

Community Clinic Grant Program

REPORT TO THE MINNESOTA LEGISLATURE

FEBRUARY 2017

Community Clinic Grant Program

Minnesota Department of Health
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Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

February 24, 2017

The Honorable Matt Dean
Chair, Health and Human Services Finance
401 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

The Honorable Joe Schomacker
Chair, Health and Human Services Reform
509 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

The Honorable Michelle Benson
Chair, Health and Human Services Finance and Policy
Minnesota Senate, Room 3109
95 University Avenue West
St. Paul, MN 55155

The Honorable Jim Abeler
Chair, Human Services Reform Finance and Policy
Minnesota Senate, Room 3215
95 University Avenue West
St. Paul, MN 55155

Honorable Chairs:

I am pleased to present this biennial report of the Community Clinic Grant Program, as required by statute. The Community Clinic Grant Program supports the state's safety net clinics in their efforts to provide equitable health services to low-income, underinsured and uninsured populations.

Since this program began in 2001, the funding requests have greatly exceeded appropriated dollars. For the current Fiscal Year 2017 grant cycle, the Office of Rural Health and Primary Care received 50 applications with over \$2 million requested in funding, almost four times the available appropriation of \$561,000. MDH caps awards at \$45,000 to provide 12 to 15 small awards, geographically dispersed.

I thank you for your continued support of this program and your commitment to the health of Minnesota and all who live here.

Sincerely,

A handwritten signature in black ink, appearing to read "Edward P. Ehlinger".

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

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Executive Summary

Minnesota Statutes, Section 145.9268, directs the Commissioner of the Minnesota Department of Health (MDH) to report biennially to the Minnesota Legislature on the needs of community clinics and recommendations for adding or changing eligible activities under the Community Clinic Grant Program. This report includes grant application and award information for fiscal years 2015 to 2017.

Community clinics are an integral part of the health care safety net for the state of Minnesota. 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 helping to provide improved care delivery infrastructure.

The definition for “community clinic” can vary; 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 use 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. The Community Clinic Grant Program helps to ensure access to health care for populations that are uninsured or underinsured by giving priority to clinics with higher percentages of those patients.

Activities eligible for funding under the Community Clinic Program are very broad. 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 need for grants to community clinics has continued despite the benefits of the Affordable Care Act and Medicaid expansion. Safety net clinics increasingly rely on grant funding not only to maintain services, but also to improve culturally/linguistically appropriate services and upgrade aging equipment, facilities and technology. Since the program began in 2002, the funding requests have greatly exceeded the appropriated dollars. For the current Fiscal Year 2017 grant cycle, the Office of Rural Health and Primary Care received 50 applications with \$2,003,312 requested in funding, almost four times the available appropriation of \$561,000.

The current statute is broadly worded to allow for any type of clinical-based project needed to support health care services to uninsured and underinsured populations. To ensure the ability to support a wide range of projects, MDH has capped awards at \$45,000 per grantee. This may be restricting the scope and scale of worthy projects, and MDH is currently considering options to offer fewer but larger awards, give priority to particular types of projects, and/or to identify new funding sources to support worthy projects.

Community Clinic Grant Program

Introduction

Minnesota Statutes, Section 145.9268 (see Appendix), directs the Commissioner of Health to report biennially to the Minnesota Legislature on the needs of community clinics and recommendations for adding or changing eligible activities under the Community Clinic Grant Program. This report includes grant application and award information for fiscal years 2015 to 2017.

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 helping to provide improved care delivery infrastructure. The Office of Rural Health and Primary Care first implemented the grant program as authorized by the Legislature in 2001.

Due to the large interest in the program, the application process is a two-part process. A pre-application focuses on financial need, the percent of patients that are uninsured and underinsured and the merit of the project. Successful pre-applicants are invited to submit a final application that is reviewed by an external review committee. Statute requires 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” can vary; 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 use 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. The Community Clinic Grant Program helps to ensure access to health care for populations that are uninsured or underinsured by giving priority to clinics with higher percentages of those patients.

