



An Assessment of the Potential Impact of Health Reform on Free/Charitable Clinics

Executive Summary

This report assesses the potential impact of health reform on free/charitable clinics. At first glance some observers might conclude that health reform—by extending insurance coverage to 32 million or 94 percent of Americans—automatically spells a diminished role for free clinics. But this analysis reaches the contrary conclusion: health reform paves the way for an *expanded* role for free clinics. To take advantage of the opportunities that exist for an expanded role under a reformed healthcare environment, however, free clinics must first embrace their historic roles in the healthcare safety net as: gap-fillers, bastions of volunteerism, mission-driven providers of free and low-cost care, and community-based training sites for health professionals.

Free clinics as gap-fillers. Free clinics have long played the role as gap fillers in the safety net and there will continue to be a need for free clinics to assert this role after health reform for two reasons.

First, gaps in coverage and services remain. It is projected that 23 million people will be without health insurance when the health reform law is fully implemented. This projection is more than 10 times the number of patients that free clinics were estimated to have served in 2006. Also, health reform does not include dental services for adults or health education—two services that many free clinics currently provide—among the list of required services in the essential health benefits package.

Second, coverage is not synonymous with access. While nearly half of the coverage expansion is achieved through making more people eligible for Medicaid, it is well documented that a sizeable minority of people who are eligible do not actually enroll. And even among those who successfully obtain (Medicaid or private) coverage, utilization of healthcare services will depend on their ability to find a provider willing to see them. This may prove difficult in an environment that is expected to face severe workforce shortages and encompasses providers who perceive low-income and formerly uninsured patients as not worth the hassle because they are believed to be sicker and less compliant. Apart from the limited supply of (willing) providers, some people will not obtain the care they need because of affordability concerns. High co-payments, coinsurance, and deductibles likely will create a class of people who are “underinsured.” People with chronic illnesses and people who require ongoing specialty care or take multiple medications on a daily basis may be especially vulnerable to experiencing access-to-care problems because of the cost of care.

With the injection of \$11 billion into the federal health center program, health reform might be expected to pick up the slack for those who are likely to fall through the cracks. While undoubtedly health centers will improve access to care for millions of Americans, there also will

be millions of people who do not benefit from the federal health center expansions for the simple reason that they do not live in an area that is (*or can be*) served by health centers.

Free clinics as bastions of volunteerism and mission-driven providers of free and low-cost care. The United States has a long history of using private charity to meet the needs of the poor and underserved. Toward that end, free clinics make extensive use of volunteer licensed clinicians to deliver healthcare services. This reflects both necessity and desire: utilizing volunteers makes it possible for free clinics to exist on very small operating budgets, while the free clinic setting attracts volunteers who seek a “pure” practice of medicine in which they are free of red tape and profitability imperatives.

Health care reform will not radically change the way in which medicine is practiced. Free clinics will continue to provide alternatives to mainstream medicine and provide opportunities where pure medicine may be practiced. Through constrained by limited resources, free clinics actually may be the only setting where idealized care can occur. Free clinics would do well to extol the virtues of the volunteer-based aspect of care delivery as a pointed rejoinder to the still-ingrained idea that in health care, as elsewhere, you get what you pay for, and when you pay more, you get more. Although volunteerism cannot solve the problems of all those who will remain uninsured or underinsured under comprehensive healthcare reform, it should be part of the solution.

Free clinics as community-based training sites for health professionals. Free clinics should seek out formal relationships with teaching institutions that are recipients of new training grant monies, and establish training opportunities for students and residents in free clinic settings. Many free clinics are currently involved in health professional training programs. Collaborations between free clinics and academic institutions are a win-win. Free clinics benefit from being involved with training programs by having ready access to a supply of health professionals, research, and know-how. In turn, clinicians-in-training gain early-on exposure to complex patients in a non-rushed setting. And clinicians’ experience with free clinics may induce them to subsequently open a practice in underserved areas—an outcome that is sorely needed in rural areas and in poor urban areas, where the projected workforce shortages are anticipated to be particularly acute.

Free clinics have a lot to think about

Free clinics must realize that a healthcare safety net is needed even after comprehensive health insurance reform. Many groups of people will continue to need free clinics: people who are not covered under the new health reform law; people who are in between coverage plans; people who are underinsured; and people who are covered yet are still unable to find care. A future role for free clinics is assured, for the simple reason that there will still be gaps, and these will still need to be filled.

As health care reform unfolds, free clinics will need to (re-)determine their essential role, i.e., what gaps they will fill, and how, given the new environment. They will need to decide whether they will remain as is, play a back-up role for people who can’t access the traditional healthcare system, participate in third-party insurance, or become another kind of entity, such as

a health center.

In deciding the “appropriate” response to health reform, a logical first step for free clinics is an external and internal assessment, which includes: finding out about other community providers that offer free or low-cost services and evaluating their own screening criteria and scope of services. Throughout this process free clinics will want to turn their attention toward quality and look for opportunities for collaboration.

