South Carolina
Rural Health Research Center

FINDINGS BRIEF
September, 2015

Free Clinics in the Rural Safety Net, 2014

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Key Findings

- Of 759 free clinics in the United States in 2014, 22 percent were located in rural counties and 78 in urban counties. Seventeen states had no free clinics in rural counties.
- A majority of free clinics (60.7 percent) were located in states that had not expanded Medicaid as of May, 2015.
- There have been few free clinic closures in recent years. Reasons for closure reported by free clinic association executives included loss of funding, difficulty recruiting volunteers, expansion of other safety net providers, and declining need after passage of the Affordable Care Act.
- Some free clinics use billing or voluntary payment to help meet expenses:
  - Nine of 14 state free clinic associations report some free clinics using *hybrid business models*. In these models, patients with Medicaid are accepted and billing is a part of the clinic's revenue plan.
  - Six of 14 state free clinic associations report a small number of clinics using *charitable care models*. In these models, a nominal fee is requested from patients for care.
- Free clinic operations continue to be subsidized and supported by philanthropic partnerships, communities of faith, and relationships with other care providers.

Introduction

The primary purpose of the Affordable Care Act (ACA), reflected in Medicaid expansion and the development of health insurance marketplaces (Sections 2001, 2201, 4106, 4108, and 5601),[1] is to reduce the number of uninsured persons. Based on Gallup data, the proportion of uninsured persons dropped from 17.1 percent in 2014 to 12.9 percent in 2015.[2] Gallup did not examine rural and urban differences. In 2012, the most recent estimate available, 19.1 percent of rural persons under age 65 lacked health insurance, versus 16.4 percent of urban residents.[3] Nearly two-thirds (65 percent) of U.S. rural residents lived in states that had not expanded Medicaid through 2014, compared to 50 percent of urban residents.[4] Despite the increases in the proportion of persons covered by health insurance, a substantial number of persons remain uninsured. Among uninsured adults, more than a third (36.6 percent) indicated they did not receive care or delayed seeking medical care due to costs.[5]

[1] The Patient Protection and Affordable Care Act. March 23, 2010. Sections 2001, 2201, 4106, 4108, and 5601.
[2] Gallup. In U.S., Uninsured Rate Sinks to 12.9%. 2015. Retrieved from http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx on January 8, 2015.
[3] National Center for Health Statistics. *Health, United States, 2013: With Special Feature on Prescription Drugs*. Hyattsville, MD. 2014..
[4] Newkirk V and Damico A. The Henry J. Kaiser Family Foundation. The Affordable Care Act and Insurance Coverage in Rural Areas. May 29, 2014. Retrieved from http://kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/ on January 8, 2015.
[5] U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2010. September 2011. Retrieved from http://www.census.gov/prod/2011pubs/p60-239.pdf on May 20, 2013.

In many communities, free clinics provide no-cost entry points to care that are essential for marginalized and at-risk populations. Free clinics, as defined by the National Association of Free and Charitable Clinics (NAFC), use volunteers and staff to provide essential medical services to persons who cannot afford care without requiring any form of payment. These clinics generally limit their services to persons who are uninsured or underinsured.[6] Because clinics are usually staffed by volunteers, there are no requirements specifying free clinic scopes of service or operations, although most states provide basic liability coverage through so called 'Good Samaritan Laws' that protect volunteer clinicians from malpractice lawsuits. Free clinics can operate in a charitable care model. In the charitable care model, patients are asked to pay a nominal fee either as an optional donation or structured payment, although payment is not required. In some instances, free clinics operate so called "hybrid" business models, whereby they accept and bill third party payers, principally Medicaid, for the purposes of addressing unmet client need or for financial sustainability. When operating in a "hybrid model," free clinics are subject to the same billing requirements and expectations the third party payer has for traditional healthcare organizations. To be defined as "free clinics," hybrid model organizations must still provide core services without charge if the individual cannot pay. These varying models for providing care are explored in this brief.