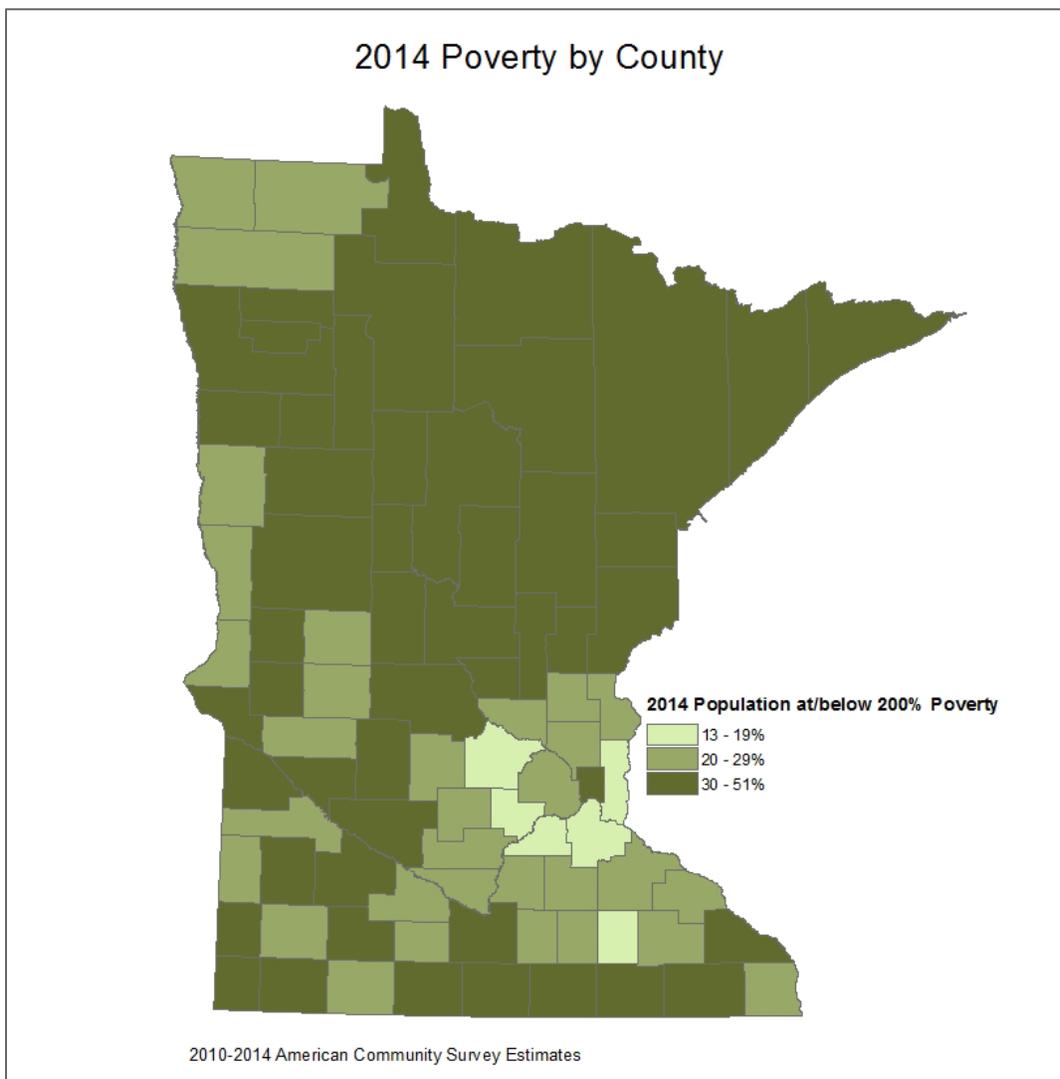
Populations at Risk

Two common indicators of health care access are poverty and uninsurance. The overall percentage of Minnesotans lacking insurance has dropped from 9 percent in 2011 to 4.3 percent in 2015 (Minnesota Health Access Survey, Minnesota Department of Health). However, insurance disparities continue to exist for populations of color. The uninsurance rate for Hispanic/Latino Minnesotans in 2015 was over three times the rate for White Minnesotans.

Additionally, the uninsurance rate for American Indian and Black Minnesotans was greater than twice the rate for White Minnesotans.

Poverty

While the overall rate of uninsurance has dropped, populations in poverty have become more widespread. According to five-year estimates from the 2014 American Community Survey (U.S. Census Bureau), about 27 percent of Minnesotans are under 200 percent of the federal poverty level. By county, the population under 200 percent of poverty varies from 13.25 percent to 50.25 percent, with 49 Minnesota counties at 30 percent or higher. This is an increase from 39 counties in 2010. The map below shows poverty levels at 200 percent of poverty, statewide by county (2014 American Community Survey).