Free clinics is a litmus test of health reform and the health system

Free clinics’ very existence exposes gaps and weaknesses in the traditional health system. Where a free clinic resides, what services it provides, its operating hours, and its volume and composition of patients all tell a story about unmet or undermet needs in the community among those who are uninsured and underinsured. As gaps and weakness will clearly continue to exist after health reform, free clinics will constitute a litmus test of the success of the reformed U.S. health system. Policymakers and other safety net providers have a lot to gain by tracking and supporting what free clinics do over the next decade.

Introduction

Free clinic executives are fond of saying that they have no greater wish than to be put out of business by universal health insurance coverage. Despite the historic achievement accomplished with the passage of comprehensive health reform, this wish has not been realized. Free clinic practitioners need to be mindful of the cracks in the new health reform law. It will be important to understand not only *who* falls through the cracks but also *what* falls through the cracks. As free clinics consider how to respond to the new realities of health reform it is perhaps most important of all for free clinics to recall their unique roles in the health safety net as gap-fillers, mission-driven providers of free and low-cost services, community-based training sites for health professionals, and bastions of volunteerism. A hallmark feature of the free clinic sector is its variety of organizational forms, ranging from clinics that operate out of a church basement one night per week to full-time clinics that provide a comprehensive array of healthcare services to patients. Their protean nature and ability to adapt in response to the environment will serve free clinics going forward, as there is no one-size-fits-all response to health reform.

In an effort to lay out potential next steps for free clinics, this brief summarizes the key features of the health reform law, describes the anticipated gaps in coverage and services, and raises concerns about access to care for those deliberately left out of the coverage expansions as well as those who stand to gain insurance coverage.

Comprehensive Health Reform is an historic achievement

Comprehensive health reform refers to the Patient Protection and Affordable Care Act, P.L. 111-148 (signed into law on March 23, 2010) as modified by the Health Care and the Education Reconciliation Act of 2010, P.L. 111-152 (signed into law on March 30, 2010). Provisions take effect gradually with full implementation in 2019; key provisions take effect in or after 2014. Of special interest to free clinics are the provisions in the new law that relate to insurance coverage expansions and those that affect the healthcare safety net, including those specifically targeting free clinics.

Expansion in health insurance coverage. The health reform law extends health insurance coverage to an estimated 32 million Americans in 2019 by mandating that most individuals purchase insurance, subsidizing insurance premiums, expanding Medicaid eligibility, providing incentives for businesses to offer healthcare coverage, creating a marketplace of health benefit exchanges where individuals can purchase insurance, and imposing new rules on insurers to prevent them from denying coverage.

Most individuals will be required to purchase health insurance, starting in 2014. With certain exclusions,¹ an individual who chooses not to obtain coverage will be assessed a per-

¹ Certain individuals are exempt from the tax penalties. A hardship exemption will be granted to people who would have to pay more than 8 percent of their income, net of the government subsidy, for the lowest cost plan in their area. People who lack coverage for less than 3 months will not be subject to the penalty. Limited exemptions are available to people who are opposed to buying health coverage for religious reasons. The penalties also do not apply to Native Americans who are covered by the Indian Health Service, veterans who are covered through the Department of Veterans Affairs, and prisoners.

person tax penalty that is the greater of a flat sum or a percent of income. The tax penalties are phased in over time: \$95 or 1 percent of income in 2014; \$325 or 2 percent of income in 2015, and \$695 or 2.5 percent of income in 2016. In subsequent years the flat sum will be increased by a cost-of-living adjustment.

The success of the individual mandate will depend largely on the affordability of coverage. In addition to expanding Medicaid coverage (described below), the new law provides advanceable and refundable tax credits for premium assistance to people whose income is up to 400% of the federal poverty line (\$88,400 for a family of four). The actual amount of the premium tax credit depends on a person’s income and the actuarial value of the second-lowest cost plan in the person’s area.

The subsidy calculator available from the Kaiser Family Foundation, <http://healthreform.kff.org/SubsidyCalculator.aspx>, makes it possible to estimate what people at different incomes might be expected to pay for health insurance coverage purchased through the new insurance exchanges. The table below provides several scenarios at varying levels of income.

Table 1: Premium payments by income

Income	Cap on premium (as a % of income)	Individual premium payment (\$)
150% of poverty: \$16,245	4.00	650
200% of poverty: \$21,660	6.30	1,365
250% of poverty: \$27,075	8.05	2,180
300% of poverty: \$32,490	9.50	3,087
400% of poverty: \$43,3200	9.5	4,115

Notes: Scenarios assume policyholder is a single adult who has no available employer coverage and lives in a medium cost area.

Four types of plans, which are known as bronze, silver, gold and platinum, will be sold through the state-based insurance exchanges. The silver plan is the second lowest cost plan. These plans will vary in the scope of benefits covered, with bronze plans being the least comprehensive. All plans must meet minimum benefit requirements.