With many states not participating, or leaning toward not participating, in Medicaid expansion,[7] free clinics will remain an important source of care for many uninsured individuals. In addition, anticipated increased demand among paying patients after ACA implementation may reduce the extent to which practitioners feel obliged to serve clients who remain without coverage, reducing the volunteer practitioner corps at free clinics. It has been estimated that by 2019 there will be as many as 24.3 million more primary care visits annually, stressing vulnerable systems of care.[8] Finally, free clinics form a venue in which philanthropic organizations can, singly or in public-private partnerships, intervene to provide direct services and/or support. If current constraints on state and federal budgets remain in place, such partnerships will become increasingly necessary to uninsured individuals. Previous research suggests the potential for rural disparities: while urban-based free clinics appear to be available where there are safety net gaps, they are not necessarily located in communities with high concentrations of people most likely to use free clinics, e.g. uninsured, minority, and low income persons.[9,10]

This brief explores two issues. First, we examine where free clinics are located and describe their availability in rural counties across all 50 states. This information was derived from clinic listings on the website of the National Association of Free and Charitable Clinics (NAFC). Second, through telephone interviews with leadership at 14 of the 21 state free clinic associations, we explore issues facing free clinics during the current period of change. Issues examined include perceived changes in demand subsequent to implementation of the Affordable Care Act and different funding models and strategies used by free clinics. Details are provided in the Technical Appendix.

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[6] The National Association of Free and Charitable Clinics. "What is a Free or Charitable Clinic?", Retrieved from http://nafcclinics.org/about-us/what-is-free-charitable-clinic on June 3 2015.

[7] The Henry J. Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision, as of December 17, 2014. Retrieved from http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ on January 7, 2015.

[8] Hofer AN, Abraham JM, Moscovice I. Expansion of coverage under the Patient Protection and Affordable Care Act and primary care utilization. Milbank Q. 2011 March; 89(1):69-89.

[9] Darnell J. What is the role of free clinics in the safety net? Med Care. 2011 Nov;49(11):978-84.

[10] Darnell JS. Free clinics in the United States: a nationwide survey. Arch Intern Med. 2010 Jun 14;170(11):946-53.

Location of Free Clinics

The NAFC website listed 779 free clinics in 2014. Of these, 759 had addresses that could be placed within a specific county. Among these 759 clinics, 165 (22 percent) were located in rural counties, with the remaining 594 (78 percent) in urban counties (See Table 1, below). Seventeen of 50 states had no free clinics located in rural counties. Free clinics were located predominately in the South. The urban concentration of free clinics was corroborated by interviews with leadership at free clinic associations who noted few, if any, free clinics in their states were located in rural areas.

Table 1. Number of Free Clinics in Rural and Urban Counties, by State*

State	Number of Free Clinics			State	Number of Free Clinics		
	Total	Rural	Urban		Total	Rural	Urban
Alabama	12	4	8	Montana	1	1	0
Alaska	**	**	**	Nebraska	3	0	3
Arkansas	26	15	11	Nevada	1	0	1
Arizona	3	0	3	New Hampshire	1	1	0
California	34	0	34	New Jersey	5	0	5
Colorado	4	1	3	New Mexico	2	0	2
Connecticut	8	0	8	New York	7	0	7
District of Columbia	1	0	1	North Carolina	92	26	66
Florida	22	1	21	North Dakota	1	1	0
Georgia	34	1	33	Ohio	45	8	37
Hawaii	1	0	1	Oklahoma	19	5	14
Idaho	3	2	1	Oregon	6	0	6
Illinois	9	1	8	Pennsylvania	19	2	17
Indiana	11	4	7	Rhode Island	2	0	2
Iowa	2	1	1	South Carolina	47	7	40
Kansas	1	0	1	South Dakota	1	1	0
Kentucky	20	7	13	Tennessee	13	4	9
Louisiana	16	3	13	Texas	89	7	82
Maine	4	0	4	Utah	3	2	1
Maryland	8	0	8	Vermont	6	6	0
Massachusetts	3	0	3	Virginia	71	18	53
Michigan	13	4	9	Washington	22	6	16
Minnesota	2	1	1	West Virginia	10	2	8
Mississippi	9	4	5	Wisconsin	25	10	15
Missouri	15	5	10	Wyoming	7	4	3

*There were no free clinics in the state of Delaware.
**20 clinic addresses, including the only free clinic listed for Alaska, could not be matched to counties.