Urban areas experience extreme concentrations of poverty. For example, half of Minneapolis census tracts have over 40 percent of the population under 200 percent of poverty and a quarter of census tracts have 60 to almost 90 percent of the population under 200 percent of poverty. (2014 American Community Survey five-year estimates).

Access to insurance

The Affordable Care Act (ACA) and Medicaid expansion helped many people access insurance. However, approximately a quarter of a million Minnesotans remain uninsured. And many of those that are insured through Medicaid expansion efforts are still poor and cannot afford out-of-pocket expenses for copays and uncovered services, such as dental services which are not fully covered nor readily available. Some people have gained insurance through the individual market (and may be counted among the newly insured), only to let it lapse due to the high cost of premiums. In addition, a significant number of individuals and families with modest incomes and high deductible policies continue to seek affordable care at safety net community clinics, which provide services on a sliding fee.

Uncompensated care

Safety net applicants under the Community Clinic Grant Program report large uncompensated care costs resulting in operating losses. Many applicants use financial reserves to maintain clinical operations for the uninsured and underinsured populations they serve. As a result, these safety net clinics increasingly rely on grant funding not only to maintain services, but also to improve culturally/linguistically appropriate services and upgrade aging equipment, facilities and technology.

Eligible Grant Activities

Activities eligible for funding under the Community Clinic Program are very broad. Per the program statute, 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 the following:

- Provide a direct offset to expenses incurred serving 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 to deliver 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.”

Applicant Information

Applications are received from all types of providers, ranging from large multi-hospital/multi-clinic health systems to grassroots organizations with a handful of employees. More specifically, applicants include medical clinics/systems, counseling and mental health organizations, dental clinics, family planning organizations, tribal clinics, free clinics, hospitals that run clinics, Community Action Programs, Community Health Boards, public health clinics, providers of specialized services, organizations representing special populations, etc.

Common uses of funding

During the current application cycle, the Office of Rural Health and Primary Care received a record high of 50 pre-applications. General categories for projects included the following:

- Direct patient services for mental health, dental health, medical care, preventive screening, support and outreach (16 applications)
- Infrastructure expenditures including renovating/expanding space and replacing aging medical or dental equipment (12 applications)
- Reproductive health services, screening and treatment (9 applications)
- Care coordination, case management and/or chronic disease management (5 applications)
- Integrating mental health into primary care services (3 applications)
- Interpretation and translation services (3 applications)
- Clinical planning (1 application)
- Specialty services (1 application)

Targeted populations

In the large number of applications involving direct services, the targeted populations include not only uninsured and underinsured patients 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, and people who are disabled, elderly, non-English speaking, Hispanic or homeless. Regardless of the type of project, applicants must demonstrate the benefits of their project to their patients.

Award Information

Since the program began in 2002, the funding requests have greatly exceeded appropriated dollars. For the current Fiscal Year 2017 grant cycle, the Office of Rural Health and Primary Care received 50 applications with \$2,003,312 requested in funding, almost four times the available appropriation of \$561,000. In response to the broad interest in the program, while the

statutory maximum grant award is \$300,000, MDH has implemented a maximum award amount of \$45,000. This allows MDH to award approximately 12-15 smaller grant awards each year rather than just one or two larger grants, and to expand the reach of the program. In the current fiscal year, twenty-four pre-applicants were invited to submit a final application, which will be due in January 2017.

A summary of grant requests and awards for the reporting biennium is below:

Community Clinic Grants Biennium Summary

Fiscal Year	Total Requested	Total Awarded	Number of Requests	Number of Awards
2015	\$1,899,893	\$561,000	40	14
2016	\$1,783,993	\$532,044	41	13
2017	\$2,003,312	Pending	50	Pending

Details of awardees and their projects for fiscal years 2015 and 2016 are summarized in the following two tables.

FY 2015 Projects

Grantee	City	Project Summary
Amherst Wilder Foundation	St. Paul	Support clinician salaries to provide bilingual/bicultural mental health services to Southeast Asian refugees and their families, targeting refugee families that have experienced significant trauma as the result of war, political persecution and living in refugee camps.
Annex Teen Clinic	Robbinsdale	Support two 4-hour clinics per week providing sexual health services to 500 high-risk adolescents, increasing access to services in a school setting.
Apple Tree Dental	Hawley	Purchase anesthesia equipment to launch an IV sedation program at the Hawley Center to increase access and decrease wait times for uninsured and underinsured patients requiring this service.
Community Dental Care	Robbinsdale	Complete renovation of the upper level on a new clinic in Robbinsdale to become a large dental safety-net provider in Hennepin County and another training site for dental hygienists and dental therapists.
Face to Face Health & Counseling Service, Inc.	St. Paul	Support medical services for uninsured, low income, high risk youth and young adults in St. Paul.