People whose income is below 250% of the federal poverty line also will be eligible for reduced cost-sharing (deductibles, coinsurance, copayments). These people will be able buy better plans that have higher actuarial values. It is important to understand that having a higher actuarial valued health plan will have the effect of lowering cost-sharing but the *actual* cost-sharing that a person will incur will depend on the amount and type of the individual plan

holder's health care utilization and the actual levels of deductibles, coinsurance, and copayment requirements in the plan.

Table 2: The Effect of Cost-Sharing Subsidies on Actuarial Values of Plans

Income as a percentage of poverty	Actuarial value
133-150%	94%
150-200%	87%
200-250%	73%
250-300%	70
300-350	70%
350-400	70%

Source: Center on Budget and Policy Priorities. 2010. *Making Health Care More Affordable: The New Premium and Cost-Sharing Credit*.

Nearly half of the anticipated increase in coverage is accomplished through an expansion of Medicaid. Before health reform, Medicaid prescribed categorical eligibility requirements for individuals under age 65. Under health reform, non-elderly individuals will be able to qualify for Medicaid based solely on their household income. Starting in 2014, the minimum threshold for Medicaid eligibility is set uniformly across states at 133% of the federal poverty line (14,404 for an individual and 24,352 for a family of three in 2010). Non-elderly, non-disabled adults without children who previously failed to meet Medicaid's categorical requirements stand to benefit the most under the changes introduced under health reform.

Despite these changes, comprehensive health reform does not achieve universal coverage. An estimated 23 million people (representing 6% of the U.S. population) are estimated to be uninsured in 2019.

Expansions to the safety net. Since the new law will increase demand for healthcare services it also augments the healthcare delivery system in an effort to accommodate this expected rise in demand. The new law contains numerous provisions aimed to improve both the supply and distribution of the healthcare workforce and the healthcare safety net.

Of note, it allocates an additional \$11 billion to the federal health center program over the next five years. Of the \$11 billion, 9.5 billion of this funding is set aside for operations: \$1 billion in 2011, \$1.2 billion in 2012, \$1.5 billion in 2013, \$2.2 billion in 2014, and \$3.6 billion in 2015. These new monies are in addition to the annual discretionary funding (\$2.2 billion in 2010) directed toward health centers. In addition to funding for operations, the new law contains \$1.5 billion in funding for capital projects.

The National Health Service Corps, which provides tuition grants or student loans to health professionals in exchange for their service in poor or rural areas with a shortage of providers, will receive an additional \$1.5 billion. These monies are in addition to the Corps' annual discretionary funding (\$142 million in 2011). It is estimated that the funding will support 15,000 primary care providers practicing in shortage areas.

Given that the new law entitles millions more people to Medicaid coverage, the new law takes steps to ensure that the 60 million current beneficiaries and 16 million new beneficiaries of the program are able to access health care services. Specifically, the new law raises Medicaid payments to primary care providers to 100% of the Medicare payments rates, but only for 2013 and 2014. Though Medicaid is financed jointly by the federal government and the states, federal funds will absorb 100% of the incremental costs during this two-year period.

A panel authorized under the Children's Health Insurance Program, the Medicaid and CHIP Payment and Access Commission (MACPAC), receives 11 million under the new health reform law. The commission, as its name suggests, will monitor payments to medical and dental providers and access issues for Medicaid and CHIP.

Certain primary care physicians will receive a 10 percent Medicare bonus for providing certain services. The bonus payments go into effect in 2012 and continue for five years.

The new law authorizes dozens of pilot programs and demonstrations. The eligibility requirements will vary by program. In some cases it is not clear which programs may be suitable for free clinics. One example is the \$50 million demonstration program for nurse-managed health clinics. Another example is a grant program to promote the community health workforce. Grants may be awarded to entities, including free clinics, to promote positive health behaviors.

The new law also reduces Medicare and Medicaid disproportionate share hospital (DSH) payments by \$36.2 billion. The federal DSH program was designed to compensate hospitals for the costs associated with providing care to low-income people who are uninsured. Because the number of uninsured will decline dramatically under health reform, there is assumed to be less need for hospitals to be compensated for providing care to uninsured individuals but organizations such as the Association of American Medical Colleges suggest that the cuts may be "premature" (AAMC 2010).

Free clinics. In an extension of medical malpractice coverage to free clinics, the new law expands Federal Tort Claims Act (FTCA) coverage beyond volunteer health professionals to employees, board members, and contractors. It does not extend coverage to the entity. As has been the case with volunteer providers, FTCA protection is not awarded automatically.

Currently free clinics remain the only setting through which volunteer providers may obtain FTCA coverage. Though health centers lobbied for an extension of FTCA coverage to volunteers in their sites, the health reform law does not extend FTCA coverage to volunteers who are serving in health centers.