Standardization or Certification

Lack of standardization around care delivery is a frequent criticism of free clinics compared to traditional safety net primary care settings, such as federally qualified health centers or rural health clinics. Absence of standardization for scope of services, staffing, and hours of availability can reduce the predictability of care for potential patients and the quality with which that care is delivered. Many state free clinic associations promote best practice and quality standards or have minimum standards clinics must maintain in order to be members of the associations. Of the 14 state free clinic associations interviewed, only the Free Clinic Association in South Carolina reported a formal certification process for free clinics. This process is newly instituted and is being rolled out

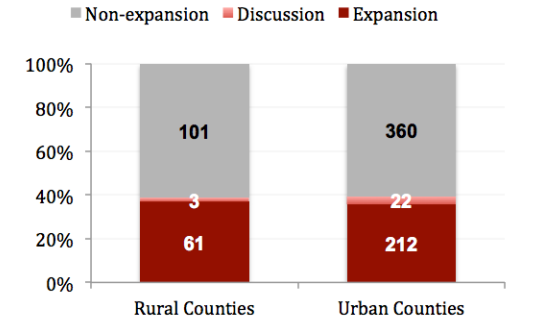
slowly, with only three or four clinics having completed it. It is still in a pilot phase as member interest and benefits for becoming certified are better understood.

Free Clinics and Medicaid Expansion

Twenty-nine states and the District of Columbia have expanded Medicaid under the ACA, while 18 states have not expanded Medicaid and 3 states remain undecided as of May, 2015.[11]

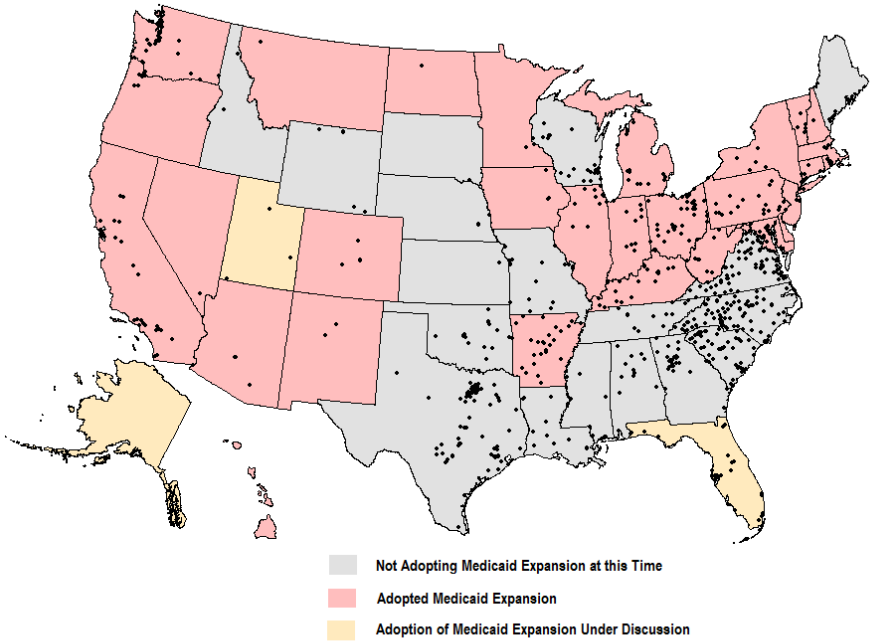
Overall, 36.0 percent of all free clinics were located in expansion states, 3.3 percent in discussion states, and 60.7 percent in non-expansion states. Proportions in each expansion category were similar when free clinics are stratified by rural versus urban county location (Figure 1, at right); however, the overall number of rural free clinics is much smaller. Some non-expansion states have virtually no free clinics, while others have significant free clinic presence (see Figure 2, below).

Figure 1. Distribution of free clinics, by Medicaid expansion status and rurality, May, 2105



The distribution of free clinics across states suggests that these facilities will continue to be an important entry point into care for many who lack health insurance and have not benefited from the expansion of Medicaid.

Figure 2. Free clinic locations, by state Medicaid expansion status as of May, 2015



[11] The Henry J. Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision, as of May 26, 2015. Retrieved from http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/.on June 10, 2015

Perceived Demand and Financial Models

Free clinic associations were asked about financial adaptations their members were using in response to ACA implementation and potential market changes, if any.

