughout the state (www.caph.org).

California Family Health Council, Inc.: Supports community clinics and organization that provide family planning services access (www.cfhc.org).

California Hospital Association (CHA): The largest state health care trade association in California with nearly 500 hospital and health system members, and other health care providers. Represents entities that operate outpatient departments and rural health clinics (www.calhealth.org).

California Primary Care Association (CPCA): Statewide trade association representing more than 600 not-for-profit community clinics and health centers that provide comprehensive, quality 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, large and small clinic corporations and clinics. CPCA 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 Indian Health Board (CRIHB): Formed to enable the provision of health care to member Tribes in California. It is devoted to the needs and interests of the Indians of rural California and is a network of Tribal Health Programs that are controlled and sanctioned by Indian people and their tribal governments (www.crihb.org).

California School Health Centers Association (CSHCA): A nonprofit advocacy organization representing school health centers (www.schoolhealthcenters.org).

California State Rural Health Association (CSRHA): Statewide trade association of rural health providers represents public and private nonprofit rural health clinics (www.csrha.org).

Central Valley Health Network (CVHN): A clinic consortium serving San Joaquin, Kern, Inyo, Colusa, Calaveras, Solano, Del Norte, 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): A clinic consortium serving Orange County (www.coccc.org).

Community Clinic Association of Los Angeles County (CCALAC): A clinic consortium serving Los Angeles County (www.ccalac.org).

Community Clinic Consortium of Contra Costa: A clinic consortium serving Contra Costa County (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. Grantees encompass 90 percent of California's community clinics and regional consortia (www.communityclinics.org).

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

Community Health Partnership (CHP): A clinic consortium serving Santa Clara County (www.chpscc.org).

Council of Community Clinics (CCC): A clinic consortium serving San Diego and Imperial Counties (www.ccc-sd.org).

National Assembly of School-Based Health Care (NASBHC): The national trade association of school-based health centers (www.nasbhc.org).

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

National Association of Free Clinics. (NAFC): A non-profit professional association composed of free clinics and state/regional free clinic associations, working together to support free clinics and the people they serve (www.nafclinics.org).

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 (RHC Program). NARHC works with Congress, federal agencies, and rural health allies to promote, expand, and protect the interests of the clinics (www.narhc.org).

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

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

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

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

Sacramento Community Clinic Consortium (SCCC): A clinic consortium serving Sacramento County (www.sacconsortium.org).