Gaps in coverage and services remain

Comprehensive health reform falls short of achieving universal insurance. At full implementation by 2019, it is estimated that 23 million people will lack health insurance. Put into perspective, 23 million uninsured is more than 10 times the number of uninsured people who were served by the free clinic sector in 2006 (Darnell 2010).

The pool of uninsured will be composed of individuals who are excluded from the coverage expansions, those who opt out of coverage, and those who are left without coverage though they are eligible. The largest share of the uninsured will be undocumented persons, who are estimated to number eight million, and account for about one-third of the uninsured, in 2019. Undocumented people are prohibited from purchasing insurance through the new exchanges and are ineligible for Medicaid coverage except for emergency medical services. People who are in the country unlawfully may be covered by an employer-sponsored health plan or purchase insurance from companies who are offering their products outside of the state-based insurance exchanges.

People who opt out of coverage include those who are subject to the penalty and those who are exempt. People who are unable to find coverage that is affordable—defined in the law as less than 8 percent of their annual household income—will not have to pay a penalty for going without insurance. This group is likely to include people with limited financial means, such as those whose income is just above the Medicaid threshold of 133% of the federal poverty level. Another group of people with limited financial resources who are exempt from the mandate includes those whose gross income is below the threshold for filing a federal income tax return. The threshold amounts vary based on age and filing status but generally reach people with limited financial resources. For the 2009 tax year, the threshold for a non-elderly single person was \$9,350 and twice that (\$18,700) for a married couple.

The new law prescribes that all health plans offered by the state-based insurance exchanges provide “essential health benefits” by 2014. To be determined through regulation by the Secretary of the U.S. Department of Health and Human Services, essential health benefits will include, at a minimum:

- ambulatory patient services;
- emergency services;
- hospital, maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services;
- chronic disease management; and
- pediatric services including oral and vision care.

Grandfathered plans and self-insured plans are exempt from the requirement. Therefore, people covered under these plans may not have access to all of the benefits to which others will be entitled.

Notably absent from the list of services that are required as part of the essential health benefits package are dental services for adults age 21 and above. (Plans participating in the exchanges must provide oral health services for children.) Adult oral health care may be included in plans offered through the exchanges but such coverage is not required. The law contains a provision requiring the Secretary of the U.S. Department of Health and Human Services to study

the issue and report to Congress. Health education also is not expressly stated as required under the essential benefits package.

Throughout their history, free clinics have provided services either not available elsewhere or not easily accessible. While the health reform law establishes a comprehensive package of services for many people, gaps in services remain, assuring one future role for free clinics. Though free clinics generally provide basic healthcare services, free clinics also already provide services that will be left out of the essential benefit package. These include health education and dental services for non-elderly adults. According to the free clinic survey, 77 percent of free clinics provide health education. More than one-third of free clinics provide on-site dental services. Free clinics ought to assess the availability of services in their geographic area and whether to continue to provide services not routinely available (or unaffordable) from alternative providers.

Coverage is not synonymous with access

The success of the Medicaid expansion in ensuring access to care for those newly insured under the Medicaid program will depend on participation by its beneficiaries—and participation by providers. It is well documented that not all people who are eligible for Medicaid actually enroll. There are several reasons eligible people do not enroll: (1) they are not interested; (2) they are unaware; and (3) they are discouraged by administrative barriers. Whatever the reason, overall Medicaid participation rates have been estimated to be 66%-70%, and for non-elderly adults the rates are much lower, 56-64% (GAO 2005). It should be remembered that Medicaid is a federal-state program. It is jointly financed and state-administered according to broad federal guidelines, and the states retain considerable control in determining the way in which people enroll in the program. Thus, it is likely that there will be considerable state- and perhaps county-level variation in the extent to which eligible populations gain coverage.

Access to care for people with a Medicaid card will depend, of course, on the ease with which beneficiaries can find providers willing to treat them. Recall that the Medicaid payment increases will expire just as the Medicaid program begins to cover 16 million more beneficiaries. It will be important to monitor whether the payment increases are adequate to attract sufficient numbers of providers to participate in Medicaid in the short term and in the period after the payment increases expire. In addition, as public opinion about health reform has been decidedly mixed, it may be difficult to secure supplemental funding for provider payment increases in future years.

There is some indication that even if Medicaid payment rates are adequate many providers will shun the formerly uninsured and poor, who they perceive as not worth the hassle because they are believed to be sicker and less compliant. In an era of pay for performance that rewards physicians for good patient outcomes, physicians have added financial incentives to compete for healthier patients and avoid patients who may be more difficult to treat. With several quality-related provisions, such as funding for comparative effectiveness research, continuation of the Physician Quality Reporting Initiative, creation of a national quality improvement strategy, testing of payment and service models that reduce spending while preserving or

enhancing quality, and creation of the Patient-Centered Outcomes Research Institute, the health reform law ensures continued emphasis on outcomes. While improving quality is a laudable goal, it will be important to monitor closely how these quality provisions are implemented. A recent RAND study (Friedberg et al. 2010) finds that if pay-for-performance programs are not designed adequately to account for patients' socio-demographic characteristics, monies may be directed away from primary care practices serving higher proportions of patients who are economically disadvantaged or are members of racial/ethnic minority group.