Hybrid financial models: Association respondents were also asked whether their members use hybrid financial models, whereby free clinics provide care both to uninsured persons, using traditional free clinic models, and to insured individuals, as a billable service. Free clinics that elect to bill for services must comply with all regulations pertinent to health care providers in their state, which can pose a significant administrative burden. Nine of the 14 free clinic associations reported knowing of member clinics that were currently using hybrid models, although in very small numbers. The four with no hybrid models stated it remains a business strategy under potential consideration. Three states (Illinois, Kentucky, and Ohio) reported that their free clinics continue to provide care to patients even after they acquire Medicaid coverage because of poor access to new providers. A summary of reported use of hybrid models, by state, is presented in Table 2 (next page).

Charitable financial models: Free clinic association respondents were also asked about charitable clinic models, whereby patients pay a nominal fee for services based on what they can afford. None were identified for Colorado, Florida, Kentucky, Missouri, North Carolina, Texas, Vermont, or Washington. In some states, charitable clinic models were perceived as not viable because, as the respondents understood it, an exchange of money would invalidate the state's Good Samaritan law, thus raising malpractice issues for participating clinicians. Other state free clinic associations expressed their belief that charging fees would be counter to the mission of the hosting organization, which is often faith-based.

In the six states that reported having some free clinics using charitable clinic models, implementation varied. In Georgia, charitable clinic models evolved because the funding communities thought it was important for patients to 'have some skin in the game,' relative to supporting resources for healthcare services. In most cases, use of charitable clinic models is rare and the fees small. In Ohio, it was reported by the interviewee that only "one percent" of free clinics charge a fee. In Virginia, 52 of the 60 free clinics request a nominal fee or donation for medical services ($5 to $10) and pharmaceuticals ($2 to $5), however, no clinics request a fee for behavioral health. Some free clinics in West Virginia charge a $2 administration fee. While no free clinics in South Carolina charge for services, some require a small fee for pharmaceuticals. Some free clinics in Illinois operate using a charitable clinic model, but it has become problematic because accepting fees negates liability coverage through the Good Samaritan Act for volunteer doctors, making it difficult to recruit staff.

Perceived demand: As of Fall, 2014 when interviews were conducted, respondents in both Medicaid expansion and non-expansion states reported that the ACA had little impact on demand for services at free clinics as of that time. Absence of perceived change was attributed to the large numbers of persons who remain uninsured and challenges for newly Medicaid-eligible persons in finding sources of care outside of free clinics.

Table 2. Use of hybrid models in free clinics, as reported by state free clinic associations, 2014

State Association	Are any free clinics using hybrid models?	Respondent Comments on Hybrid Models
Colorado	Yes	There are very few free clinics in rural Colorado because the proportion of people without insurance is very low. There are high participation rates of Medicare in rural Colorado. In addition, the few free clinics that exist are faith based and not rural. (n=2).
Florida	No	Very little discussion about the use of hybrid models.
Georgia	Yes	Eight of 90 clinics accept Medicaid and tend to be in urban areas with hospital relationships.
Illinois	No	Some free clinics see patients with Medicaid but do not bill. These patients are unable to find care elsewhere. As a result of the inability of patients to find providers, some free clinics are considering becoming federally qualified health centers.
Kentucky	No	Free clinics are considering the model. About 40% of free clinics keep their Medicaid patients but do not bill for services.
Missouri	Yes	One third of free clinics bill Medicaid and Medicare
North Carolina	No	Many free clinics are exploring hybrid models. NC "expects community dynamics and market will be more accepting of a hybrid model if clinics are located in communities that lack existing safety net providers such as rural health clinics or federally qualified health centers."
Ohio	Yes	One quarter of free clinics have converted to hybrid models. Many other clinics treat Medicaid beneficiaries because patients are unable to find providers; however, they do not bill.
South Carolina	Yes	There is one hybrid clinic in a rural county. The conversion was a community decision as no other safety net provider was available. Five or six free clinics are considering becoming hybrid.
Texas	Yes	A few have started billing Medicaid.
Vermont	No	They operate as either free standing or referral clinics and are funded by the state's Department of Health and Human Services for case management and referrals.
Virginia	Yes	Two clinics participate with private insurance. Another 12 to 15 are interested in becoming Medicaid providers.
Washington	Yes	Two clinics became hybrid with an emphasis on providing behavioral health services.
West Virginia	Yes	Eight of 10 free clinics operate using hybrid models.

