Community Clinic Grant Program

Report to the Minnesota Legislature 2008

Minnesota Department of Health

January 16, 2008

MINNESOTA MDH DEPARTMENT OF HEALTH

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Community Clinic Grant Program

Executive Summary

Minnesota Statute 145.9268 directs the commissioner of the Department of Health to report the needs of community clinics to the Legislature and provide recommendations for adding or changing eligible activities under the Community Clinic Grant Program (M.S. 145.9268.)

The purpose of the Community Clinic Grant Program is to support the capacity of eligible community clinics to serve low-income populations by helping to reduce current or future uncompensated care burdens or provide for improved care delivery infrastructure.

Community clinics are an integral part of the health care safety net for the state of Minnesota. The definition for "community clinic" varies from program to program; however, under this program, a community clinic is a nonprofit, tribal, Indian Health Service or publicly owned clinic that is established to provide health services to low income or rural population groups. Eligible clinics are required to provide medical, preventive, dental or mental health primary care services and must utilize a sliding fee scale or other procedure to determine eligibility for charity care or to ensure that no person will be denied services because of inability to pay. These safety net clinics help to ensure access to health care for population that are uninsured or underinsured.

Eligible activities under the Community Clinic Program are broad, ranging from medical supplies to capital expenditures. Statute also provides for grant awards for "other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve." The statute clearly allows for a wide variety of projects to help safety net clinics provide health care services to uninsured and underinsured populations.

The total appropriation currently is $567,000. Since the program began in 2002, the demand for funds has greatly exceeded the availability of appropriated dollars. Safety net clinic applicants under the Community Clinic Grant Program report large and growing uncompensated care costs that produce operating losses and put them at financial risk. In the last two years, these increased costs have resulted in the closing of two Federally Qualified Health Center satellite clinics.

The recommendations for changes to the Community Clinic Grant Program are straightforward. There is no need to change or expand the eligible activities under this program. The current statute is broad and allows for an expansive variety of projects to help safety net clinics provide health care services to uninsured and underinsured populations. Given the marked growth in the uninsured population seeking care at these clinics, increased funding through this program or a variety of other funding approaches would further support services to these populations.

Legislative Authority

Minnesota Statute 145.9268 directs the commissioner of the Minnesota Department of Health to report the needs of community clinics to the Legislature and provide recommendations for adding or changing eligible activities under the Community Clinic Grant Program.

Program Introduction

The purpose of the Community Clinic Grant Program is to support the capacity of eligible community clinics to serve low-income populations by helping to reduce current or future uncompensated care burdens or provide for improved care delivery infrastructure.

The Office of Rural Health and Primary Care implemented the Community Clinic Grant Program as authorized by the Legislature in 2001. During the 2005 legislative session, the program was revised to incorporate the Rural Community Health Center Program. The Rural Community Health Center Program was similar and had been dually administered with the Community Clinic Program. Revised statutes require a geographic representation of grant awards among all regions of the state, urban and rural.

