The Primary Care Safety Net:
Strained, Transitioning, Critical

BACKGROUND PAPER NO. 79

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OVERVIEW — *This background paper examines the primary care safety net. It describes key primary care safety net providers, including federally qualified health centers, free clinics, local health departments, and safety net hospital outpatient departments and clinics, among others. The paper also explores the changing role of the primary care safety net in a post–health reform marketplace.*

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Millions of Americans depend on the health care safety net—the loosely knit constellation of people and institutions willing to provide health care to uninsured, underinsured, and vulnerable people—for access to primary, specialty, and inpatient care. In the context of national health reform legislation[1] that seeks to achieve near universal health insurance coverage, safety net providers are adapting and evolving. They face great opportunities and challenges as implementation unfolds. Health insurance expansions, particularly for low-income people through Medicaid, could be a boon for safety net providers, who spend a lot of energy scraping together multiple funding streams from local, state, and federal governments and private sources to pay for the care they provide to the uninsured. Because of Medicaid program variability, one would expect the impact to be more significant in states with limited Medicaid eligibility than in those with more generous eligibility. However, safety net providers may face increased competition for newly insured patients, and the payment rates and the terms of contracts with insurers will be critically important to their financial viability. At the same time, an estimated 23 million nonelderly people living in the United States will remain uninsured[2] and will continue to depend on providers willing to serve them, regardless of their ability to pay.

What constitutes a safety net provider varies from community to community; as is said of politics, all safety nets are local. Despite this variability, wide use of the Institute of Medicine (IOM) 2000 report *America's Health Care Safety Net: Intact but Endangered* has produced some definitional consensus. The IOM report defines safety net providers as "those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients."[3] Within that broad group, core safety net providers are those that are either required by federal law

Core safety net providers bear the greatest burden of providing care to the uninsured and vulnerable populations.

to provide services to all comers, regardless of ability to pay, such as federally qualified health centers (FQHCs),[4] or do so because they consider it their mission. Core safety net providers bear the greatest burden of providing care to the uninsured and vulnerable populations. There is consensus, although it is somewhat subjective, that core safety net providers include FQHCs, free clinics, public hospital systems, and local health departments. However, the safety net includes a broader set of providers whose burden of care is not generally as heavy as that borne by core providers. School-based health centers (SBHCs), nurse-managed health centers, retail clinics, rural health clinics (RHCs), emergency departments (EDs), private not-for-profit hospitals, academic medical centers, and private providers play a significant safety net role in many communities. Despite the plethora of provider types, the vagaries of funding and local capacity to access it mean that their distribution across the country is uneven, leaving significant gaps in access to care.

While some data exist for certain safety net provider types, little exist about the safety net as a system of care. The only longitudinal data available come from the Community Tracking Study conducted by the Center for Studying Health Systems Change, which monitors the health care markets of 12 U.S. communities.[5] In 2000, spurred by the IOM safety net report, the Health Resources and Services Administration and the Agency for Healthcare Research and Quality, both part of the U.S. Department of Health and Human Services (HHS), jointly launched a safety net monitoring initiative that became defunct a few years later.[6] The lack of easily analyzed baseline data makes assessing the impact of key financial, economic, and social changes difficult. It also makes it challenging to quantify the relative importance of various safety net providers in terms of the magnitude of care they provide and to make strategic investment decisions.

Many express concern that the insurance card that will come with the expansions set forth in the Patient Protection and Affordable Care Act (PPACA) will not equate to access to health care services, particularly for the additional 16 million people expected to enroll in Medicaid and the Children's Health Insurance Program (CHIP) by 2019. Health reform includes a number of safety net investments, but implementation of them and of the insurance coverage provisions remains unclear. At a time of record budget shortfalls and associated budget cuts, many states are wondering if they can afford to implement health

reform. Enhanced federal Medicaid matching rates expire after June 30, 2011, and additional disproportionate share hospital (DSH) payments and FQHC funds authorized by the American Recovery and Reinvestment Act of 2009 (ARRA) end soon. Upcoming federal investments to help bolster capacity and improve access, two-year Medicaid primary care provider payment enhancements, and new mandatory funding for FQHCs might improve primary care access, but challenges in specialty care access will remain. Given the strict maintenance-of-effort provisions written into ARRA and PPACA, state Medicaid programs could have few options, other than cutting payments to providers as they try to rein in spending to balance their budgets. Such cuts might further limit private provider participation in the program, thereby driving more Medicaid patients to already overburdened safety net providers.

CORE SAFETY NET PROVIDERS

The subset of safety net providers who mainly provide primary care services (as opposed to specialty care services or inpatient care) are key to building a system of care. These core providers include FQHCs, certain hospital outpatient departments and clinics, free clinics, and local health departments.