Health care utilization ultimately will depend on whether having health insurance coverage makes health care services affordable. Federally qualified health centers have defined "affordability" in terms of a sliding fee scale based on family size and income for their uninsured patients. In contrast, free clinics base their approach on (1) the recognition that irrespective of where any sliding scale might place them, some uninsured patients simply cannot afford even \$10 at the time of their visit; and (2) the assumption that this should not be an impediment to receiving needed health care. This latter assumption may be seen as fundamental, or even axiomatic, for free clinics: indeed, more than one-third of free clinics cite "health care as a right" as a reason for their founding (Darnell 2010). Questions of principle aside, it is clear that by offering their services at no charge or for a nominal fee, free clinics have effectively removed the financial barriers to healthcare service utilization. It also appears clear that free clinics are the only providers where this is the case.

The experiences of Massachusetts residents after the enactment of health reform provide some evidence concerning the magnitude of the access problems that we may encounter on a national level and point to some areas where access-to-care concerns may arise due to unaffordability or a limited supply of providers. A recent study in Massachusetts finds that while the state has the lowest rate of uninsurance in the country and has substantially improved access to care, that some groups still face problems obtaining coverage and getting the healthcare they need. This study of 15 residents reports that 17 percent of people with incomes below 300 percent of poverty said that they didn't get care they needed because of the cost. The study concludes that "substantial numbers of people are having trouble getting care that is affordable to them" (Pryor and Cohen 2009). Another longitudinal study of 3,000-plus residents (Long and Masi 2009) reaches a similar conclusion. Long and Masi (2009) find that 21.5 percent of all Massachusetts adults 18-64 did not get needed care in the past year, and among those with family income below 300 percent of poverty, the percentage is 31.8 percent. Furthermore, Long and Masi (2009) report that the percentages of people who report problems obtaining needed care has increased since the law's enactment. Reflecting well-known provider shortages (Massachusetts Medicaid Society 2009), about 20 percent of patients reported difficulty obtaining care because the provider they contacted was not accepting patients. Among those with household income below 300 percent of poverty, the percentage of patients who reported difficulty obtaining care was nearly 30 percent. Emergency room use for non-emergencies also did not improve when compared with earlier post-reform periods (Long and Masi 2009). A separate study that examined emergency room use in Massachusetts by the uninsured for asthma or upper respiratory tract infection (URI) before and after health care reform found that the number of uninsured patients with a URI who presented to the emergency room declined but the number of uninsured patients who came to the E.R. with asthma stayed about the same (Smulowitz et al. 2009).

Though medications are covered under the essential benefit requirement, it is possible that prescription co-payments may make medications unaffordable for some people, especially people with chronic illnesses who take multiple medications on a daily basis. The health reform law provides subsidies for out-of-pocket costs to people whose income is below 250 percent of the federal poverty level but the subsidies may prove to be inadequate, especially for the chronic illness / ongoing medications subset. The experience of Massachusetts after it adopted comprehensive health reform provides a cautionary tale with regard to medication access for certain insured people taking numerous medications. Recent studies of Massachusetts residents have documented that people taking numerous medications went without needed medications despite having good coverage under an employer-sponsored plan, due to the copayment costs. (Perry 2009; Pryor and Cohen 2009). Assuring access to medications has been a priority of most free clinics. Eighty-four percent of free clinics dispense free medications through a licensed pharmacy (25 percent) or, more commonly, through a dispensary (66 percent) (Darnell 2010). Free clinics ought to closely monitor access to prescription medications especially among those with chronic illnesses, because as health reform unfolds medications may become victims of underinsurance.

A similar problem may unfold for specialty services. People who require ongoing treatment from specialists may find that the copayment costs associated with each visit become unaffordable. While free clinics provide few specialty services on site, they have developed formal networks of referral specialists who have been willing to treat free clinic patients at no charge or at deeply discounted rates. Developing or maintaining these free clinic specialty networks can help patients who will fall through the cracks.

By injecting \$11 billion into the federal health center program, the new health reform law will dramatically increase the capacity of health centers. But one issue that has failed to receive any attention thus far is the fact that health centers must be located in federally-designated medically underserved areas or must serve medically underserved populations. These requirements limit the options available to health centers about where they choose to locate. Given these geographic constraints, I wanted to investigate how much overlap there was between health centers and free clinics. Using data on health center grantees² (but not all sites) and all known free clinics as of 2006, I explored two questions:

- (1) To what extent do free clinics reside in county areas that are designated as medically underserved but have no health center grantees?
- (2) To what extent do free clinics reside in county areas that are not designated as medically underserved?

² It is important to note that I examined health center grantees and not all sites. A single grantee may operate several sites. As a result, this analysis has a tendency to understate the reach of health centers if grantees operate sites outside of the county in which the grantee is located. Follow-up analysis taking into account all health center sites is planned.

