



Federally Qualified Health Centers and State Health Policy: A Primer for California

Introduction

Federally funded community health centers connect 16 million people to primary health care services at nearly 6,700 delivery sites nationally, forming much of the country's health care safety net.¹ In California, there were 110 such health centers in 2007, with 796 delivery sites serving more than 2.3 million patients.² These health centers are considered by the Institute of Medicine to be "core safety-net providers" because of two distinguishing characteristics:

1. By legal mandate or explicitly adopted mission, they maintain an "open door," meaning they offer access to services regardless of a patient's ability to pay; and
2. A substantial share of their patient mix is uninsured, enrolled in Medicaid, or is otherwise vulnerable.³

In its early years, the federal community health center program operated without significant state involvement. But state governments' relationships with these safety net providers have increased over time. In particular, as state Medicaid programs have grown, so has the dependence of health centers on Medicaid's federal-state payments. Nationally, Medicaid funding accounts for 36.5 percent of community health center operating revenues; direct aid from state and local governments accounts for an additional 9.8 percent (see Table 2). In California, the figures are 41 percent from Medi-Cal (Medicaid), and 12 percent from state and local grants and contracts.⁴

This substantial financing of health center operations, along with other levers, presents California with significant opportunities for influencing the viability, quality, and performance of health centers, and for helping to integrate them into the state health care system as well as into plans for its reform. This issue brief provides an overview of California health centers and the state policies that affect their operations, along with a comparison of other state approaches to health centers. The intent is to inform California policy makers about the role health centers may play in helping the state meet health goals that result in improved access, controlled costs, and high quality care, as well as the role the state may play in overseeing and supporting those health centers.

The specific ways in which California state policy engages with community health centers, as discussed in this brief, include:

- **Medi-Cal.** Medi-Cal's various payment methodologies, including its multi-faceted managed care structure, affect not only payment rates to health centers but also patient volume.
- **Other health care purchasing.** The brief discusses how, through its health care purchasing power, the state can encourage health plans to include health centers in their networks, provide wrap-around insurance payments, support chronic care management programs, and integrate behavioral health services.

- **Primary care office (PCO).** Through its PCO, the state collaborates with safety net organizations to address workforce shortages.
- **State-based grants.** Direct state funding of health centers supports workforce recruitment as well as patient care.
- **Directed federal funding.** The state can direct federal block grants and other sources of federal funding, such as federal “stimulus package” funding, toward support for health center infrastructure and information technology improvements.
- **Licensing facilities and professionals.** Licensing laws and processes help ensure quality and patient safety, and prevent fraud and abuse, but also can help

Establishment of Federally Qualified Health Centers

In the 1960s, the first two community health centers opened their doors—first in urban Boston, next in rural Mississippi—supported by federal grants and local community resources. By the end of that decade, federal funds supported over 100 community health centers that met four core requirements (later formalized in Section 330 of the Public Health Service Act [PHSA]).⁵ A qualifying health center must:

- Be located in a medically underserved area;
- Provide a detailed scope of primary health care,⁶ as well as supportive services;
- Provide services to all, based on ability to pay; and
- Be governed by a majority of community members who represent the population served.⁷

Initially, the federal community health center program was viewed as complementary to the Medicaid program and there was little intersection between the states and the health centers—health center operations were guided and funded largely by the federal government.⁸ This changed, however, as Medicaid revenues supplanted federal grants to become the health centers’ largest single source of income based on the Omnibus Budget Reconciliation Act (OBRA) of 1989.⁹ OBRA established the Federally Qualified Health Center (FQHC) reimbursement designation and applied it to three types of health centers:¹⁰

- **Community health centers**, which are public¹¹ and private nonprofit clinics that meet certain Medicare and Medicaid criteria and receive federal grant funds under the Health Center Program established by Section 330 of the PHSA;
- **“Look-alike” health centers**, which are public and private nonprofit clinics that meet the definition of health center under Section 330 but do not actually receive Section 330 federal grant funding; and
- **Tribal or urban Indian FQHCs**, which are outpatient health programs or facilities operated by tribal or urban Indian organizations.

OBRA resulted in FQHCs receiving cost-based rates to replace inadequate Medicaid and Medicare fee-for-service rates. The Institute of Medicine called these cost-based rates a “critical silent subsidy” that helped FQHCs pay for fixed overhead and infrastructure costs as well as primary health care services, freeing up limited grant dollars to cover the cost of caring for the uninsured.¹² Over time, cost-based rates became viewed as inflationary and were replaced by a prospective payment system (PPS) that maintained a higher per-visit rate than the Medicaid fee-for-service rates paid to non-FQHC providers. Despite their higher per-visit costs, the National Association of Community Health Centers asserts that patients who receive care at FQHCs save Medicaid 30 to 33 percent in total costs compared to patients who receive care elsewhere.¹³ A review done by Starfield and Shi also found that overall health outcomes were better for patients treated at FQHCs compared to patients treated elsewhere, and that FQHCs outperformed other providers such as health maintenance organizations in the delivery of primary care.¹⁴

FQHCs are also permitted to use the 340B Drug Pricing Program¹⁵ to purchase pharmaceuticals for less than the Medicaid rebate price. In addition, FQHCs were given access to the National Health Service Corps and J–1 Visa Waiver Program (for foreign medical graduates), which helped address workforce shortages.

expand the number of practitioners and sites of care for the underserved.

- **Enrollment efforts.** The state can partner with health centers to enroll the eligible uninsured in Medi-Cal or the Children’s Health Insurance Program (CHIP).

California Health Center Fundamentals

California’s nearly 1,000 federal community health center delivery sites—along with county-based, hospital-based, rural health,¹⁶ and free clinics—serve some of the most vulnerable populations in California and form an essential part of the state’s primary care safety net. These health centers are located throughout the state, concentrated in the most populous counties. For example, Los Angeles County is home to the most delivery sites (151), while San Diego County, second in population, has the second highest total (102). On the other hand, 19 of the state’s 58 counties (each of the 19 being primarily rural, with a relatively small population) have three or fewer sites each, with 10 counties having no community health center sites at all. (See Appendix A for a map of California’s federal community health center sites, and Appendix B for a table showing health centers per county.)