FQHCs: Health Centers and Look-Alikes

Eligibility for FQHC designation is limited to three types of primary care clinics: (i) those that receive a grant under section 330 of the Public Health Service Act (commonly called "health centers"), (ii) those that are determined by the Secretary of Health and Human Services to meet all the requirements for receiving such a grant but do not actually receive grant funding (commonly called "look-alikes"), or (iii) those outpatient facilities that are operated by a tribe or tribal organization or by an urban Indian organization (not discussed in this paper).[7]

Health centers—Today's health centers, initially named neighborhood health centers, were created in 1965 and were administered by the Office of Economic Opportunity to provide health and social services access points in poor and medically underserved communities and to promote community empowerment. Federal funds for neighborhood health centers flowed directly to not-for-profit, community-level

organizations, bypassing state governments. In 1975, Congress authorized neighborhood health centers as "community and migrant health centers"[8]; subsequent authorizations added primary health care programs for residents of public housing and homeless populations. The Health Centers Consolidation Act of 1996 combined these separate authorities (community, migrant, homeless, and public housing) under section 330 of the Public Health Service Act (PHSA) to create the consolidated health centers program.[9] Health center program grantees are often called 330 grantees because of this statutory authorization. Most recently, PPACA permanently reauthorized the health centers program, specifying funding levels through fiscal year (FY) 2015 and automatic increases in future years. HRSA's Bureau of Primary Health Care within HHS administers the program.

To receive section 330 grant funds, a clinic must meet certain statutory requirements, including but not limited to the following:

- Be located in or serve a federally designated medically underserved area or a federally designated medically underserved population[10]
- Have not-for-profit or public status
- Provide comprehensive primary health care services, referrals, and other services needed to facilitate access to care, such as case management, translation, and transportation
- Have a governing board, the majority of whose members are patients of the health center[11]
- Provide services to all in the service area, regardless of ability to pay, and offer a sliding fee schedule that adjusts according to family income

Health centers have expanded in number and capacity during the last decade, beginning with an initiative by the George W. Bush administration between 2002 and 2008 that increased annual health center grant funding to $2 billion and created an additional 1,300 new or expanded sites.[12] In 2009, 1,131 health center grantees served nearly 19 million patients, 38 percent of whom were uninsured, and provided 74 million patient visits at over 7,900 sites.[13] Health center program growth continued with the addition of $2 billion for FYs 2009 through 2011 under ARRA to expand services and fund capital improvements.[14] Most recently, PPACA created and appropriated funding for an $11 billion community health center fund for FY 2011 through FY 2015 ($1.5 billion of the $11 billion is set aside for

construction and renovation). These dollars are in addition to any discretionary appropriations for those fiscal years. The National Association of Community Health Centers estimates that this dedicated fund will allow health centers to serve 40 million patients by 2015.[15] (See Table 1 for health center federal appropriations for FYs 2005 through 2015.)

Health centers tend to serve a low-income, female, relatively young population, although the fastest-growing population served is patients aged 45 to 64.[16] In 2009, among patients reporting their income level, 71 percent of health center patients lived below 100 percent of the federal poverty level and 92 percent below 200 percent of the federal poverty level.[17] In 2009, nearly 25 percent of health center patients reported that they were better served in a language other than English. Among patients reporting their racial and ethnic background, 35 percent were Hispanic/Latino, 27 percent were African American, 62 percent were white, 3.3 percent were Asian, 1.5 percent American Indian/Alaska Native, and 1.2 percent Native Hawaiian or Pacific Islander. Health center patients are much less likely than the general population to have health insurance and, when insured, they rely heavily on public insurance programs like Medicaid. In 2009, approximately 38 percent of health center patients were uninsured, 37 percent were covered by Medicaid, 7 percent by Medicare, 3 percent by other public insurance like CHIP, and 15 percent by private insurance.[18] In 2008, health centers served about 6.5 million uninsured patients, just over 14 percent of the estimated 46 million uninsured people nationwide.[19]

TABLE 1 **Federal Appropriations for Health Centers, by Source, FYs 2005–2015** (in billions of dollars)

	FUNDING SOURCES		
FISCAL YEAR	Discretionary Appropriation	ARRA Funding	Community Health Center Fund*
2005	1.74		
2006	1.79		
2007	1.99		
2008	2.07		
2009	2.19	2.00	
2010	2.19		
2011	2.48† 3.86‡		1.00
2012	4.99‡		1.20
2013	6.45‡		1.50
2014	7.33‡		2.20
2015	8.33‡		3.60