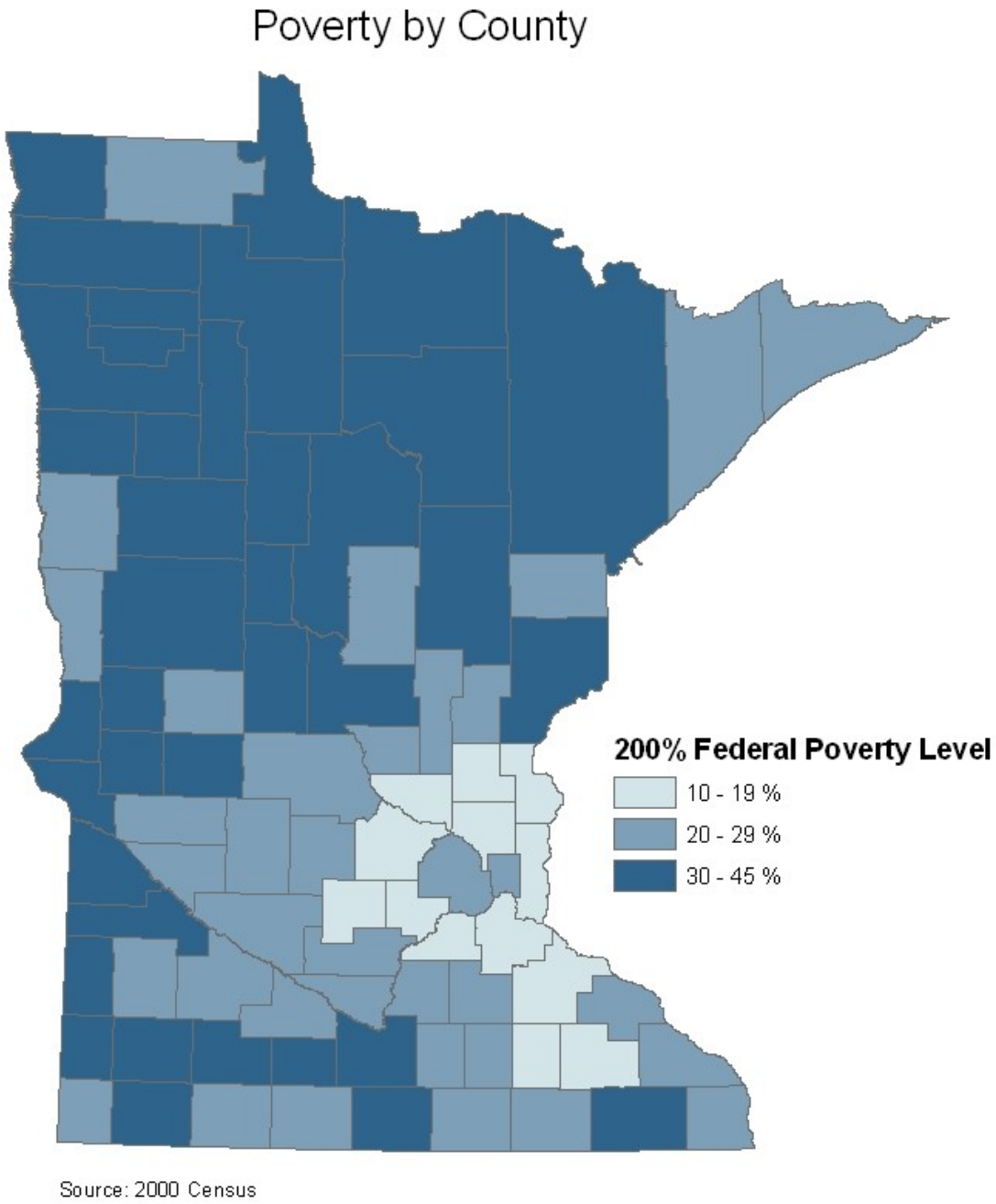
Community Clinics

Community clinics are an integral part of the health care safety net for the state of Minnesota. The definition for “community clinic” varies from program to program; however, under this program, a community clinic is a nonprofit, tribal, Indian Health Service or publicly owned clinic that is established to provide health services to low income or rural population groups. Eligible clinics are required to provide medical, preventive, dental or mental health primary care services and must utilize a sliding fee scale or other procedure to determine eligibility for charity care or to ensure that no person will be denied services because of inability to pay. These safety net clinics help to ensure access to health care for population that are uninsured or underinsured.