The socioeconomic status of California’s 2.3 million community health center patients is similar to that of health center patients nationwide, with approximately three-quarters of patients reporting household incomes at or below the federal poverty level. A considerable percentage of community health center patients in California and elsewhere in the U.S. are dependent upon Medicaid,¹⁷ while California community health centers see about 6 percent more uninsured patients than other U.S. health centers. In terms of ethnicity, nearly 62 percent of community health center patients in California identify themselves as Hispanic or Latino, compared to 34 percent nationally. Approximately half of all California patients prefer a language other than English, compared to 27 percent nationally.¹⁸ (See Table 1.)

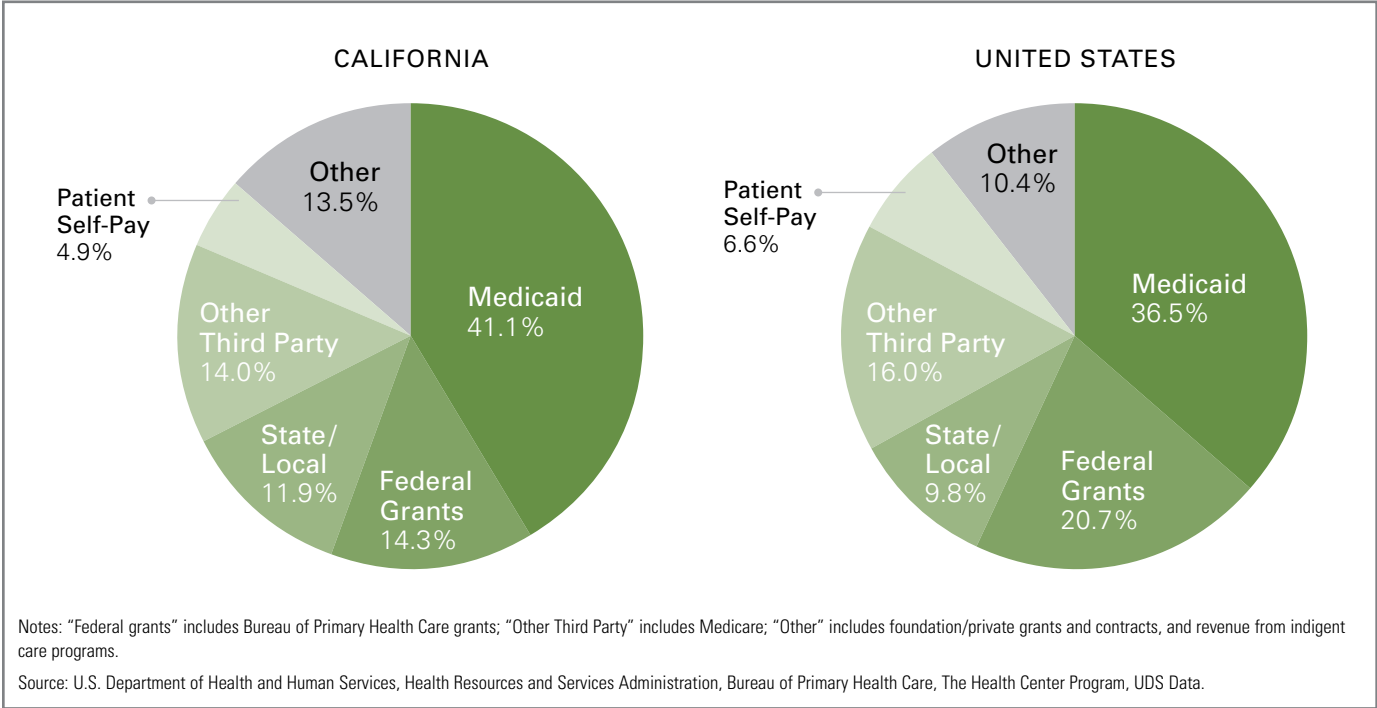
Table 1. Community Health Center Patients, California and National, 2007

	CALIFORNIA	U.S.
Household Income		
Federal poverty level or below	76.4%	70.4%
Double the federal poverty level or below	94.9%	91.4%
Insurance Status		
Uninsured	45.2%	39.0%
Medicaid	37.8%	35.4%
Ethnicity		
Hispanic/Latino	61.9%	33.8%
Language		
Prefer language other than English	48.6%	26.9%

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, The Health Center Program, UDS Data.

With regard to community health center financing, Medi-Cal payments made up 41 percent (\$597 million) of operating revenue in 2007, more than the U.S. average of 37 percent and placing California in the upper quartile of states. This higher percentage of payments is most likely explained by more expansive Medi-Cal eligibility rules and the inclusion of comprehensive benefits such as adult dental coverage.¹⁹ The remainder of California community health centers’ operating revenue comes from: other public and private third-party payers (including Medicare); federal grants; state and local grants and contracts; foundation and other private grants and contracts; indigent care programs; and patient out-of-pocket payments.²⁰ (See Figure 1.)

Figure 1. Federally Funded Community Health Centers' Operating Revenue, by Source, California and National, 2007



California's Primary Care Office and Primary Care Association

The federal Health Resources and Services Administration (HRSA) maintains cooperative agreements with each state and territory to support Primary Care Offices (PCOs). California's PCO is located within the Healthcare Workforce Development Division (HWDD) of the Office of Statewide Health Planning and Development (OSHPD). As in other states, the California PCO is charged with collecting and analyzing demographic and provider data to determine areas within the state that are underserved according to federal Health Professional Shortage Area (HPSA) criteria, and with recruiting and retaining providers to work in these areas.²¹ Designation as an HPSA allows California communities to apply for recruitment and retention assistance through various state and federal programs, and is often used to secure other sources of public and private funds. The HPSA designation process may assess the need for primary medical care, dental health, or mental health providers in an area.