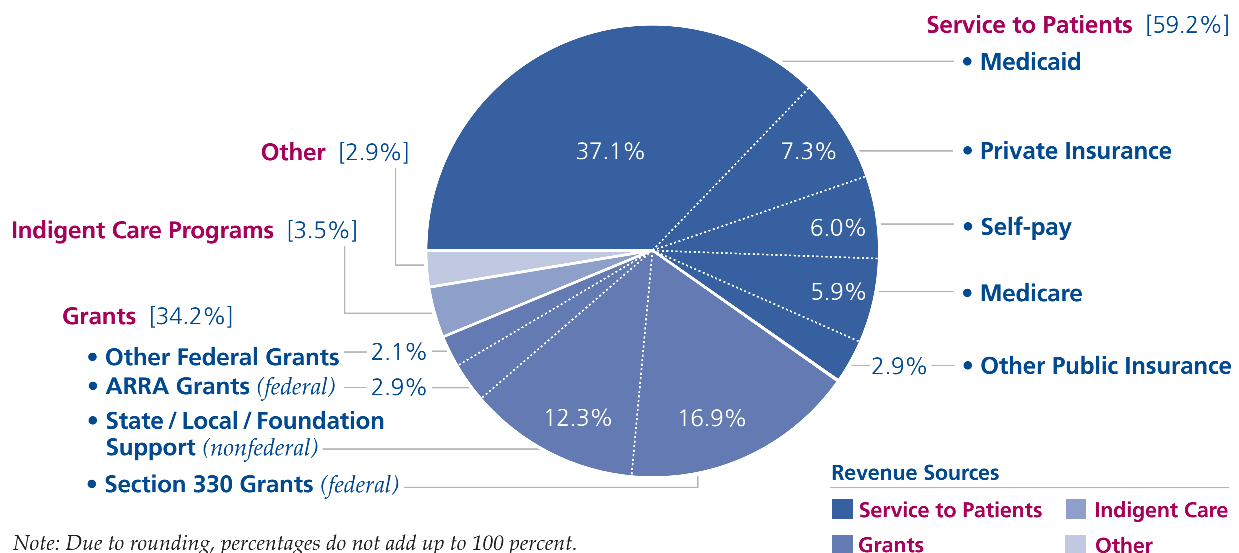
** An additional $1.50 billion is appropriated for FYs 2011 through 2015 for construction and renovation.*
† President's budget request.
‡ Authorized to be appropriated in the PPACA, section 5601, P.L. 111-148. As of this publication, funds had not been appropriated.
Source: Health Resources and Services Administration, "Justification of Estimates for Appropriations Committees, Fiscal Year 2011," available at www.hrsa.gov/about/budgetjustification/budgetjustification11.pdf; and Patient Protection and Affordable Care Act, sections 5601 and 10503.

The services health centers provide reflect the diverse needs of the populations they serve. The health center patient population is almost 59 percent female and 36 percent age 19 or younger, a demographic that creates a high demand for obstetric/gynecologic, family

practice, and pediatric services. Because of the combination of low incomes, linguistic barriers, and often poor health status, health center patients require access to both comprehensive primary care and enabling services. Health centers are unique among primary care providers for the array of enabling services they offer, including case management, translation, transportation, outreach, eligibility assistance, and health education. The incidence of chronic conditions among health center patients is higher than among the general population. As a result, health centers commit significant resources to managing these conditions. In many areas, health centers are the only providers of dental, mental health, and substance abuse services for medically underserved families and individuals. FQHCs are required to have a sliding fee scale in place and to bill patients for services provided; typically the fee charged a patient with an income below 100 percent of poverty ranges from $5 to $20.[20]

Medicaid is the largest source of revenue for health centers, followed by section 330 federal grants (see Figure 1).[21] Health centers are paid for the services they provide to Medicaid patients through a prospective payment system (PPS), a modified cost-based payment system.

FIGURE 1 | Percentage of Health Center Revenues, by Source, 2009



Note: Due to rounding, percentages do not add up to 100 percent.

Source: Health Resources and Services Administration (HRSA), "2009 National Summary Report"; available at www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009nattotsumdata.html.

The PPS is tied to the average of each FQHC's allowable costs from FY 1999 and FY 2000 and is adjusted for inflation by the Medicare economic index for primary care.[22] It is notable that these payments are determined by federal policy, while Medicaid physician fees are state-determined; the result can be significant differences between the amounts private physicians and FQHCs are paid for a similar service. These differences are intended to account for the broader range of services that health centers provide relative to private physicians, as well as the increased complexity of their patient populations. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandated that CHIP programs that are not part of a state's Medicaid program reimburse FQHCs based on a PPS as of October 1, 2009. Currently, Medicare services are paid on an all-inclusive, per encounter rate, but are capped by an upper payment limit set by the Centers for Medicare & Medicaid Services. PPACA authorized a PPS for Medicare payments to FQHCs beginning October 1, 2014.[23] (For additional information about the history and funding of community health centers, see Jessamy Taylor, "The Fundamentals of Community Health Centers," National Health Policy Forum, Background Paper, August 31, 2004; available at www.nhpf.org/library/background-papers/BP_CHC_08-31-04.pdf.)

Look-alikes—In 1990, when Congress first authorized FQHC cost-based reimbursement, it also established the concept of the "FQHC look-alike" as a way to increase access to services to a greater number of uninsured and underinsured populations, despite limited federal grant funding. FQHC look-alikes do not receive grant funding under section 330; however, they operate and provide services in much the same way as grant-funded programs. As with section 330–funded health centers, HRSA determines FQHC eligibility for look-alikes. Look-alikes are required to meet the statutory, regulatory, and policy requirements of section 330 and to demonstrate a commitment to providing primary health care services to medically underserved populations, regardless of their ability to pay. Benefits that accrue to look-alikes include the following:

- Eligibility to be reimbursed by Medicare, Medicaid, and CHIP under the FQHC payment system (These systems include the PPS for Medicaid and CHIP and the all-inclusive payment rate under Medicare, which will be replaced by a PPS beginning October 1, 2014.)