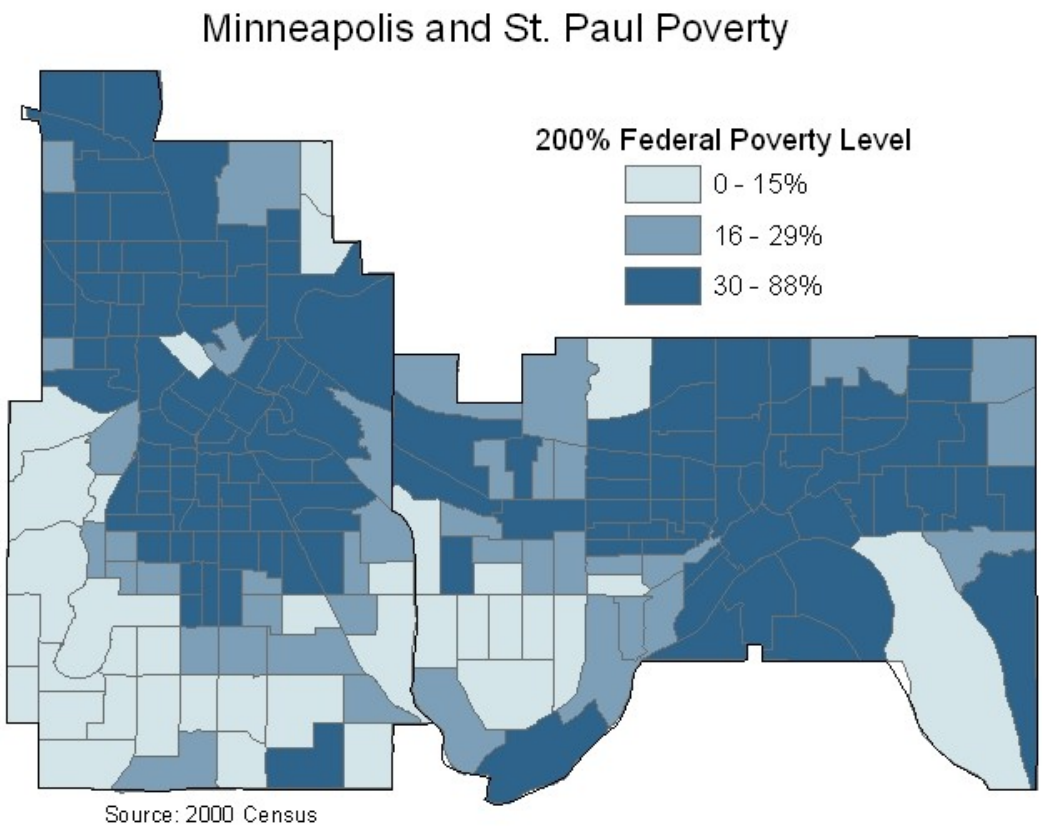
Target Population

Two common indicators of health care access are poverty status and uninsurance rate. Populations in poverty are often underinsured and, like the uninsured, lack a medical home. According to the 2000 Census, over 21.5 percent (1,035,000 people) of Minnesotans are under 200 percent of the federal poverty level.

By county, the population under 200 percent of poverty varies from 9.8 percent to 44.8 percent with nearly half of Minnesota counties at 30 percent or higher. The following map shows poverty levels statewide by county.