The preliminary analysis reveals that there are 290 counties that have 1 or more free clinics and no health center grantees. This finding suggests that free clinics are operating as gap-fillers, providing affordable care where there may be few (or possibly no other) options. In addition, 88 clinics (out of 1,007) or 8.7% of free clinics reside in areas that are not designated as medically underserved and generally beyond the reach of health centers. This result suggests that free clinics are located in areas of high need—in some cases, areas where no FQHC may be found. Combined, these results reaffirm the need for free clinics even in light of a significant expansion of health centers.

Free clinics embrace the volunteer spirit, and this orientation bestows benefits to patients

The spirit of volunteerism is strong at free clinics. Free clinics make extensive use of volunteer licensed clinicians to deliver healthcare services. This reflects both necessity and desire: utilizing volunteers makes it possible for free clinics to exist on very small operating budgets, while the free clinic setting attracts volunteers who seek a “pure” practice of medicine in which they are free of red tape and profitability imperatives. According to a study of free clinics conducted in 2005-2006, nearly a quarter of all free clinics reported that a reason for founding was to provide care free of red tape and more than one-third reported that a reason for founding was to provide care without concern about making a profit (Darnell 2010). For retired clinicians, free clinics offer a setting which they may continue treating patients in a supportive setting. The many benefits of working in free clinic are captured in a recent article by one physician volunteer (Reynolds 2009):

I have provided regular general medical care as a volunteer since 2003. Caring for patients with a spectrum of chronic illnesses is not simple, but most of the problems encountered are familiar to experienced health care providers. Because one is not grappling with unexpected illnesses, there is confidence in deciding treatment, which may free up some time with the patient to delve into other health concerns not usually or easily broached in a rushed office practice setting. This extended conversation permits a broader, more in-depth assessment of the patient, which gives the physician greater satisfaction. Moreover, the clinic provides a supportive milieu for us senior (many, retired) health care givers. One can enjoy the comradeship of colleagues in a less competitive medical practice arena. In contrast to the medical students and residents who are volunteering in the Bethesda Mission Clinic, we senior physicians are not building clinical skill at this point but, rather, preserving skills, which is a satisfying benefit (both to us and to our patients) late in a career. We feel that we are still helpful and essential and staying mentally active and involved in medicine. Keeping skills current is an educational endeavor.

Having the luxury to spend as much time as necessary with a patient in an environment unaffected by pressures of profit-making facilitates high quality patient care. In a recent essay, noted physician scholar Larry Casalino imagines the ideal primary care model in which physicians are “freed from the tyranny of the ten-to-fifteen-minute visit.” He recommends that primary care physicians see only eight or ten patients per day, with the remainder of their time spent communicating by email and telephone and overseeing staff (Casalino 2010). He uses a Martian visiting Earth as the entrée to this prescription, presumably in light of how radical he knows it is. What Casalino may not realize is that free clinics practitioners already have adopted the central tenet of his approach, and see only a handful of patients each day.

Health care reform will not radically change the way in which medicine is practiced. Free clinics will continue to provide alternatives to mainstream medicine and provide opportunities where pure medicine may be practiced. Through constrained by limited resources, free clinics actually may be the only setting where idealized care can occur. (Recall that health centers failed to secure FTCA coverage for volunteer clinicians at health center sites.) Free clinics would do well to extol the virtues of the volunteer-based aspect of care delivery as a pointed rejoinder to the still-ingrained idea that in health care, as elsewhere, you get what you pay for, and when you pay more, you get more.

The United States has a long history of using private charity to meet the needs of the poor and underserved. Although volunteerism cannot solve the problems of all those who will remain uninsured or underinsured under comprehensive healthcare reform, it should be part of the solution. Federal and state policies that promote volunteerism—such as providing malpractice protection or tax incentives in exchange for volunteer service—should be supported.

Free clinics have become important community-based training sites for health professionals

People involved in free clinics like to say, “If you’ve seen one free clinic, you’ve seen one free clinic” as a way of articulating the diversity in the structures and process of free clinics, each of which is designed to respond to the particular needs of the community in which it resides. This diversity of needs entails a corresponding diversity of experiences of practitioners working in free clinics, thus providing a rich setting for the training of health professionals. Clinicians-in-training gain early-on exposure to patients in a non-rushed setting. By working in free clinics, clinicians can observe first-hand how the incidence and prevalence of disease varies by demographic backgrounds. Reflecting their communities, free clinic patients suggest that non-biological risk factors, such as lack of income and shortage of community assets, are associated with health behaviors and health outcomes. Armed with knowledge of these social and contextual factors, practitioners can help devise better treatment regimens for their patients.