- Eligibility to purchase prescription and nonprescription medications for outpatients at reduced cost through the 340B drug pricing program
- Automatic designation as a Health Professional Shortage Area, which provides eligibility to apply to receive National Health Service Corps personnel

In 2010, 87 FQHC look-alikes are operating; many look-alikes have become section 330 grantees through health center program expansion.[24]

Safety Net Hospital Outpatient Departments and Clinics

Safety net hospitals serve racially and ethnically diverse populations.

Public hospitals are considered core safety net providers, although many private, not-for-profit hospitals also provide substantial amounts of care to the uninsured and publicly insured. The 1,100 public hospitals represent about one-fifth of all community hospitals and are owned by state or local governments or public authorities.[25] Most are relatively small hospitals, and almost three-quarters are in rural areas. Public hospitals and health systems serve millions of people each year. In addition to traditional inpatient and outpatient health care services for the uninsured, underinsured, and vulnerable populations, public hospitals provide emergency, trauma, and burn services that benefit the entire community. Compared to private hospitals, they serve a higher proportion of uninsured and Medicaid patients and a lower proportion of privately insured patients; the high proportion of uninsured and Medicaid patients tends to mean they serve a sicker patient population.[26]

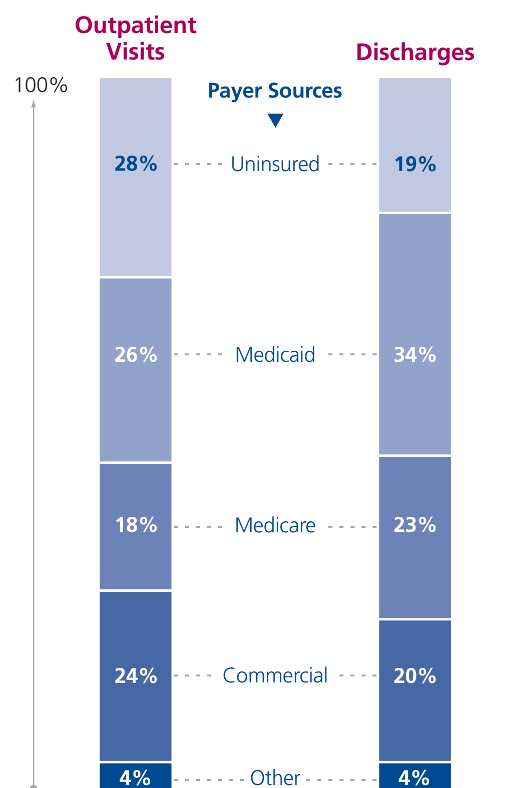
The National Association of Public Hospitals and Health Systems (NAPH) represents about 10 percent of all safety net hospitals, mostly large, metropolitan hospitals. In 2007, NAPH hospitals provided 39 million nonemergency outpatient visits, approximately 40 percent of these for primary care services and 60 percent for specialty care services; 21 percent of the 39 million visits were to uninsured people. According to data from the American Hospital Association, the average NAPH hospital has more than four times the volume of nonemergency outpatient visits seen in other acute care hospitals in the country and more than three times the number handled by other acute care hospitals in their markets. In addition to hospital-based clinics, many safety net hospital systems operate community clinics.[27]

Safety net hospitals serve racially and ethnically diverse populations. NAPH collects race and ethnicity data based on inpatient discharges,

not outpatient services. In 2007, 39 percent of discharged patients were white, 28 percent black, 25 percent Hispanic/Latino, 3 percent Asian American/Pacific Islander, and 5 percent other.

Payments—Medicaid pays for the largest share of outpatient visits and discharges for NAPH members (Figure 2). In 2007, it accounted for 33 percent of total revenues, followed by Medicare at 20 percent, 14 percent from state and local sources, 26 percent from privately insured patients, 4 percent from uninsured patients, and 3 percent from other sources. Medicaid DSH payments are an important component of total Medicaid revenues; they are distributed by the federal government to states and in turn to safety net hospitals to partially subsidize the care provided to Medicaid and uninsured patients. Medicare revenues are supplemented by Medicare DSH payments, which also target hospitals that serve low-income and uninsured patients, and by indirect medical education payments, which subsidize the costs incurred by teaching hospitals.[28] In addition, public hospitals rely heavily on state and local government funding. Given the coverage expansions authorized by PPACA and the expectation that safety net hospitals will generate more revenue from paying patients, PPACA made significant changes to Medicaid DSH payments to states. Between FY 2014 and FY 2020, total Medicaid DSH spending will be reduced by $18 billion. DSH reductions begin at $500 million for FY 2014, with the largest reductions pushed to FY 2018 and beyond.[29]

FIGURE 2 **Percentage Distribution of Outpatient Visits and Discharges at NAPH Member Hospitals and Health Systems, by Payer Source, 2007**



Source: Obaid S. Zaman, Linda C. Cummings, and Sari Siegel Spieler, America's Public Hospitals and Health Systems, 2007: Results of the Annual NAPH Hospital Characteristics Survey, National Public Health and Hospital Institute (May 2009); available at www.naph.org/Publications/Characteristics-2007.aspx.

