Introduction

For millions of uninsured and underinsured people residing in the United States, accessing the healthcare system can be difficult and sometimes impossible. A loose network, or safety-net of providers, including those described below, works diligently to provide a range of care to these individuals.

Community Health Centers

Many clinics operate through charitable funding and do not receive federal funding or enhanced reimbursement. These health centers are hard to generalize. They may or may not offer comprehensive services be faith-based, be open full-time, or be run by volunteers.

Disambiguation: In the safety-net world, many community or neighborhood-based health centers that treat all patients regardless of insurance status are called community health centers. This is due to the community health movement of the 1960s in which this concept and many health centers still operating today got their start. Not all of these community health centers receive federal funding under Section 330 of the Public Health Service Act. In this series of papers, the community health centers that receive Federal support will be referred to as Section 330 Funded health centers to avoid any confusion.

Community/ Migrant Health Centers (Sec. 330 funded health centers)

Health centers funded under Sec. 330 of the Public Health Service Act are colloquially called Community and Migrant Health Centers and must:

- See anyone who seeks care there, regardless of the person’s ability to pay for the service
- Provide comprehensive primary care and enabling services like transportation and translation
- Be located in, or serve, medically underserved areas or populations.

Health centers frequently provide prevention-based care and offer programs designed to help people control chronic diseases. Additionally, health centers receive enhanced reimbursement from Medicare
and Medicaid under the Federally Qualified Health Center program. Comprehensive information regarding Sec. 330 funded health centers is available from the Bureau of Primary Health Care (BPHC) http://www.bphc.hrsa.gov/about/ and the National Association of Community Health Centers’ (NACHC) http://www.nachc.com/about-our-health-centers.cfm

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**Disproportionate Share Hospitals**

The term “Disproportionate Share Hospital” (DSH) comes from a federal program that pays an adjustment to those hospitals that serve a significantly disproportionate number of low-income patients. States receive an annual allotment to cover the costs of DSH hospitals that provide care to low-income patients that is not reimbursed by other payers, such as Medicare, Medicaid, the Children’s Health Insurance Program or other health insurance. The annual allotment is calculated by law and includes requirements to ensure that the payments to individual DSH hospitals are not higher than the actual uncompensated costs.

**Federally Qualified Health Centers**

Federally qualified health centers (FQHCs) include all organizations receiving grants under Sec. 330 of the Public Health Service Act, certain tribal organizations, and FQHC look-alikes. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must provide services to an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

**Disambiguation:** “FQHC” is frequently inappropriately interchanged with Sec. 330 funded health centers. Although all Sec. 330 funded health centers are FQHCs, not all FQHCs are Sec. 330 funded health centers.

**Federally Qualified Health Center Look-Alikes**

Federally qualified health center look-alikes are healthcare providers that meet all of the requirements to qualify for Sec. 330 funding, but do not receive that funding. Look-alikes receive several of the same benefits as Sec. 330 funded health centers including:

- Enhanced reimbursement for Medicare and Medicaid
- Access to National Health Service Corps providers
- Public Health Service prescription drug pricing discounts.
Retail Clinics

For-profit retail clinics or “convenient care clinics” have emerged as a popular health care delivery model that may significantly impact critical safety net challenges such as access to care and health care costs. Retail clinics provide a limited scope of services and are typically located within a pharmacy, grocery store or even a mass merchandise store. For more information, click here for ASTHO's Retail Clinics Fact Sheet.

Rural Health Centers

The Rural Health Centers (RHCs) program is intended to increase primary care services for Medicaid and Medicare patients in rural communities and can be public, private, or non-profit. The main advantage of RHC status, which is granted by the Centers for Medicare and Medicaid Services, is enhanced reimbursement rates for Medicaid and Medicare services. RHCs must be located in rural underserved areas and must use mid-level practitioners. A health center may not be both a Rural Health Center and a Federally Qualified Health Center at the same time. For more information about this program, please visit the Rural Assistance Center’s information pages at http://www.raonline.org/info_guides/clinics/rhc.php

State Health Agencies

All state health agencies have some input into the health care safety net from providing direct services to performing oversight duties. They also interact directly with other safety-net providers in a variety of ways including:

- Determining areas of medical underservice and health professional shortage areas;
- Placing providers of care in underserved communities via loan repayment and scholarship programs; and
- Operational grants to providers to treat underserved populations.

For more information about the types of safety net services provided by state health agencies, please visit the ASTHO fact sheet on this topic: State Health Agency Inputs into the Safety Net Fact Sheet

Resources:

IOM Report “Intact But Endangered”

HRSA
http://www.hrsa.gov