HWDD also helps FQHCs with their National Health Service Corps applications and assists prospective applicants by reviewing and providing feedback and consultation during the Section 330 grant process. In addition, HWDD is charged with developing and managing a workforce clearinghouse that will help inform policy decisions affecting California's critical long-term workforce shortages.

To varying degrees, PCOs often collaborate with state primary care associations to identify and coordinate scarce resources that can be used to protect and expand the safety net. For instance, in New Mexico, this partnership arranged seed funding to help look-alike health centers, National Health Service Corps sites, and tribal sites develop into Section 330 FQHCs.

The nonprofit California Primary Care Association (CPCA) is also supported through an HRSA National Cooperative Agreement. Primary Care Associations are private, nonprofit organizations that provide training and technical assistance to health centers and other safety-net providers, support the development of health centers in their state, and enhance the operations and performance of health centers.²² CPCA's membership includes community and free clinics, FQHCs, rural and urban clinics, large and small clinic corporations, and clinics dedicated to special needs and special populations. CPCA also works closely with the legislature and state offices to advocate on behalf of its members.

Medi-Cal: The State's Primary Lever for Health Centers

California has developed and implemented a number of specific Medi-Cal policies to influence both the volume of patients and the reimbursement mechanisms at FQHCs. Through these policies—as well as analogous mechanisms that policymakers might develop in the future—the state can significantly affect the viability and reach of the health center as a vital element of the California safety net. This section describes a number of these Medi-Cal-related state policies.

Medi-Cal Alternative Payment Methodology

In 2001, federal law required states to phase out cost-based, fee-for-service reimbursement to FQHCs and instead to use an all-inclusive, per-visit, prospective payment system (PPS).²³ For 2001, each state was allowed to set the base rate using each FQHC's reasonable costs of providing Medicaid-covered services in 1999 and 2000.²⁴ Subsequent years' payments are adjusted annually, using the Medicare Economic Index (MEI) for primary care. (Texas uses the MEI +1.5 percent.)²⁵ In addition, the PPS reimbursement rate can be adjusted for certain scope-of-service changes. With federal Centers for Medicare & Medicaid Services (CMS) approval, states were allowed to establish an alternative payment methodology (APM) plan instead, as long as the resulting rate was not less than the state's PPS rate would have been. In a 2008 survey of state Primary Care Associations, out of 43 states responding, 19 states used PPS, 11 used APM, and 9 used a combination of both.²⁶

California has gained federal approval for an APM plan (based on 2000 rates rather than on an average of 1999 and 2000 rates) to provide a higher base on which to calculate future payments. In 2003, Senate Bill 36 (Chapter 527, Statutes of 2003) set into place this alternative payment methodology plus a process allowing for adjustment of FQHC reimbursement rates to account for changes in costs associated with an increase or decrease in services.

Establishing the process to account for a change in scope of services was a significant accomplishment for the state and its FQHCs. A service change might significantly increase costs for a health center, but since the transition to PPS there has been little guidance from CMS to help states determine what kind of changes in scope of service would trigger a recalculation in rates.²⁷ California's own regulatory policies and procedures provide FQHCs with the guidance to determine whether a change in service would trigger either an increase or decrease in an FQHC's PPS visit rate.

According to CPCA, however, these regulatory policies and procedures still require clarification and more guidance, due to inconsistencies in their interpretation between the California Department of Health Care Services (DHCS) and health centers. These inconsistencies can result in significant overpayment and underpayment errors in processing cost reports relating to changes in scope of services. Other states, such as Indiana and Pennsylvania, have provided more detailed written guidance, and Indiana uses a third party auditor to perform rate adjustments.

PPS to Be Used for CHIP Reimbursement

Beginning October 1, 2009, states will use PPS when reimbursing FQHCs under a state CHIP. Although only a small percentage of FQHCs' operating revenue (about 2 percent)²⁸ is derived from CHIP (known in California as Healthy Families), the total figure is significant enough to note that the Children's Health Insurance Program Reauthorization Act (CHIPRA) applies FQHC PPS policies to the CHIP program.²⁹ CHIP programs may also develop alternative payment methodologies for FQHCs, like the one in California for Medi-Cal health center reimbursement. CHIPRA appropriated five million dollars for the Secretary of Health and Human Services to distribute among states so as to help with the cost of transitioning to the new payment system.

Medi-Cal Managed Care Policies

The State of California has developed a number of ways to use its multi-faceted Medi-Cal managed care structure, and the large number of Medi-Cal beneficiaries enrolled in managed care, to channel support—in the form of patient flow and reimbursement—to health centers.

California's Unique Medi-Cal Managed Care Structure

Unique to California, Medi-Cal managed care plans are organized county by county, with three primary models operating in 23 counties, and prepaid health plans operating in an additional two counties, altogether providing 3.4 million Medi-Cal beneficiaries with health care. About half of FQHC Medi-Cal patients are enrolled in managed care, most in full capitation plans.³⁰ The plans vary from county to county, but there are state policies that cover all plans. The plan models are:

- **Two Plan.** This model operates in the 12 counties with the largest Medi-Cal populations. In the Two-Plan model, the state contracts with two managed care health plans in each of the designated counties. One plan is an established commercial health care plan awarded through a competitive bidding process, and the other is a “local initiative” organized and developed by the county Board of Supervisors. The local initiative is essentially a public-private partnership that has a contractual obligation to include safety net providers in its network.³¹
- **County Organized Health System (COHS).** These plans operate in nine counties. In this model, the state contracts with a locally developed plan that enrolls almost the entire Medi-Cal population in that county and manages their care.
- **Geographic Managed Care (GMC).** Plans in this model operate in two counties, providing access to a choice of several commercial health plans contracted by the state.
- **Prepaid Health Plan.** Plans in this model operate in two counties.