Free Clinic Closures

Respondents at the 14 free clinic associations for which interviews were completed identified very few closures of free clinics across the country. Leaders from free clinic associations in Florida, Kentucky, Vermont, and West Virginia reported no closures. In the remaining states, most closures were due to unique local circumstances, ranging from expanded services being provided by other safety net providers to staffing challenges. Only two states identified closure situations that were

attributed to reduction in need associated with the ACA. These closures are summarized in Table 3, (below).

Table 3. Reasons for recent free clinic closures identified through interviews with 14 free clinic associations, by State, 2014**.**

Reason	States and estimated facilities affected	Details Provided by Free Clinic Association Respondents
Safety Net Expansion in Community (Six states)	Georgia (n=1)	One closed when community got an FQHC, but it subsequently reopened
	Illinois (n=uncertain)	FQHCs were expanding sites, therefor free clinic(s) determined they were no longer needed in the service area
	North Carolina (n=uncertain)	Converted to something like an FQHC
	Ohio (n=2)	Clinics are closing due to narrow mission, in that they only treat people who do not qualify for public health insurance. These communities have FQHCs and other resources, so the free clinics were no longer deemed necessary.
	Texas (n=1)	Clinic was taken over by private practice and was located close to FQHC; the funder felt it was redundant.
	Washington (n=2)	One clinic experienced a planned closure. A second clinic discontinued medical services but maintains vision and dental service offerings.
Loss of Funding (Four states)	Illinois (n=uncertain)	Financial problems in local free clinics
	Missouri (n=1)	One clinic opens and closes, changes operating schedules based on volunteers & funding availability.
	North Carolina (n=1)	One closed because it was hospital owned and the organization had new priorities.
	South Carolina (n=1)	One clinic lost funding.
Staffing Challenges (Three states)	Georgia (n=1)	Provider moved away
	Illinois (n=1)	The only physician serving this clinic retired, leaving it unable to provide services.
	Virginia (n=1)	Clinic closed because couldn't get providers; clinic had plenty of funding but providers don't want to live in rural.
ACA (Two states)	Colorado (n=1)	Private practices and rural hospital were willing to accept newly qualified Medicaid patients and absorb free clinic patients
	Illinois (n=2)	Two free clinic boards deemed the organization to be not needed

Funding Strategies and Partnerships

State Government Support. Free clinics or their associations have unique relationships with state governments in at least four states through public-private partnerships. In South Carolina, free clinics receive funding through a competitive grant process from the state Medicaid agency for the South Carolina Healthy Outcomes Plan (HOP). As partners in HOP, free clinics collaborate with their local health care systems to provide care and case management services for uninsured persons

who have a history of frequent visits to emergency rooms. The goal is to improve the health status of high-risk uninsured persons by getting them into medical homes and into appropriate levels of care. In Ohio, there is a line item in the state's budget specifically for free clinic activities, with 90 percent of funding reported to go directly to the clinics. Similarly, West Virginia free clinics benefit from a small state appropriation. Washington State uses a more entrepreneurial model, whereby the clinic association has a fee for service contract with the public health department to provide direct care services for uninsured persons.

Philanthropic Support. For most free clinics, philanthropic partnerships are essential to their financial viability. We learned from our interviews that free clinic operations are made possible through investments and efforts of local charitable organizations that are too numerous to inventory. In addition to these grassroots partners, eight state free clinic associations in our study reported robust funding either directly or through its member free clinics from large philanthropic organizations. These charitable organizations, listed in Table 4 (right), appear to be important partners in addressing safety net healthcare issues, especially for uninsured persons. These organizations do not constitute an exhaustive list. For the most part, these large philanthropic organizations provide general or programmatic support. A few, however, have conditional use of funds. The Florida Blue Foundation, for example, provides financial support to innovative models of care for the uninsured, rather than funding free clinic operations. The Visiting Nurses Association Foundation in Illinois provides staffing for the state's free clinic association rather than financial support.