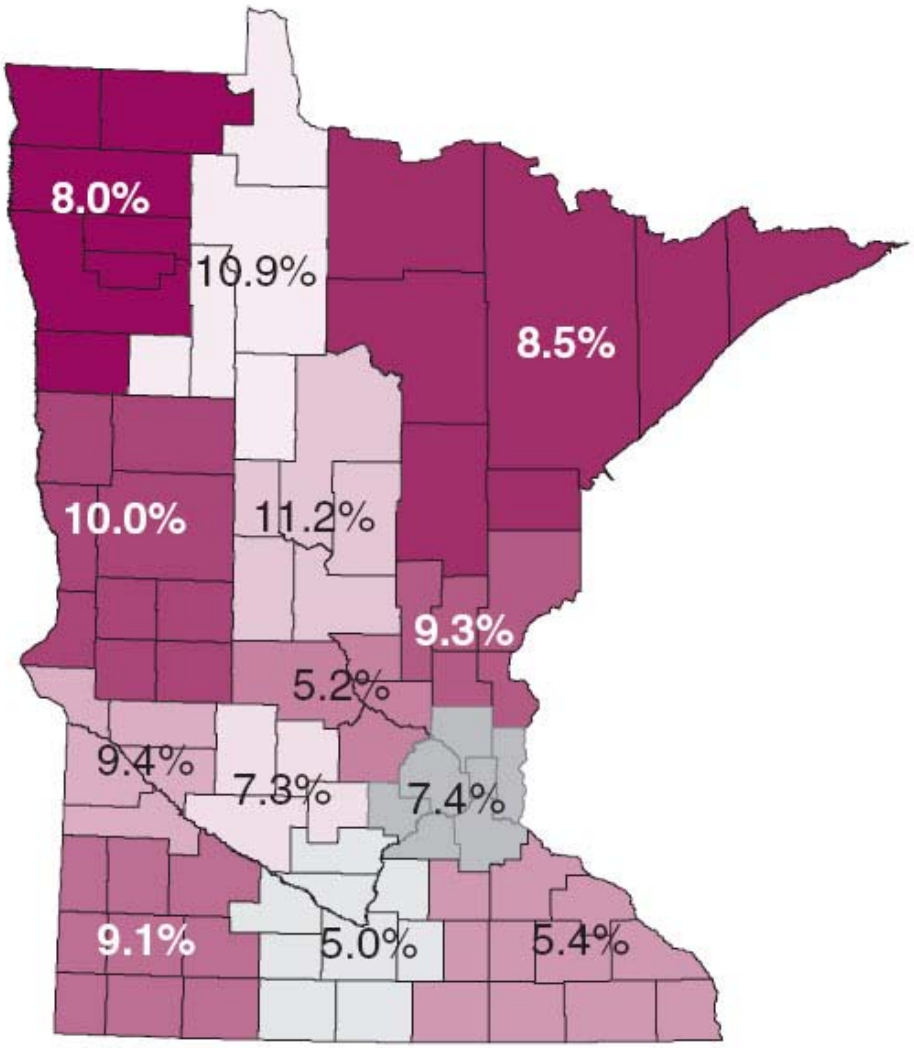


Urban areas experience heavy concentrations of populations in poverty. Within the cities of St. Paul and Minneapolis, many census tracts report 30 to 88 percent of the population under 200 percent federal poverty level. The following map shows poverty levels for Minneapolis and St. Paul by census tract.



According to the 2004 Minnesota Health Access Survey (a collaborative survey by the Minnesota Department of Health and the University of Minnesota, School of Public Health), the overall rate of uninsurance in Minnesota is 7.4 percent. This is an increase from the 2001 rate of 5.7 percent. Geographically, these rates vary from 5 percent to 11.2 percent with major portions of the rural areas over 9 percent, as shown in the map below.

Map of 2004 Uninsurance Rates by Geographic Region in Minnesota



Source: 2004 Minnesota Health Access Survey

Not only do the rural populations experience higher rates of uninsurance, it is also important to note that many of the populations of color in Minnesota experience great disparities with regard to uninsurance. The uninsurance rate for White populations is at 5.9 percent, 12.8 percent for Black populations, 9.8 percent for Asian populations, and 21 percent for American Indians. Hispanic/Latinos have the greatest uninsurance disparity at 34.2 percent. Similar to poverty, St. Paul and Minneapolis have large concentrations of populations of color, with some census tracts

as high as 91 percent. These inner city populations experiencing poverty and uninsurance are primarily served by the community clinics, such as Federally Qualified Health Centers (FQHCs).

Eligible Grant Activities

The eligible activities under the Community Clinic Program are broad, ranging from medical supplies to capital expenditures. Per the program statutes, awards may be made to community clinics to plan, establish or operate services to improve the ongoing viability of Minnesota's clinic-based safety net providers. Eligible grant activities include:

- Provide a direct offset to expenses incurred for services provided to the clinic's target population
- Establish, update or improve information, data collection or billing systems, including electronic health records systems
- Procure, modernize, remodel or replace equipment used in the delivery of direct patient care at a clinic
- Provide improvements for care delivery, such as increased translation and interpretation services
- Build a new clinic or expand an existing facility.

The statute also provides for grant awards for "other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve." The statute clearly allows for an expansive variety of projects to help safety net clinics provide health care services to uninsured and underinsured populations.