Health Plans Rewarded for High Number of Beneficiaries to FQHCs

When a Medi-Cal beneficiary who is required to participate in managed care does not select a plan within 30 days of notification, the state automatically assigns the beneficiary to a plan. This affects 18 to 23 percent of newly eligible Medi-Cal beneficiaries in a given month.³² Medi-Cal has adopted performance-based automatic assignment policies as a way of rewarding high-performing plans (currently, only those that operate in Two-Plan and GMC counties) by giving them a greater share of Medi-Cal beneficiaries. Performance is determined using five Healthcare Effectiveness Data and Information Set (HEDIS) measures, plus two other measures that specifically support safety-net providers.³³ One of these measures—percentage of managed care Medi-Cal members assigned to a safety-net primary care provider—clearly benefits FQHCs.

California Facilitates “Managed Care Differential Rate” Payments to FQHCs

Under federal law, when a managed care organization reimburses an FQHC for a visit at less than the full PPS reimbursement rate, the state must make a supplemental or “wrap-around” payment making up the difference, though states vary in how often they reconcile these payments. According to the National Association of Community Health Centers, approximately two-thirds of states provide wrap-around payments; most provide these payments on a quarterly basis, while some pay monthly and a few pay as claims are submitted.³⁴ California law (Senate Bill 36, Chapter 527, Statutes of 2003)³⁵ allows FQHCs to bill an estimated difference each time they submit a claim for a visit by a Medi-Cal managed care patient rather than being paid the differential on a quarterly basis. This policy provides a more stable cash flow to the health centers, while decreasing the administrative burden of quarterly reconciliation for both the state and FQHCs.

California's Healthy Families Program Encourages Health Plans to Contract with Safety-Net Providers

California's Managed Risk Medical Insurance Board requires health plans to annually report the number of Healthy Family beneficiaries who receive care from what are called "traditional and safety-net (TSN) providers" as their primary care providers. (TSN providers are caregivers who have historically served California's uninsured children.) The plan in each county that has the most TSN contracts is designated as the county's community provider plan (CPP). Program-eligible families can choose any plan available in the county, but if they choose a CPP, their premiums will be reduced by \$3 per child, per month.³⁶ This policy not only rewards plans by giving them a potentially greater share of beneficiaries through discounted premiums but also helps safety-net providers by increasing their revenue stream.

Other Health Care Purchasing as Health Center Levers

In addition to Medi-Cal, California purchases a significant share of health care through such programs as Healthy Families and the California Public Employees Retirement System. This purchasing power can be used to help FQHCs become more self-sufficient through policies that support their financial base and help them to meet their mission of caring for the state's most vulnerable residents.

Encouraging Health Plans to Include FQHCs in Provider Networks

Medi-Cal managed care contracts require all health plans to meet federal requirements for access to FQHC services, and Medi-Cal requires Local Initiative plans to offer subcontracts to FQHCs (see sidebar on page 6). State law also requires DHCS to provide incentives in the competitive application process to encourage commercial plans to offer subcontracts to FQHCs.³⁷

Encouraging or requiring the inclusion of FQHCs in commercial insurance provider networks and adequate

reimbursement rates from those insurers to cover federally mandated services is another state policy lever to consider.³⁸ This mechanism is used by Minnesota, which requires all health plans to contract with FQHCs and other safety-net providers designated as "essential community providers" if they are located within the area served by the plans.³⁹ Such rules help FQHCs negotiate adequate reimbursement rates, which contributes to their financial stability.

Providing Wrap-around Payments to Supplement Private Insurance

In California, private insurance payments constitute approximately 7 percent of primary care clinics' gross revenue.⁴⁰ Payments from private insurance companies are often insufficient to cover the costs of treating privately insured patients at FQHCs.⁴¹ These payment shortfalls can also indirectly affect care for the uninsured by requiring FQHCs to cost-shift to cover the costs of treating privately insured patients. Wisconsin provides wrap-around payments, similar to what is required to supplement payments from Medi-Cal managed care organizations, for beneficiaries who are eligible for both Medi-Cal and private insurance.⁴² This coordination of payment helps keep FQHCs from shifting costs from other programs to make up for their losses from inadequate private insurance reimbursement.

Supporting Providers Who Serve Chronically Ill Patients

DHCS has implemented two disease management pilot programs and one coordinated care management pilot program, and is in the process of implementing a second coordinated care management pilot program. The four pilot programs will test disease management and care coordination concepts under the Medi-Cal fee-for-service delivery system and will target various chronically or seriously ill population groups. These projects link patients with primary care providers that may include FQHCs. Although providers do not receive enhanced reimbursement, they do receive assistance managing

complex patients: outreach; disease state and co-morbidity assessment; evidence-based treatment plan development; 24-hour nurse advice telephone line; utilization monitoring and feedback; and patient education.

Other states are moving away from disease management contracts to directly supporting practices (including FQHCs) through enhanced payments and infrastructure assistance intended to help them become high-performing medical homes. For example, New Hampshire Medicaid is phasing out its disease management contract and shifting funds to a new medical home initiative.⁴³ Pennsylvania, Rhode Island, and Vermont are leading multi-payer medical home collaboratives that involve FQHCs. Providers in these programs are supported with added per-member, per-month care coordination fees, along with support for hiring additional care coordination staff, accessing registries or electronic health records, and using the services of on-site practice coaches.⁴⁴ In return, providers must achieve medical home recognition by the National Committee for Quality Assurance, report data and track care through a registry, and participate in learning collaboratives.

Behavioral Health Integration

FQHCs are required to provide behavioral health services to their patients, either on-site or through referral. Given the large number of patients who have behavioral or mental health diagnoses integrating behavioral health with primary health care services needs to be an important aspect of service delivery reform. (In 2007, California health centers had more patient visits for mental health and substance abuse conditions than for hypertension or diabetes.)^{45,46} Patients who see their primary care provider on the same day as their mental health provider are more likely to comply with treatment regimens. However, FQHCs are not reimbursed by Medi-Cal for separate, same day mental health encounters (as is allowed for dental visits, for example) and must either absorb the cost of one visit or direct a patient to return the next day,

which often results in missed appointments and lack of care.