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Grantee	City	Project Summary
Family Tree, Inc.	St. Paul	Support the clinic's Long Acting Reversible Contraception (LARC) Initiative, targeting uninsured, underinsured, low-income, high risk patients.
HealthFinders Collaborative	Northfield	Purchase a dental chair and support dental hygienist salaries to expand dental services to uninsured and underinsured populations in the service area.
Hennepin County Human Services	Minneapolis	Co-locate physical health services provided by Hennepin County Health Care for the Homeless with Hennepin County Mental Health Center, both Hennepin County programs, to improve integrated service delivery to uninsured and underinsured populations.
Lake Superior Community Clinic	Duluth	Replace outdated dental equipment to improve patient safety, service efficiency, best practices and recruitment of new dentists.
Lutheran Social Services Teen Clinic	Duluth	Support clinic operations and increase RN time and contract for 4 hours of Nurse Practitioner time to serve area's homeless, uninsured and underserved youth.
Mississippi Headwaters Area Dental Health Center	Bemidji	Expand onsite services for low-income populations to access dentures, space maintainers, sleep apnea appliances, athletic mouth guards to improve overall health.
North Metro Pediatrics PA	Coon Rapids	Support nurse practitioner salaries to increase access to preventive care and childhood vaccinations targeting uninsured and underinsured children in Anoka County.
Outlook Health Services, Inc.	North Branch	Support screening for sexually transmitted infections (STI) for patients not covered by any other source of funding.
Walk-In Counseling Center	Minneapolis	Support expansion of free walk-in mental health services at a new location in St. Paul. This grant funding would support the start-up costs for one of those locations, Neighborhood House, which just opened for services October 2014.

FY 2016 Projects

Grantee	City	Project Summary
Annex Teen Clinic	Robbinsdale	Support two 4-hour clinics per week providing sexual health services to 500 high-risk adolescents in the school setting.
Apple Tree Dental	Madelia	Support the purchase of a panoramic x-ray machine to increase access to oral surgery services to a significantly underinsured population in the central Minnesota region.
Center for Victims of Torture	Saint Paul	Support comprehensive mental health and social services to Karen refugees that have experienced severe torture and suffer from post-traumatic stress disorder.
Community Dental Care	Robbinsdale	Support the implementation of their Program to Improve Community Oral Health (PICOH) in their new Robbinsdale clinic.
Face to Face Health & Counseling Service, Inc.	Saint Paul	Support medical services for uninsured, low income, high risk youth and young adults in St. Paul. Specifically, funds will offset Nurse Practitioner salaries, lab fees and medical supplies.
Family Tree, Inc.	St. Paul	Support for clinic's Long Acting Reversible Contraception (LARC) Initiative, providing medical services and free LARC implants for very low-income, uninsured, high-risk patients.
HealthFinders Collaborative, Inc.	Northfield	Support salaries for dental therapist position to increase oral health services and decrease a significant wait list at the new Faribault clinic.
Mississippi Headwaters Area Dental Health Center	Bemidji	Support the purchase of panoramic and other orthodontic equipment to increase medically necessary orthodontia and apnea services provided on site to a significant underinsured population.
myHealth for Teens & Young Adults	Hopkins	Support free or low-cost health services to young people ages 12-23, ensuring mental health screening for every patient accessing care and the availability of at least one counselor during clinic hours.
North Metro Pediatrics PA	Coon Rapids	Support nurse practitioner salaries to increase access to preventive care and childhood vaccinations.
Outlook Health Services, Inc.	North Branch	Support screening for sexually transmitted infections (STI) for patients not covered by any other source of funding.
Polk-Norman-Mahnomen Community Health Board	Crookston	Support the establishment of the infrastructure for sustainable screening and disease surveillance for HIV and HepC.
Touchstone Mental Health	Minneapolis	Support a nutritionist position to provide dietary counseling for mentally ill patients to overcome barriers to eating healthy as well as the negative side effects of medication related to mental health management.