Types of Awards

Awards have been provided in each of the eligible categories allowed in statute. In the many cases involving direct services, the targeted populations have included not only uninsured and underinsured but also other disadvantaged populations experiencing barriers in accessing health care. These include farmers, migrant farm workers, American Indians, African and Asian refugees, immigrants, low-income children and pregnant women, rural/frontier populations, people who are disabled, elderly, non-English speaking, Hispanic and homeless.

A summary of the program awards include the following major categories:

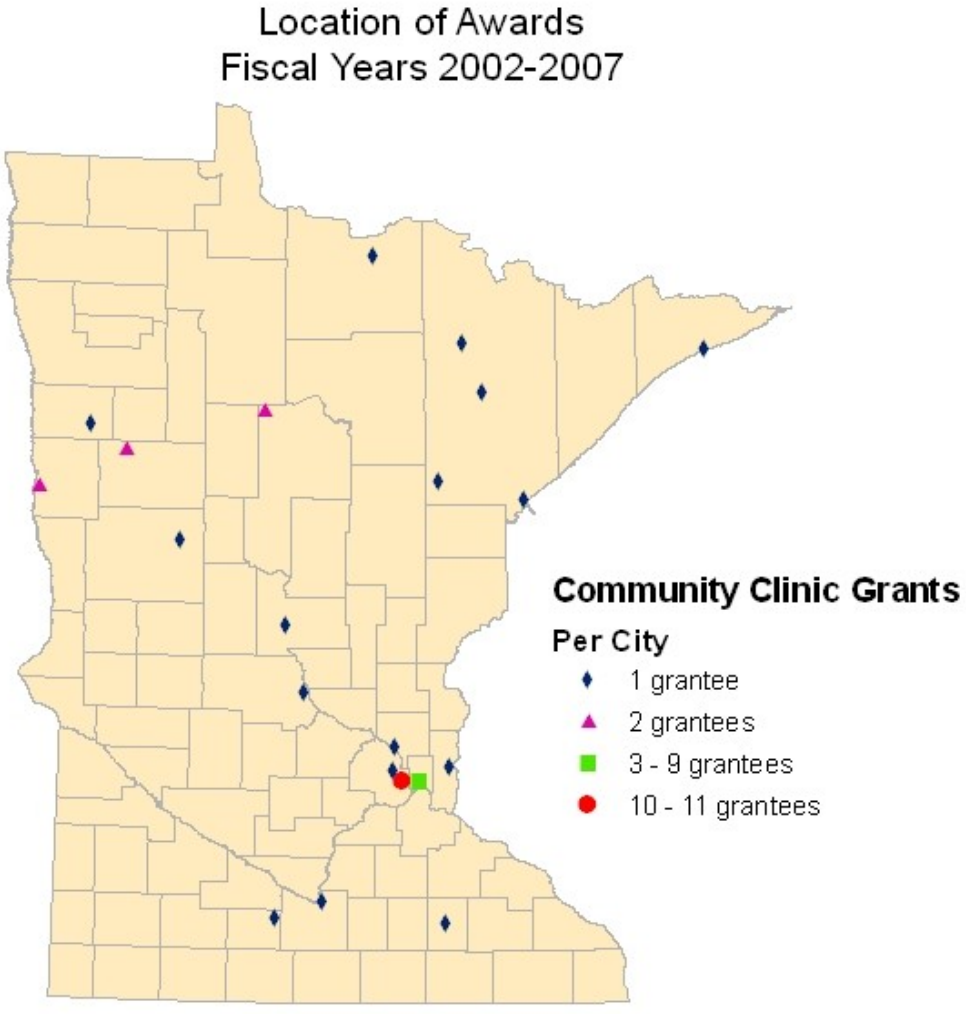
- Direct health care services, including medical, dental, mental health, ob/gyn, pediatric
- Equipment, including dental, medical, technological
- Health information technology, including electronic health records
- Homeless medical services
- Immunization programs
- Mobile clinic services
- Offset of uncompensated care costs
- Offset of uncompensated lab and testing services
- Patient assistance for public program applications
- Pharmaceuticals

- Renovation of space, including medical clinics, dental clinics, mental health clinics
- Renovation of mobile clinic
- Translation/interpretation services.