DHCS states that although FQHCs are not reimbursed by Medi-Cal for separate, same day mental health encounters, the costs of mental health services and primary care services were included in their cost report data at the time the PPS reimbursement rate was computed. If FQHCs were allowed to bill for additional same day visits for mental health, that might require recalculation of their PPS base rates in order to avoid paying inflated rates. The effect of this recalculation on any one facility is unknown.

Other states (such as Michigan) have adopted different approaches aimed at supporting mental health care access and primary care integration. These policies include:

- Paying FQHCs for two different encounters on the same day (primary care and behavioral health); and
- Reimbursing for a new, comprehensive list of behavioral procedure codes that allows FQHCs to receive payments for an expanded range of services including screenings, brief interventions, and parenting classes.⁴⁷

State-based Grants as Health Center Levers

According to a survey of primary care associations conducted annually by the National Association of Community Health Centers, 38 states and the District of Columbia will provide direct grant funding totaling \$518 million to FQHCs in state fiscal year 2009, derived largely through general funds and tobacco taxes or legal settlements. While these investments underscore the importance to these states of health center programs, this funding is nonetheless \$48 million less than in 2008. This is the first decline in state funding for health centers in many years, an effect of the difficult state budget situations. While 19 states have increased their funding to health centers in the last year, health centers in 13 states will see a decline in state dollars.⁴⁸

State funds are provided to the health centers in various ways. Some funding is directed to a specific purpose and/or one-time use. For example, Nebraska provided health centers with one-time funds of \$250,000 for oral health services and equipment and New Jersey provided a one-time \$3 million to stabilize struggling health centers. Wisconsin and Minnesota health centers, on the other hand, receive unencumbered funds, which they are able to direct for any project or purpose.⁴⁹

California's FY09 state funding to health centers will total \$44.1 million, a decrease of \$3.2 million from the previous year.⁵⁰ This direct funding includes a number of grant programs that fund health center workforce recruitment as well as direct patient care activities, including:

■ **Expanded Access to Primary Care Program.**

Administered by the Primary and Rural Health Division of California DHCS, it provides eligible, licensed primary care clinics (not limited to FQHCs) with funds for expanding their level of services, including preventive health care.

■ **Rural Health Services Development Program.**

Administered by the Primary and Rural Health Division of DHCS, it awards grants to community-based, private, nonprofit, licensed primary health care clinics throughout rural California for the provision of comprehensive primary and preventive health care services, including dental and nutritional services.

■ **Seasonal Agricultural and Migratory Workers Program.**

This initiative awards grants to community-based, private, nonprofit, licensed primary health care clinics throughout California through a variety of funding streams. (The program is funded by the state's General Fund only.) Administered by the Primary and Rural Health Division of DHCS, the program goal is to improve the health status of a targeted population of medically underserved, indigent persons, or those who experience cultural or language barriers in the context

of health care. This program also focuses on the development of bilingual services in health education and nutrition.

■ **Steve Thompson Loan Repayment Program.**

Administered by the Health Professions Education Foundation in the Office of Statewide Health Planning and Development, this program repays up to \$105,000 in outstanding government or commercial education loans obtained for undergraduate and graduate medical education. Those eligible are licensed physician graduates who are practicing direct patient care within California. Each graduate in the program commits to a three-year service in a medically underserved area in California. (Texas is beginning an analogous loan repayment program to increase the number of doctors and dentists who provide care for children with Medicaid coverage. Providers in this program are eligible for up to \$140,000 in loan repayments over four years if they meet targets for services provided to children on Medicaid.)⁵¹

■ **Song-Brown Program.** Administered by the Office of Statewide Health Planning and Development, this program encourages universities and primary care health professionals to provide health care in medically underserved areas. It also provides funding to institutions (not individuals) that provide clinical training for family medicine residents, family nurse practitioners, physician assistants, and registered nurses throughout California.

In the recent past, California has also provided grant funding for infrastructure. The Cedillo and Alarcon Investment Act has been a periodic source of grant funding to eligible primary care clinics for capital outlay projects, including buildings and health information technology, but has not received funding since 2005. Other states have also used funding streams to support health center capacity, including Maryland, where the Board of Public Works is spurring investments in FQHCs by offering grants for the renovation or purchase of

capital equipment for FQHCs or conversion of buildings to become FQHCs.⁵²

Directing Federal Grant Funding

States can seek federal funds and make them available to help strengthen the safety net. (State access to funds made available by the American Recovery and Reinvestment Act of 2009 [ARRA] “stimulus package” are discussed in the section “California’s Challenges and New Federal Help,” below.) In 2005, California received a Medicaid hospital demonstration project waiver which provides \$540 million in federal funds for county demonstration projects to expand coverage and care to uninsured populations. Guided by state legislation (SB 1448, Stats. 2006, Chapter 76, Kuehl), ten Health Care Coverage Initiatives (HCIs) were established to support the following goals:

- Reduce the number of Californians who do not have health insurance or Medi-Cal coverage, and provide them with a medical home;
- Strengthen and build upon local safety-net systems;
- Improve health outcomes and access to high-quality health care; and
- Create cost efficiencies in the health delivery system.⁵³

According to CPCA, the experiences of community clinics implementing their county’s HCIs are varied. However, CPCA says that most clinics surveyed report that the program is reaching some of its intended goals and providing them with an additional revenue stream. Were the program to be extended beyond 2010, these clinics say, they would continue to subcontract with the county.