Many free clinics are currently involved in health professional training programs. In a recent national free clinic survey 40 percent of free clinics reported training medical students (Darnell 2010). The survey also documented that 57 clinics were known to be medical student-run during the 2005-2006 study period. In addition to training future physicians, free clinics serve as training sites for nurses (48 percent), dentists (24 percent), psychologists (5 percent) and social workers (14 percent).

It has been estimated that there will be a shortage of between 124,000-159,000 physicians in the United States by 2025. With millions more people having access to health insurance, comprehensive health reform is expected to increase demand for healthcare and exacerbate the physician shortage by an additional 25 percent. (AAMC no date). Shortages are particularly acute in rural areas and in poor urban areas. And the shortfall is expected to be greatest for primary care physicians, whose role will be expanded under the new health reform law. It seems reasonable to suppose that free clinics can be part of the solution to this looming supply shortage.

Though the evidence is not definitive, experience with free clinics can induce clinicians to subsequently open a practice in underserved areas (Beck 2008).

Collaborations between free clinics and academic institutions are a win-win. Free clinics should seek out formal relationships with teaching institutions that are recipients of new training grant monies, and establish training opportunities for students and residents in free clinic settings. In this way, the clinics benefit from a direct link to academic research and know-how, with a presumable positive impact on patient outcomes, while the schools gain access to a wider array of practical clinical settings in which their health professional students can acquire experience.

Free clinics have a lot to think about

Free clinics must realize—first and foremost—that a healthcare safety net is needed even after comprehensive health reform. With origins dating back nearly a century, free clinics have played a vital role as gap-fillers in the safety net, and this role is will not disappear even as health care reform is implemented. Many populations will continue to need free clinics: people who are not covered under the new health reform law; people who are in between coverage plans; people who are underinsured; and people who are covered yet are still unable to find care. A future role for free clinics is assured, for the simple reason that there will still be gaps, and these will still need to be filled.

But this does not mean that no changes are in order. As health care reform unfolds, free clinics will need to (re-)determine their essential role, i.e., what gaps they will fill, and how, given the new environment. They will need to decide whether they will remain as is, play a back-up role for people who can't access the traditional healthcare system, participate in third-party insurance, or become another kind of entity, such as a health center.

In deciding the “appropriate” response to health reform, a logical first step for free clinics is self-assessment: each free clinic must start by considering where it sits on the free clinic continuum. The free clinic sector is highly heterogeneous. On one pole are walk-in clinics with no paid staff that are open to see patients with urgent conditions one night a week. On the other pole are long-standing free clinic institutions that have a small paid staff supporting hundreds of volunteers who deliver a comprehensive array of services to patients on a full-time basis. And in between the two poles are clinics that are open about half time, provide more than just basic care, and employ one or more paid staff to oversee operations.

Once a clinic places itself on the free clinic continuum, it should then assess the capacity of the primary care delivery environment. To get a sense of its level of need and eligibility for federal resources, free clinics should explore first whether their free clinic site is located in a medically underserved area (MUA) or a health professional shortage area (HPSA) because several federal programs (e.g., health centers, rural health clinics, health professional training programs) use these designations to target federal monies. As was suggested by the analysis of health center/free clinic overlap above, not all MUAs contain a health center. In fact, the General Accountability Office estimated that 43 percent of all medically underserved areas lacked a

health center in 2007 (Bascetta 2009). Thus, free clinics need to separately determine the area's status and then whether there are federally supported health centers or other kinds of clinics located within it.

In addition to conducting an environmental scan, free clinics should assess future demand by their current patients. As part of this assessment, free clinics should determine what percentage of their patients would qualify for coverage under health reform; their patients' employment status and employer (large, large-self insured, small) and if they currently are offered insurance from their employer; their patients' perceptions about affordability of care; whether or not patients would return to the free clinic if other options were available to them; what services patients currently utilize and what additional services they would be interested in obtaining were they made available; their patients' awareness of alternative sources of primary care in the area; and their prior experiences seeking primary care. The free clinic literature has surprisingly little to say about these questions. To get the answers, free clinics will need to ask the questions themselves.

Free clinics ought to become a visible part of the primary care fabric in their communities. They should get to know other safety net primary care providers and hospitals that target services to uninsured and Medicaid populations. Free clinics need to educate other safety net providers about what they do and devise strategies to work together in a reformed healthcare environment.

Devising strategies to work with other members of the safety net would be greatly facilitated if there were tested models of collaboration. There is a need now—more than ever—for leadership from the free clinic associations to develop and disseminate models of collaboration. This might be facilitated by establishing ties with other associations overseeing other primary care safety net clinics, such as the National Association of Community Health Centers and the National Association of County and City Health Officials. And there is a need for grant dollars from government agencies or private foundations to support the development, evaluation, and dissemination of such collaborations.

While models of collaboration likely already exist, they are largely unknown. One model of which I am aware has been devised by the Free Clinic of Kalamazoo. It has an understanding with a nearby health center that the free clinic will provide only urgent care to its patients and will facilitate the transition of its patients to the health center, which will become the patients' medical home.