Historical Allocation of Grants

Grants have been provided to a variety of organizations including Rural Health Clinics, Federally Qualified Health Centers, Community Mental Health Centers, hospitals, Indian Health Services, community networks, tribal clinics, public health clinics, rural medical clinics, dental clinics, family planning clinics, counseling and mental health clinics, teen clinics, and faith-based clinics.

The following map shows the location of grantees across the state, with many communities having multiple recipients.



Source: Office of Rural Health and Primary Care

Prior to Fiscal Year 2006, when the Community Clinic and the Rural Community Health Center Programs were combined, most of the awards were made to organizations located in urban areas. Rural awards were offset by the Rural Community Health Center program. Current statutes require a geographic representation of grant awards among all regions of the state, urban and rural.

Grant Availability

The current appropriation for this program is drastically less than it was in the first and second years of operation. Over $3 million was appropriated in Fiscal Year 2002 and just over $1 million in Fiscal Year 2003. The appropriation was $317,000 in Fiscal Year 2004. The total available appropriation currently, with the combined Rural Community Health Center funds (programs combined in statute in 2005), is $567,000.

Based on the limited funding, program staff implemented a maximum award amount of $45,000, allowing for approximately 12-14 grant awards each year. Since the program began in 2002, the demand for funds has greatly exceeded the availability of appropriated dollars. For the current grant cycle, the Office of Rural Health and Primary Care received 40 applications with $1,706,721 requested in funding, *over three times the available appropriation*. An historical summary of grant requests and awards is below:

Community Clinic Grants Summary				
Fiscal Year	**Total Requested**	**Total Awarded**	**Number of Requests**	**Number of Awards**
2002	$6,293,752	$3,039,300	27	22
2003	$2,569,613	$1,009,907	27	21
2004	$ 896,604	$ 317,000	20	9
2005	$ 967,700	$ 337,000	22	8
Community Clinic Grants Summary (after statute revision to incorporate Rural Community Health Center Program)				
2006	$1,155,962	$567,000	37	13
2007	$1,599,004	$567,000	36	14
2008	$1,706,721	Not finalized	40	

Need for Grants

The need for grants to community clinics has increased with the rising cost of health care. Providing care to uninsured and underinsured patients has resulted in uncompensated care costs for community clinics that put them at financial risk. Since health care clinics, other than certain designated clinics, are not regulated by the state, clinic-level data is not collected by the Minnesota Department of Health. Some data is available for the Federally Qualified Health Centers (FQHCs). FQHCs, often referred to as community health centers, are federally

designated under Section 330 of the Public Health Service Act. These clinics are private nonprofit or public organizations that provide primary and preventative health care services to medically underserved populations. All of the FQHCs in Minnesota are members of the Minnesota Association of Community Health Centers (MNACHC) to which the clinics provide data for use in policy formation.

According to MNACHC, FQHCs provided care to over 68,000 (41 percent of their total patients) uninsured Minnesotans in 2005. Additionally, 81 percent of patients had household incomes under 200 percent of the federal poverty level and 35 percent of patients were enrolled in a public health care program (MinnesotaCare, GAMC, Medicaid or Medicare).

In 2006, the uncompensated care costs for these clinics totaled $11,886,301, ranging from approximately $55,000 to $4,000,000 per clinic. In the last two years, these increased costs have resulted in the closing of two FQHC satellite clinics. Other safety net clinic applicants under the Community Clinic Grant Program also report large uncompensated care costs resulting in operating losses. Many applicants report using financial reserves to maintain clinical operations for the uninsured and underinsured populations they serve. These safety net clinics increasingly rely on grant funding to not only maintain services to the uninsured and underinsured, but more important continue to operate.

Recommendations

The recommendations for changes to the Community Clinic Grant Program are straightforward. There is no need to change or expand the eligible activities under this program. The current statute is broad and allows for an expansive variety of projects to help safety net clinics provide health care services to uninsured and underinsured populations. Given the marked growth in the uninsured population seeking care at these clinics, increased funding through this program or a variety of other funding approaches would further support services to these populations.

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