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

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

Endnotes

1. There is no one commonly used definition of the phrase "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. *See* "America's Health Care Safety Net: Intact But Endangered," brief report, Institute of Medicine, June 2000.
2. "Public hospitals and health systems" are defined as all county-owned facilities, and state university-based medical centers that fulfill their Section 17000 obligations in their respective counties. *See* "California's Public Hospital and Health Systems: An Inside Look at Outpatient Services," published by the California Association of Public Hospital and Health Systems, 2001.
3. Health care district powers are statutorily defined in California Health & Safety Code §32000, et. seq.
4. California Welfare & 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. OSHPD collects hospital and clinics utilization data. It also publishes demographic data by county for urban and rural Medical Service Study Areas in the state, as found at www.ruralhealth.ca.gov. A Medical Service Study Area is "rational service areas [RSAs]" for purposes of designating health professional shortage areas [HPSAs] , medically underserved areas [MUAs] or medically underserved populations [MUPs].
6. "California's Public Hospital and Health Systems: An Inside Look at Outpatient Services," published by the California Association of Public Hospital and Health Systems, 2001.
7. "2003 Clinic Fact Book Based on OSHPD Data from the 2003 Annual Utilization Report," published by the California Primary Care Association, 2005.
8. HRSA/BPHC: "Bureau of Primary Health Care Section 330 Grantees Uniform Data System," Calendar Year 2004 Data, California Rollup Report, accessed July 15, 2005.
9. Social Security Act, §§ 1095(1)(2)(B) and 1861(aa)(4). Also see 42 U.S.C.A. § 1396d(l)(2)(B) and 42 U.S.C.A. § 1395x(aa)(4).
10. Public Law 93-638
11. 25 U.S.C.A. 1651, et.seq.
12. Authorized by the Federally Supported Health Centers Assistance Act of 1992 [P.L. 102-501].
13. *See* HRSA/BPHC Program Information Notice (PIN), Doc No. 2003-21. "Federally Qualified Health Center Look-Alike Guidelines and Application" and PIN 2005–17, "Revisions to Policy Information Notice 2003–21, Federally Qualified Health Center Look-Alike Guidelines and Application."
14. The Balanced Budget Act of 1997 P.L. 105–33 changed the rule about who may own or operate FQHC look-alikes.
15. List provided by the BPHC, July 21, 2005.
16. *See* www.ihs.gov/publicinfo.
17. Public Law No. 93-638
18. Public Law No. 94-437
19. Public Law No. 95-210
20. House Report No.95–548(I).
21. Gale, J.A., and Coburn, A.F, "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.
22. A list of California RHCs can be found at www.ruralhealth.ca.gov.
23. The OSHPD 2003 Annual Utilization Report Data and the list of Rural Health Clinics that are Medicare certified as reported by OSHPD, February 4, 2005, reports 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 designation as an FQHC or FQHC look-alike. Technically, a clinic may not be designated as both a 95-210 clinic and a FQHC.
24. California Health & Safety Code § 1204(a)(1)(B).
25. *See* www.nafclinics.org/info.htm.

26. Federal Register: December 3, 2003 (Volume 68, Number 232).

27. HRSA/BPHC: "Bureau of Primary Health Care Section 330 Grantees Uniform Data System," Calendar Year 2004 Data, National Rollup Report, accessed July 15, 2005.

28. U.S. Census Bureau population estimates for 2004 found at factfinder.census.gov.

29. The Migrant Health Act, signed into law in 1962 [Public Law No:87-692] added section 310 to the Public Health Service Act to established the MHC program.

30. "An Overview of California's School Health Centers," published by the California School Health Centers Association found at www.schoolhealthcenters.org.

31. *See* bphc.hrsa.gov/cap.

32. "Healthy Communities Access Program (HCAP), New and Competing Continuation Grants Announcement" Number: HRSA 05-104 Catalog of Federal Domestic Assistance (CFDA) No.93.252, found at www.hrsa.gov/grants/preview/guidance primary/hrsa05104.htm.

33. HRSA-05-022 Title III: Categorical Grant Program to Provide Outpatient Early Intervention Services with Respect to HIV Disease (EISEGA); Application Guidance, CFDA Number: 93.918.

34. Kaiser Family Foundation, "Distribution of Ryan White CARE Act Funding By Title, FY2003," found at www.statehealthfacts.kff.org.

35. Conversation with Marlene Cole, program manager, California Family Health Council, Inc., July 18, 2005.

36. 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 multi-year awards on an as-needed basis.

37. *See* www.prh.dhs.ca.gov/Programs/IHP.

38. Kominski, G.F., Roby, D.H., and Kincheloe, J.R., "Cost of Insuring California's Uninsured," UCLA Center for Health Policy Research, May 2005.

39. "Population Distribution by Insurance States Data 2002–03, U.S. 2003" found at www.statehealthfacts.kff.org.

40. 2000 U.S. Census Data found at factfinder.census.gov and "We the American People Foreign Born," based on 1990 U.S. Census data found at www.census.gov.

41. For Medicaid purposes, FQHC and RHC services are defined in Title 42 U.S.C. §1396d(l). These services are mandated Medi-Cal benefits.

42. Public Law 104-299.

43. *See* "Service Area Competitions Funding for the Consolidated Health Center Programs," Program Guidance, Fiscal Year 2006, released July 1, 2005.

44. Public Law No: 107-251, Sec. 404.

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