Another potential revenue stream could come from the state partnering with FQHCs to deliver services from categorical federal public health programs. Directing a portion of the funds provided by federal block grants, such as Title V Maternal and Child Health Block Grants, Title X Family Planning Grants, and Title IV Ryan White

AIDS CARE Act Grants, to safety-net providers could help the state achieve important public health goals, such as meeting immunization and newborn screening targets. In Colorado, for example, the state provides portions of a number of federal block grants to various safety-net providers for direct care or for enabling of non-medical services.⁵⁴

Licensing Health Facilities and Professionals

Through the licensing of health facilities and health professionals, states help protect the public by ensuring that facilities meet minimum safety and quality standards. In addition, the licensing and certification process is intended to prevent fraud and abuse of the Medi-Cal and Medicare billing systems. However, licensure laws can also be used to help states improve access to health care by expanding sites of care and the ranks of practitioners who provide it.

Health Facility Licensing

FQHCs, FQHC look-alikes, nonprofit rural health centers, free clinics, and other types of nonprofit community clinics are required to be licensed as primary care clinics by the California Department of Public Health, Licensing and Certification Division. (Publicly owned FQHCs that are not included on a public hospital license are not required to be licensed as primary care clinics.) A licensed primary care clinic is required to regularly send workforce and other data to the Office of Statewide Health Planning and Development.

California does not require its primary care clinics to monitor patient safety by reporting patient safety data, but many other states do. For instance, Massachusetts requires FQHCs (which are licensed under clinic regulations) to report incidents that seriously affect patient health and safety.⁵⁵ The intake staff in the complaint unit review each report and determine whether an on-site investigation is required to assess compliance, whether issues or questions can be resolved through

“off-site” intervention, or whether some other action, such as a referral to a professional board in regards to licensed staff, is most appropriate. If an on-site investigation is required and the health center is found to be deficient, a correction plan may be required. If no corrective action is taken, the state could proceed with license revocation.

States also have the power to ease regulatory oversight to help facilities meet their mission. For instance, New Mexico has given certain health centers more flexibility in their pharmacy operations in areas such as supervision, hours of operation, and dispensing guidelines to address access and workforce shortage needs.

Licensing laws can also help facilitate access to health care by opening new points of care. However, according to CPCA, the process for submitting a new application is daunting and can be discouraging for new applicants, and it has sponsored legislation to streamline this process. The Licensing and Certification Division has established an online application and information site to help those applying for a new license. It also has dedicated staff to provide technical assistance with the application process. In addition, a new training curriculum for licensing staff has been implemented. The Licensing and Certification staff holds quarterly meetings with CPCA to address improvements in the licensing process.

Health Professionals’ Licensing

Through professional licensure requirements, states can provide opportunities for new kinds of practitioners and expanded roles for existing practitioners to help address critical workforce shortages. State legislatures have the authority to determine licensing and practice requirements and scope of practice.

California has developed a program that allows organizations to test, demonstrate, and evaluate new provider models before changes are made in licensing laws. The Health Workforce Pilot Projects Program (HWPP), established by the legislature in 1972 in

response to serious healthcare workforce shortages, allows for expanding the roles of health care workers on a demonstration basis.⁵⁶ One of these pilot programs led to the licensure of the Registered Dental Hygienist in Advance Practice (RDHAP), a practitioner who has played an important role in providing dental services for community health centers. Community health centers can serve as important locations for demonstrating such innovative workforce solutions.

Other options the state might consider to help expand the capacity of safety-net providers to better serve vulnerable populations include broadening the permitted scope of practice of non-physician health professionals such as pharmacists, nurse practitioners, physician assistants, dental hygienists, psychologists, and social workers. Another option is to offer flexible licensure, such as temporary licensure for providers arriving from other states. New Mexico, for example, offers licensing by credentials, and waives licensing exams for these providers after they have practiced in the state for several years with a temporary license.

Enrolling Those Eligible for Public Coverage

As California looks to expand coverage to the uninsured, health centers can help them enroll eligible populations. (Using data from the 2005 California Health Interview Survey, UCLA researchers found that more than half of the uninsured children in California are eligible for public programs but are not enrolled.)⁵⁷ Federal law requires states to provide workers at each FQHC to enroll eligible low-income women, infants, and children into Medicaid or to provide an alternative plan approved by CMS.⁵⁸

One of the ways California is addressing this mandate is through Certified Application Assistants (CAA). The state reimburses CAAs who successfully enroll an applicant into Healthy Families or Medi-Cal through the Single Point of Entry process, which allows applications to be sent to a single site for eligibility screening. CAAs

are located in community based organizations, county hospitals, county clinics, and some FQHCs. Despite this CAA program, according to the National Association of Community Health Centers, California has only partially met its mandate, which is to say there are enrollment workers in “some health centers and some sites, paid for somewhat by the state and somewhat by the health center.”⁵⁹

Some states are using private funding to help bolster local enrollment efforts. With private grant funding, Alabama has developed an innovative enrollment approach: a five-county pilot program that uses kiosks placed in local health departments to walk applicants through the enrollment process in both English and Spanish.⁶⁰ Wisconsin uses state funds matched by a grant from a commercial insurer to train community based organizations to assist with enrollment.

In California, there are programs that help simplify and streamline the enrollment process. For example, One-e-App is a Web-based system for connecting families with a range of publicly funded health and social service programs. This one-stop approach improves the efficiency and user-friendliness of the application process for families seeking health coverage. Communities can use One-e-App to screen individuals and families for programs such as Medicaid, CHIP, and their own local health insurance expansion programs, and submit the applications to those programs electronically. One-e-App is being used in several counties and locations throughout the state. There is also an on-line application called Health-e-App, which facilitates enrollment in the Healthy Families program. This work is being supported by the California HealthCare Foundation and the California Endowment in coordination with the state.

CHIPRA offers federal funds for states to improve outreach and enrollment, including facilitating efforts through health centers. CHIPRA includes increased, multi-year funding estimated to cover 4.1 million

children nationally who would otherwise be uninsured. The legislation includes a focus on outreach and enrollment, including \$100 million for national outreach efforts, of which \$80 million is to be awarded through federal grants. Eligible grant recipients include states, federal health safety-net organizations, community-based organizations, schools, and others. These outreach grants are meant to target geographic areas with high rates of eligible but unenrolled children, including racial and ethnic minorities and children living in rural areas. California and its health centers have an opportunity to apply jointly for CHIPRA outreach grants to expand enrollment of the uninsured into publicly financed programs.