Free Clinics

Free clinics are private, not-for-profit organizations that provide medical, dental, pharmaceutical, mental health, and other services to uninsured individuals by licensed volunteer providers, for little or no cost. An estimated 1,000 of these clinics are currently operating throughout the country, serving about

1.8 million mostly uninsured persons annually. Some treat only the working poor; others are focused on a very specific vulnerable population, such as the homeless, immigrants, or those with a particular diagnosis like HIV/AIDS. A recent national survey found that 58 percent of free clinic patients are female, 80 percent are between the ages of 18 and 64, 56 percent live below the federal poverty level, and 41 percent have incomes between 100 percent and 200 percent of the federal poverty level. One-quarter of patients are Latino, one half are white, 20 percent are black, 3.4 percent Asian American Pacific Islander, and less than one percent American Indian or Alaska Native.[30]

Most free clinics are supported primarily through volunteers and charitable donations from community resources.

Most free clinics are supported primarily through volunteers and charitable donations from community resources, such as the United Way, hospitals, faith-based organizations, foundations, or individuals. Almost 60 percent do not receive any local, state, or federal government revenue and only 4 percent receive reimbursement from third-party payers. The clinics generally operate on small budgets, the mean being $287,810 in 2006. Volunteers include physicians, dentists, nurse practitioners, nurses, pharmacists, and other health professionals and community volunteers. Staffing variations are substantial; some clinics are exclusively nurse-managed, while others are staffed by over 100 volunteer physicians. About two-thirds of free clinics employ a paid executive director and about half pay administrative staff.

The services, policies, and case loads of free clinics vary significantly from clinic to clinic. A recent survey found that the most offered services are primary care and pharmaceutical assistance. Nearly one-quarter of clinics responding to the survey offer specialty services, over one-third provided dental care and vision screening, one-third provided mental health services, and 37 percent provided immunizations. Fifty-four percent of free clinics do not charge anything; the mean fee or donation requested by those that do charge was $9.30 in 2006.[31] The mean number of hours open per week was 18, but 29 percent of clinics report being open 5 or fewer hours per week and 25 percent reported being open, on average, 41 hours per week; most clinics have evening hours in addition to daytime hours.

Local Health Departments

The approximately 2,800 local health departments provide a limited amount of personal health services; few of these departments

provide comprehensive primary care services. The capacity of these local agencies and the services available through them vary dramatically. Most local health departments provide some type of clinical preventive service. Adult and child immunizations (respectively provided by 88 percent and 86 percent of local health departments) and screenings for communicable diseases, such as tuberculosis (provided by 81 percent), are the types of clinical preventive services most widely available through local health agencies. Screenings for diabetes (by 45 percent), cancer (by 42 percent), and cardiovascular disease (by 35 percent) are less commonly available. Relatively few local health departments (by 11 percent) provide comprehensive primary health care services, and this has been declining in recent years; however, most provide treatment for communicable diseases, such as tuberculosis (by 72 percent) and sexually transmitted diseases (by 57 percent). Services for maternal and child health, such as perinatal home visitation (by 63 percent), well child clinics (by 41 percent), developmental screening (by 44 percent), and WIC (Special Supplemental Nutrition Program for Women, Infants and Children) nutrition counseling services (by 62 percent) are also offered by many local agencies. These services are typically restricted to high-risk populations, such as low-income families and mothers and children with special health care needs. Twenty-nine percent of local health departments provide oral health services, but they tend to be agencies serving larger populations. Nine percent of local health department provide mental health services, and 7 percent provide substance abuse services.[32]

Most local health departments provide some type of clinical preventive service.

Although variation exists, on average, local health departments receive 25 percent of their revenues from local government. They receive another 20 percent directly from the state, 17 percent from the federal government passed through the state, 2 percent directly from the federal government, 10 percent from Medicaid, 5 percent from Medicare, 11 percent from regulatory and patient fees, and 9 percent from private and other sources.[33]

OTHER SAFETY NET PROVIDERS

In the absence of core providers, noncore providers play a critical role in creating a local health care safety net and providing access

to care for uninsured and vulnerable populations. SBHCs, nurse-managed health centers, retail clinics, RHCs, EDs, and private providers are considered noncore providers from a national perspective, but, in the absence of the traditional core providers discussed earlier in the paper, they may be de facto core safety net providers in many localities.