Conclusion and Next Steps

The Community Clinic Grant Program remains a critical tool to support the provision of high-quality care to vulnerable populations, and to retain the financial viability of the clinics that provide these services. MDH will continue to monitor the types of support that applicants are seeking through the program, with a goal of ensuring that the program can best meet evolving needs in the community and maximize the leverage of the program. As we move into the next cycle of funding, the following principles will be important to consider:

Maintain flexibility to respond to changing needs

The current statute is broadly worded to allow for any type of clinical-based project needed to support health care services to uninsured and underinsured populations. That flexibility allows the program to adjust to the current needs of clinics and the patients they serve, and needs to be retained. As these needs adjust, MDH has seen related trends in the kinds of applications requesting funding. For example, due to Medicaid expansion, MDH has seen the number of applications shift slightly from projects designed to connect more patients with basic care, towards projects that focus services on chronically uninsured populations, and on projects that fill gaps in Medicaid coverage.

Consider options to prioritize funding

While the administrative decision to distribute grant funds widely by limiting awards to \$45,000 has allowed MDH to support a broader range of clinics and projects around the state within a limited budget, it may be restricting the scope and scale of worthy projects. MDH is working with internal and external stakeholders to consider whether the program should shift to offer fewer but larger awards and/or to give priority to particular types of projects that are aligned with critical statewide or local health reform goals.

The increasing mismatch of grant requests and available funding also demonstrates that the program could make effective use of additional funds should they become available. MDH will continue to explore options for aligning this work with other available funding streams, or for identifying new sources of funding to support community clinics.

Appendix

145.9268 Community Clinic Grants

Subdivision 1. **Definition.** For purposes of this section, "eligible community clinic" means:

- (1) a nonprofit clinic that is established to provide health services to low income or rural population groups; provides medical, preventive, dental, or mental health primary care services; and utilizes 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;
- (2) a governmental entity or an Indian tribal government or Indian health service unit that provides services and utilizes a sliding fee scale or other procedure as described under clause (1);
- (3) a consortium of clinics comprised of entities under clause (1) or (2); or
- (4) a nonprofit, tribal, or governmental entity proposing the establishment of a clinic that will provide services and utilize a sliding fee scale or other procedure as described under clause (1).

Subd. 2. **Grants authorized.** The commissioner of health shall award grants to eligible community clinics to plan, establish, or operate services to improve the ongoing viability of Minnesota's clinic-based safety net providers. Grants shall be awarded to support the capacity of eligible community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delivery infrastructure. The commissioner shall award grants to community clinics in metropolitan and rural areas of the state, and shall ensure geographic representation in grant awards among all regions of the state.

Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an eligible community clinic must submit an application to the commissioner of health by the deadline established by the commissioner. A grant may be awarded upon the signing of a grant contract. Community clinics may apply for and the commissioner may award grants for one-year or two-year periods.

(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

- (1) a description of the purpose or project for which grant funds will be used;
- (2) a description of the problem or problems the grant funds will be used to address;
- (3) a description of achievable objectives, a workplan, and a timeline for implementation and completion of processes or projects enabled by the grant; and
- (4) a process for documenting and evaluating results of the grant.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (d), the commissioner shall establish criteria including, but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also take into account other relevant factors, including, but not limited to, the percentage for which uninsured patients represent the applicant's patient base and the degree to which grant funds will be used to support services increasing or maintaining access to health care services. During

application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant. The commissioner has discretion over the number of grants awarded.

(d) In determining which eligible community clinics will receive grants under this section, the commissioner shall give preference to those grant applications that show evidence of collaboration with other eligible community clinics, hospitals, health care providers, or community organizations.

Subd. 3a. **Awarding grants.** (a) The commissioner may award grants for activities to:

- (1) provide a direct offset to expenses incurred for services provided to the clinic's target population;
- (2) establish, update, or improve information, data collection, or billing systems, including electronic health records systems;
- (3) procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic;
- (4) provide improvements for care delivery, such as increased translation and interpretation services;
- (5) build a new clinic or expand an existing facility; or
- (6) other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve.

(b) A grant awarded to an eligible community clinic may not exceed \$300,000 per eligible community clinic. For an applicant applying as a consortium of clinics, a grant may not exceed \$300,000 per clinic included in the consortium. The commissioner has discretion over the number of grants awarded.

Subd. 4. **Evaluation and report.** The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress reports to evaluate the grant program from the eligible community clinics receiving grants. Every two years, as part of this evaluation, the commissioner shall report to the legislature on the needs of community clinics and provide any recommendations for adding or changing eligible activities.