California’s Challenges and New Federal Help

As California and the nation consider health care reform, it is essential that the health service delivery system be able to respond to the needs of both the insured and the uninsured, and that there are accessible, affordable sources of regular, high-quality primary health care services. States such as Pennsylvania, Rhode Island, and Vermont are pooling their resources with the private sector, including commercial insurers and state quality improvement organizations, to help ensure that comprehensive primary care is being supported through enhanced payments and on-site assistance, with a particular focus on chronically ill populations. FQHCs are important partners in these states’ efforts.

Infrastructure

Expanding access to health care and meeting capacity and technology demands will require significant infrastructure improvements. Building an overall information technology infrastructure is important for helping providers keep pace with activities such as care coordination, evidence-based medicine, population management, patient safety, and quality monitoring, as well as improve efficiencies in care. In addition, this infrastructure can help safety-net providers gain access

to scarce specialists, particularly in rural areas, through telemedicine. Several states, including Idaho, Maine, and Vermont, are fostering an environment that will support an information technology infrastructure. In Vermont, a health information exchange network is underway that will allow for information sharing among health care facilities, health care professionals, public and private payers, and patients, as well as give providers access to a Web-based registry. The network is being financed through an assessment on paid insurance claims.⁶¹

States can expand the capacity of their safety net by using federal dollars to build more health centers. California can draw upon the expertise of its PCO and PCA, as well as safety-net providers such as county hospital systems, to seek federal grant funds to expand care in underserved areas by establishing more health centers and helping existing health centers update or expand their facilities.

The American Recovery and Reinvestment Act of 2009 (ARRA) provides assistance to meet many of these infrastructure goals by funding several major initiatives related to health centers, totaling well over \$2 billion nationally. (Concerns have been raised, and federal intervention has been requested, after a few states signaled that they planned to reduce funding for health centers as a direct response to ARRA funding, which would work against the Congressional intent to serve additional patients, hire more staff, and improve facilities during the economic downturn.)⁶² Elements of the ARRA stimulus related to health care include:

- **Health center infrastructure funding.** The stimulus package includes \$1.5 billion in infrastructure funding that will be awarded to federally funded health centers for facility construction and renovation, equipment, and acquisition of health information technology (HIT).
- **Health center operations funding.** The package contains \$500 million for new health center sites and services across the country, as well as supplemental

payments to existing health centers to address spikes in the number of uninsured patients.

- **HIT payments through Medicaid.** ARRA also makes available, through Medicaid, more than \$60,000 per eligible provider over the next five years for the adoption, maintenance, and use of electronic health records. FQHCs are specifically listed as eligible for these payments.⁶³

Workforce

California must engage in a great deal of work to assure that the state's health care systems have the workforce capacity to address the needs of its complex, growing population. This includes making sure that California's diverse population has access to providers that offer culturally and linguistically competent health care. It also means addressing a lack of access to specialty providers by its large underserved population, a problem exacerbated by the fact that Medi-Cal pays physicians only 59 percent of Medicare rates for the same services, making it difficult for primary care providers to get specialists to see Medi-Cal patients.⁶⁴

ARRA may help California to meet many workforce goals by providing targeted federal assistance. One of ARRA's funding streams provides primary care workforce funding totaling \$500 million, including funds for the National Health Service Corps and federal Health Professions and Nurse Training programs. There is also national service funding: \$89 million for existing AmeriCorps grantees and \$65 million for VISTA programs could provide a boost to the approximately 800-member Community HealthCorps program, which has 150 delivery sites across 19 states, the district of Columbia, and Puerto Rico. Community HealthCorps has six program sites in California.^{66,67}

The State's PCO and Workforce Shortages

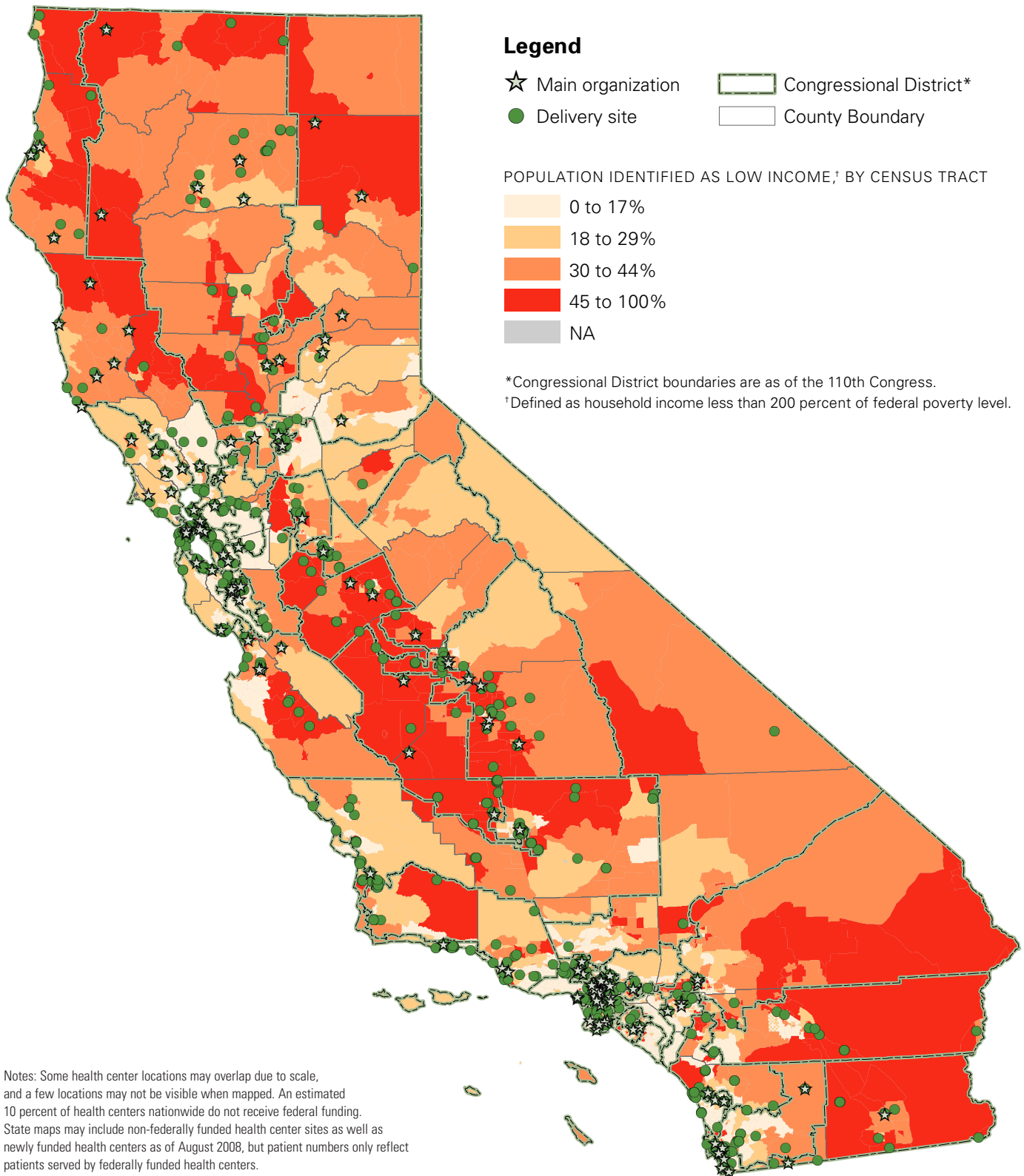
Like other states, California has chronic health care workforce shortages that create challenges for its health centers in recruiting and retaining all levels of staff. Additionally, California health centers must hire staff that are culturally and linguistically able to serve California's increasingly diverse population.⁶⁵