Nurse-managed health clinics play an important role in many local safety nets. There are approximately 250 nurse-managed health clinics across the United States. Through their more than 2.5 million annual patient encounters, they provide a full range of health services, including primary care, health promotion, and disease prevention, to approximately 250,000 low-income, underinsured, and uninsured patients. Most are either independent not-for-profits or academically based clinics affiliated with schools of nursing, and all are managed by advanced practice nurses.[34] PPACA authorized funding for nurse-managed health clinics for the first time as section 330A-1 of the PHSA. For FY 2010, $50 million was authorized to be appropriated; authorized for FYs 2011 through 2014 were "such sums as necessary."[35] As of this publication, funds have not been appropriated.

Nearly two thousand SBHCs provide comprehensive primary care services, including behavioral health services to 1.7 million children and adolescents in schools or on school grounds across the country. SBHCs are located in 44 states and the District of Columbia; on a per-capita basis, SBHCs have the strongest presence in Louisiana, Oregon, New Mexico, and Michigan. SBHCs are sponsored and managed by community hospitals, local health departments, school districts, or academic medical centers; about 28 percent are sponsored by a section 330 health center or FQHC look-alike. SBHCs are typically staffed by a nurse practitioner or physician assistant, under physician supervision, and provide primary care services, including mental health services and sometimes oral health services. Some argue that SBHCs are well positioned to handle chronic health issues, such as obesity, asthma, and smoking, given their access to children and adolescents. Historically, the expansion of the model has been curtailed in a number of communities amid concerns related to the provision of certain reproductive health services.[36]

Medicaid is the largest federal funding source for SBHCs, and there has been considerable debate around Medicaid's payment of services provided at schools, which has been a factor in limiting their expansion. Section 505 of CHIPRA clarified that services provided through

SBHCs may be covered under state CHIP plans, which marked the first time that the term "school-based health center" was defined in statute. Section 4101(a) of PPACA appropriated a total of $200 million for FYs 2010 through 2013 for facilities, equipment, and similar expenditures at SBHCs. Section 4101(b) established section 399Z-1 of the PHSA, which authorizes such sums as may be necessary for grants to support SBHC operations, thus creating the possibility of a new federal grant funding source for the model.[37] As of this publication, no funds had been appropriated for operational grants.

Since rural communities are less likely to have the types of core safety net providers found in urban areas, RHCs were created as a special class of provider found only in rural areas to serve a safety net function in the communities where they are located. RHCs provide outpatient primary care services and basic laboratory services in areas that are medically underserved. Over 3,000 federally certified RHCs provide primary care services to more than 7 million people in 47 states.[38] They use a team approach of physicians and midlevel practitioners, such as nurse practitioners, physician assistants, and certified nurse midwives, to provide services. RHCs must be staffed at least 50 percent of the time with a midlevel practitioner. They can be for-profit or not-for-profit, public or private. Although RHCs receive special Medicaid and Medicare reimbursement, they do not receive supplementary funding for the provision of services to the uninsured.[39] Some agree to see all, regardless of ability to pay; others do not.

Over 3,000 federally certified RHCs provide primary care services to more than 7 million people in 47 states.

Because of their "24/7" nature, hospital EDs are where many uninsured or underinsured individuals seek treatment for nonurgent conditions. Treating nonurgent conditions in EDs can be more expensive, given the higher fixed costs of a hospital than of a clinic or physician office. The largest percentage of visits to EDs is made by the privately insured, followed by those with Medicaid, the uninsured, and lastly, those with Medicare. However, when looking at the number of visits per 100 persons of a specific insurance type, a different picture emerges. Medicaid beneficiaries have the highest visit rate, close to double that of the uninsured and more than three times that of the privately insured. In terms of visit acuity and appropriateness of ED use, about 16 million visits, or 13.9 percent of the 115.3 million ED visits in 2005, were nonurgent and thus treatable in a primary care setting. The uninsured constitute the

largest proportion of these nonurgent visits, at 18.5 percent, which is roughly consistent with their share of the population.[40] In many ways, EDs serve as a barometer of the state of the health care system, and their crowded state may signal trouble in access to primary and specialty care, especially outside of traditional work hours.

Many private, not-for-profit hospitals are major safety net providers, although the role they play and the amount of care they provide to the uninsured varies considerably. In recent years, policymakers have been scrutinizing the tax-exempt status of not-for-profit hospitals to see if the level of public benefit they provide is commensurate with the tax exemption they receive.[41]

The majority of primary care visits for the uninsured and Medicaid beneficiaries are made to private physicians because of the sheer volume of physicians in private practice, although the distribution is highly skewed, since some physicians see many such patients and some see none or almost none. According to the Community Tracking Study Physician Survey conducted by the Center for Studying Health Systems Change, 59 percent of physicians provided some charity care in 2008. The amount of physician charity care relative to the number of uninsured Americans has declined from 7.7 charity care hours per 100 uninsured patients in 1996–1997 to 6.3 in 2004–2005, an 18 percent drop. Levels of charity care are highest among physicians in solo or small group practices, but increasingly physicians are moving toward larger practice arrangements.[42] Thus the uninsured must rely even more on formal safety net providers, where they exist and have capacity, or else forgo care.