This model of collaboration—one among many possible templates—leverages some of the typical characteristics of free clinics in order to create a valuable role for a free clinic within a collaboration where its strengths dovetail with those of its partner. The Kalamazoo free clinic is aware that the health center cannot always accommodate patients immediately, so it agrees to treat patients until there is an opening at the health center. Free clinics are typically open during the evenings and weekends when other alternative providers are closed. They also typically use flexible scheduling arrangements, making them an easy access point for people who may experience difficulty finding care elsewhere.

The “back-up” strategy employed in Kalamazoo—in which the free clinic meets patients’ immediate needs and facilitates ongoing care at a separate entity—could work in tandem with or in isolation (i.e., without a formal agreement) from other safety net providers. Many free clinics likely will find themselves in a facilitation role as their patients become newly insured through public programs, their employers, or through the insurance exchanges. Because most free clinics have been in the business of providing health education, taking on this facilitation role may come naturally. In any case, free clinics need to unearth and explore various models of collaboration, “trying them on for size” in their own particular environments to determine if there are valuable collaboration-based missions for themselves that might emerge.

Often free clinics have utilized screening criteria in based on income, health insurance status, and geographic location, in order to target their limited resources to those people who have the greatest needs. In an era of health reform, it is prudent to revisit these screening criteria to make sure they have not become outdated. Fifty-seven percent of clinics reportedly use screening criteria based on income; of these, about one-third set the income threshold at 150 percent of poverty or below (Darnell 2010). Given that health reform extends Medicaid coverage to all people below 133 percent of poverty it may be necessary to raise the income threshold higher unless clinics want to target their services primarily to low-income undocumented immigrants and new immigrants for the first five years after U.S. entry, two groups that are barred from Medicaid. Fifty-six percent of clinics limit their services to uninsured patients. In light of the lessons learned after Massachusetts reformed its healthcare system and anticipated physician shortages at the national level, free clinics may want to re-examine this requirement and consider making their care available to people who are underinsured or those who experience difficulties finding a provider who is accepting patients.

Some free clinics may decide that they wish to compete for the new federal funds available under the health center program. For many free clinics the sliding fee scale requirement that health centers must utilize runs contrary to free clinics’ core mission to provide free care. While the U.S. Health Resources and Services Administration, the agency responsible for administering the health center program, has traditionally upheld this requirement, there is a precedent for its waiver. When the Venice Family Clinic applied for health center grantee status for one of its sites under the Public Housing Primary Care grantee program it obtained a waiver from the sliding fee scale requirement. Free clinic leaders ought to engage the Administration in a dialogue about the requirements for health center status and explore possibilities for modifying requirements to accommodate free clinics. Free clinics ought to consider that with their years of experience serving vulnerable populations that they may be very appealing applicants and find themselves in a strong bargaining position.

Once free clinics decide upon their basic role, they then face questions about the scope of services they should offer. The choice will depend, in part, on the model each particular free clinic chooses. It seems almost inevitable that free clinics will play an expanded role as health educators, perhaps moving from disease-specific education to more general education about choices under health reform and how to access the health system. The lack of adult dental care under health reform suggests another area where there will continue to be high unmet need.

Free clinics will continue to depend on volunteers to donate their time to deliver

healthcare services. For now, free clinics remain the only setting in which volunteers may obtain FTCA coverage, giving free clinics a competitive advantage over health centers that may wish to expand services through the use of volunteers. When recruiting volunteers, in addition to making known the unmet needs that exist in the community, free clinics may want to appeal to providers' desire to have extended conversations with patients whereby issues that might otherwise go unrecognized are treated. Given the looming provider shortage and new monies for training programs, free clinics will want to look at partnering with health professions training programs as one method to ensure an adequate supply of providers.

Similar messages about unmet or undermet need should be crafted for the philanthropic community. They too need to be able to appreciate the unique setting that free clinics provide.

Healthcare reform steps up the focus on quality and its key metric, outcomes. If free clinics want to stay current, they will also need to turn their attention toward quality. Data is not a four-letter word. National, regional, and state free clinic associations need to lead the way in establishing benchmarks for high quality care in free clinics. Individual free clinics need to design their systems, such as adopting health information technology, to make it possible to track not only outputs (e.g., number of patients served, number of visits) as they have been accustomed to doing but, importantly, also *outcomes* (e.g., percentage of patients who receive standard of care). These data also will be requested by funders, who increasingly are demanding evidence of return on their investment.

Free clinics will be the litmus test of health reform and the health system

Free clinics' very existence exposes gaps and weaknesses in the traditional health system. Where a free clinic resides, what services it provides, its operating hours, and its volume and composition of patients all tell a story about unmet or undermet needs in the community among those who are uninsured and underinsured. As gaps and weakness will clearly continue to exist after health reform, free clinics will constitute a litmus test of the success of the reformed U.S. health system. Policymakers and other safety net providers have a lot to gain by tracking and supporting what free clinics do over the next decade.

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