California's PCO is charged with addressing these workforce needs in a number of ways. The PCO helps manage state workforce grants and provides technical assistance to health centers so that they may achieve federal designation for workforce assistance. In addition, California's PCO is mandated to develop and manage a workforce clearinghouse to address long-term workforce shortages. In 2007, California legislation (SB 139, Chapter 522, Statutes 2007) called for OSHPD to centralize the state's existing health care workforce and education data into a central, electronically accessible clearinghouse. OSHPD was also charged with analyzing the data collected, and with submitting annual findings and recommendations to the legislature. OSHPD will test data collection and reporting on the use of two health care occupations (registered nurses and physicians assistants) before full implementation of the clearinghouse in the 2010–11 fiscal year.

Conclusion

Serving the most vulnerable populations in difficult economic times is a challenge for all states. California has a long history of supporting safety-net providers such as FQHCs through direct grant support, indigent care programs, and Medi-Cal. Changes in demographics, unemployment, and insurance status have increased pressure on limited state resources and on FQHCs to respond to more people in need. However, with continued collaboration among FQHCs, the state, and the federal government, and by developing new relationships with private partners, California can help ensure that the safety net is capable of responding to the increased number of people in need and be a reliable source of primary care for the underserved.

Appendix A: California Health Center Sites



Notes: Some health center locations may overlap due to scale, and a few locations may not be visible when mapped. An estimated 10 percent of health centers nationwide do not receive federal funding. State maps may include non-federally funded health center sites as well as newly funded health centers as of August 2008, but patient numbers only reflect patients served by federally funded health centers.

Sources: Site data: Bureau of Primary Health Care (BPHC) Uniform Data System (UDS) July 2008 list of non-federally funded health centers, BPHC list of August 2008 funded health center grantees. Geographic and demographic information: U.S. Census 2000 and the most recent boundary file from www.healthlandscape.org. Map: National Association of Community Health Centers and Robert Graham Center.

Appendix B: Number of Federal Health Center Delivery Sites per California County, 2007

COUNTY	NUMBER OF HEALTH CENTERS	COUNTY	NUMBER OF HEALTH CENTERS
Alameda	69	Placer	0
Alpine	0	Plumas	0
Amador	0	Riverside	21
Butte	5	Sacramento	24
Calaveras	0	San Benito	1
Colusa	1	San Bernardino	6
Contra Costa	19	San Diego	102
Del Norte	3	San Francisco	66
El Dorado	2	San Joaquin	6
Fresno	19	San Luis Obispo	30
Glenn	2	San Mateo	22
Humboldt	21	Santa Barbara	42
Imperial	7	Santa Clara	29
Inyo	1	Santa Cruz	17
Kern	36	Shasta	10
Kings	2	Sierra	1
Lake	1	Siskiyou	6
Lassen	4	Solano	11
Los Angeles	151	Sonoma	15
Madera	3	Stanislaus	34
Marin	8	Sutter	5
Mariposa	2	Tehama	0
Mendocino	14	Trinity	0
Merced	19	Tulare	19
Modoc	0	Tuolumne	0
Mono	0	Ventura	44
Monterey	16	Yolo	13
Napa	8	Yuba	6
Nevada	3	Total in California	961
Orange	15		

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, "Find a Health Center" http://findahealthcenter.hrsa.gov/Search_HCC_byCounty.aspx. Retrieved 10 July 2009.

Note: Total number of health centers according to HRSA "Find a Health Center" differs from Appendix A map due to an increased number of health centers opening since publication of map.

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ABOUT THE FOUNDATION

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

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 - (I) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;
 - (II) diagnostic laboratory and radiologic services;
 - (III) preventive health services, including prenatal and perinatal services; appropriate cancer screening; well-child services; immunizations against vaccine-preventable

- diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; voluntary family planning services; and preventive dental services;
- (IV) emergency medical services; and
- (V) pharmaceutical services as may be appropriate for particular centers:
- (ii) referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services);
- (iii) patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services;
- (iv) services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals); and
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