Retail clinics are for-profit medical clinics located in grocery stores, pharmacies, and other retail outlets.

Though not typically thought of as safety net providers, retail clinics are an appealing option for the near-poor uninsured because of their lower cost, price transparency, and convenience. Retail clinics are for-profit medical clinics located in grocery stores, pharmacies, and other retail outlets. Designed to treat simple acute conditions and provide routine clinical preventive services, they typically offer daytime, evening, and weekend hours. They have proliferated in the last decade and are now operating in more than 1,000 sites nationwide. A 2008 comparison of visits to retail clinics, office-based physicians, and EDs found that 33 percent of retail clinic patients were uninsured, compared to 10 percent of office-based physician patients and

25 percent of ED patients.[43] Proponents argue that retail clinics offer a less costly alternative to patients who might otherwise seek care in EDs. Opponents contend that they further fragment the health care delivery system, disrupt existing patient-provider relationships, and miss opportunities for prevention. Research shows that retail clinics tend to be located in relatively affluent, large, urban areas rather than in medically underserved areas.[44]

THE SAFETY NET AFTER REFORM

Safety net providers are living in interesting times. Many are excited about the prospect of new resources that will come from currently uninsured patients who become insured starting in 2014, concerned about the payment rates they will receive to provide care to those individuals, wondering whether public and private insurers will contract with them favorably,[45] and worried about the adequacy of federal subsidies to continue to care for the estimated 23 million nonelderly people who will remain uninsured.[46] Physical and workforce capacity to serve more patients are additional concerns. Some free clinics that have not traditionally billed for services are contemplating their future in the context of diminished but, in some areas, still significant uninsured populations. Certain local health departments may view this new environment as an opportunity to focus on core public health activities, while others may use the availability of federal funding for new health centers to bolster their primary care capacity. Unquestionably, safety net providers are in transition and have many opportunities and challenges ahead.

The PPACA investment of $11 billion in health centers, in addition to annual discretionary appropriations, raises a number of questions about the program and its administration, including expectations for ultimate program size, interest in maximizing the federal investment to reduce safety net fragmentation, and HHS's strategies for distributing funds and ensuring program accountability. Some ask whether the set of safety net providers receiving federal support ought not to be broadened; the federal government might incubate a variety of clinic models, not just fund fully formed FQHCs. New authorizations for nurse-managed health centers and SBHCs suggest that Congress is interested in subsidizing models beyond the FQHC.

Despite shared missions to serve the uninsured and underserved, some safety net providers view each other as competitors rather than

collaborators and complementary of each others' efforts. Concern exists that the new infusion of federal money through grant funds and coverage expansions, without concerted effort to encourage safety net integration and collaboration, will perpetuate existing local delivery system fragmentation. Grants for community-based collaborative care networks that were authorized in PPACA but are currently unfunded may provide an opportunity to test such integration.[47] Safety net provider participation in accountable care organizations and patient-centered medical home demonstrations provide other opportunities. These new programs and demonstration projects have the potential to help integrate and strengthen local safety nets.

Safety net providers are a vital part of the health care system, and many of them, especially core providers, are experiencing significant strain. Thoughtfully monitoring the myriad factors that will affect them in the years to come will be critical to ensuring access to high-quality, timely, and affordable care for the insured and uninsured.

ENDNOTES

1. Patient Protection and Affordable Care Act (PPACA, P.L. 111-148).

2. Congressional Budget Office (CBO), letter to Nancy Pelosi, final estimate of the direct spending and revenue effects of the "reconciliation proposal" for H.R. 4872, March 20, 2010, p. 9; available at www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

3. Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered*, Marion Ein Lewin and Stuart Altman, Eds. (Washington, DC: National Academy Press, 2000), p. 21; available at www.nap.edu/catalog.php?record_id=9612.

4. This requirement applies only to those federally qualified health centers (FQHCs) that receive section 330 grant funds and to "look-alikes." It does not apply to the third category of FQHC, tribally based clinics, unless they receive section 330 grant funds.

5. The 12 Community Tracking Study sites are nationally representative, which allows researchers to identify national trends in health care delivery and financing. The 12 communities are Seattle, Washington; Orange County, California; Phoenix, Arizona; Little Rock, Arkansas; Indianapolis, Indiana; Cleveland, Ohio; Lansing, Michigan; Syracuse, New York; Boston, Massachusetts; Northern New Jersey; Greenville, South Carolina; and Miami, Florida.

6. Agency for Healthcare Research and Quality (AHRQ), "Safety Net Monitoring Initiative: Fact Sheet"; available at www.ahrq.gov/data/safetynet/netfact.htm. The initiative consolidated data relating to safety net demand, financial support, structure, community context, and performance.

7. Social Security Act, section 1861 (aa)(4).

8. Health Revenue Sharing and Health Services Act (P.L. 94-63).

9. Health Centers Consolidation Act of 1996 (P.L. 104-299).

10. For additional information about medically underserved areas and populations, see Eileen Salinsky, "Health Care Shortage Designations: HPSA, MUA, and TBD," National Health Policy Forum, Background Paper No. 75, June 4, 2010; available at www.nhpf.org/library/background-papers/BP75_HPSA-MUA_06-04-2010.pdf.

11. This requirement can be waived for clinics that focus only on migrant, homeless, or public housing populations.

12. Kevin Sack, "Community health clinics increased during Bush years," *New York Times*, December 26, 2008; available at www.nytimes.com/2008/12/26/world/americas/26iht-bush.1.18936658.html?pagewanted=1&_r=3.

13. Health Resources and Services Administration (HRSA), "2009 National Summary Report"; available at www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009nattotsumdata.html.

14. Under ARRA, $500 million was designated for services and $1.5 billion for capital improvements. See Health Resources and Services Administration, "The Health Center Program: Recovery Act Grants"; available at http://bphc.hrsa.gov/recovery/hcqr/.

15. National Association of Community Health Centers, "Expanding Health Centers under Health Care Reform: Doubling Patient Capacity and Bringing Down Costs," June 2010; available at www.nachc.com/client/HCR_New_Patients_Final.pdf.

16. HRSA, "2009 National Summary Report."

17. The 2009 federal poverty levels were $10,830 for one person and $22,050 for a family of four in the contiguous 48 states and the District of Columbia.

18. HRSA, "2009 National Summary Report."

19. HRSA, "2008 National Summary Report"; available at www.hrsa.gov/data-statistics/health-center-data/NationalData/2008/2008_national_summary.pdf. Health Centers served 7.2 million uninsured patients in 2009 but, as of this writing, the national statistic for uninsured persons in 2009 was not available to calculate the percentage of the total those 7.2 million represent.

20. Michael K. Gusmano, Gerry Fairbrother, and Heidi Park, "Exploring the Limits of the Safety Net: Community Health Centers And Care For The Uninsured," *Health Affairs*, 21, no. 6 (November/December 2002): pp. 188–194; available at http://content.healthaffairs.org/cgi/reprint/21/6/188. Tribal FQHCs that do not receive section 330 grant funds are not required to use a sliding fee scale and serve all, regardless of ability to pay.

21. HRSA, "2009 National Summary Report."

22. The Medicare economic index (MEI) is a national weighted average of the annual change in prices for the various inputs used to furnish physician services, such as professional liability insurance, physician earnings, employee wages, and rent. In a June 2005 report, the Government Accountability Office (GAO) expressed concerns about the appropriateness of the MEI as the annual inflation index to adjust prospective payment system (PPS) rates because it is based on the costs of an average physician and therefore does not reflect the broad array of services that FQHCs provide. GAO, "Health Centers and Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System," GAO-05-452, June 2005; available at www.gao.gov/new.items/d05452.pdf.

23. PPACA, section 5502.

24. Tonya Bowers, HRSA, e-mail to author, August 13, 2010; HRSA, "Health Centers: America's Primary Care Safety Net, Reflections on Success, 2002–2007," June 2008; available at ftp://ftp.hrsa.gov/bphc/HRSA_HealthCenterProgramReport.pdf.

25. These data represent community hospitals, which comprise 85 percent of all U.S. hospitals. Federal hospitals, long-term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and chemical dependency hospitals are excluded. Kaiser Family Foundation, "State Health Facts: Hospitals by Ownership Type, 2008 (based on American Hospital Association data); available at www.statehealthfacts.org/comparebar.jsp?ind=383&cat=8.

26. Marsha Regenstein and Jennifer Huang, "Stresses to the Safety Net: The Public Hospital Perspective," Kaiser Commission on Medicaid and the Uninsured, June 2005; available at www.kff.org/medicaid/upload/Stresses-to-the-Safety-Net.pdf.

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28. Zaman, Cummings, and Spieler, "America's Public Hospitals," p. 15.

29. Evelyne P. Baumrucker *et al.,* "Medicaid and CHIP: Changes Made by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152) to the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148)," Congressional Research Service, R41125, April 1, 2010; available at www.ncsl.org/documents/health/MACHIPchgs.pdf.

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31. Darnell, "Free Clinics," p. 949.

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33. NACCHO, *2008 National Profile,* page 19. For more information on local health departments, see Eileen Salinsky, "Governmental Public Health: An Overview of State and Local Public Health Agencies," Background Paper No. 77, National Health Policy Forum, August 18, 2010; available at www.nhpf.org/library/background-papers/BP77_GovPublicHealth_08-18-2010.pdf.

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35. PPACA, section 5208.

36. National Assembly on School-Based Health Care, "School-Based Health Centers: National Census School Year 2007–2008"; available at www.nasbhc.org/atf/cf/%7Bcd9949f2-2761-42fb-bc7a-cee165c701d9%7D/NASBHC%202007-08%20CENSUS%20REPORT%20FINAL.PDF.

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45. Section 1302(g) of PPACA requires all plans operating in the exchanges to pay FQHCs a rate that is no less than their Medicaid PPS rates.

46. CBO, letter to Nancy Pelosi.

47. PPACA, section 10333.