Table 4. Philanthropic partners reported by free clinic state associations

State	Philanthropic Partners
Colorado	Colorado Health Foundation
Florida	Florida Blue Foundation
Georgia	United Way Kaiser Permanente Healthcare Georgia Foundation
Illinois	Blue Cross Blue Shield of Illinois Chicago Community Trust Visiting Nurses Association Foundation
Kentucky	United Way Good Samaritan Foundation
North Carolina	NC Foundation for Advanced Health Programs Blue Cross Blue Shield Foundation of North Carolina Kate B. Reynolds Charitable Trust Sisters of Mercy The Duke Endowment United Way
South Carolina	The Duke Endowment Blue Cross Blue Shield Foundation of South Carolina
Virginia	Virginia Health Care Foundation

Faith Community Partnerships. The faith community plays a significant role in supporting free clinics. Eleven of the 14 state free clinic associations described in detail the interconnectedness local free clinics have with churches. In Texas, it is common for churches to pay for needed services that exceed what free clinic volunteers can provide, such as laboratory and surgeries. Approximately 65% of the free clinics in Georgia and 50% in Missouri are reported to be faith-based. In North Carolina, churches are a source of both financial support and referrals for free clinics. Having a faith-oriented mission as a free clinic appears to also influence decisions around alternative funding models, such as billing Medicaid. Respondents noted that faith-based free clinics are less likely to adopt either hybrid or charitable care models as these approaches violate their mission of service to the poor.

Healthcare Partnerships. In many cases, there is a symbiotic relationship between hospitals and free clinics. Clinics can offer hospitals relief from potentially avoidable emergency room visits by the uninsured, while hospitals can provide free clinics with additional clinical services such as diagnostic testing. Every participating free clinic association described the presence of clinic-hospital relationships that followed this pattern. In some Georgia and Washington communities, hospitals provide salary support to free clinics. Hospitals in certain Illinois communities provide Medicaid eligibility verifications for free clinic clients. In Ohio, hospitals assist free clinics using hybrid business models with Medicaid billing.

Only one state association, Colorado, indicated that occasionally hospitals perceived free clinics as potential threats to emergency room revenue. Concerns were shared anecdotally about free clinics potentially diverting business from hospitals.

In addition to hospitals, many free clinics across the country have relationships with other members of the primary care safety net, notably FQHCs. In some cases, the relationship is defined by a shared advocacy agenda for the uninsured, leading state free clinic associations and primary care associations to collaborate. Florida and Texas shared examples of this type of relationship. At the local level, partnerships are community-specific with both collaborative and competitive relationships. In Washington state, many free clinics and FQHCs collaborate on case management and referral services. In some states, however, free clinics and FQHCs find themselves competing for local philanthropic support due to their shared mission of providing care to underserved persons.

Free clinic associations were asked about public health partnerships at either the state or local levels. There was consensus that public health agencies in each state have experienced significant budget cuts. For financial and philosophical reasons, public health has transitioned away from providing direct care services such as well child care. Participants stated this has affected their free clinics by removing a potential referral point for clients and removing an entry point into the healthcare system for uninsured persons in their communities.

Innovative Partnerships. In addition to traditional partners, a few states described innovative health-related partners essential to fulfilling the missions of their free clinics. In Illinois, medical schools partner to counsel patients. This is especially true in urban communities that are in close proximity to academic medical centers. The Center on Rural Health and Social Development at Southern Illinois University has been an important partner for the state's free clinic association, ensuring that the needs of the uninsured living in the state's rural communities are not forgotten. Texas described a similar relationship with the Center for Public Policy Priorities, which provides help with hospital and physician advocacy for free or low cost laboratory services. Kentucky indicated that their free clinics have relationships with pharmaceutical companies so that they do not have to maintain onsite pharmacies. They have contracts with all major pharmaceutical companies who participate in a statewide prescription program.

According to the state's free clinic association, North Carolina is 'held out as an example of collaborations among safety net systems.' Around 2006, the state legislature restructured its financial appropriations for safety net providers, such as free clinics and FQHCs. Instead of responding to individual funding requests, the legislature encouraged a 'collective ask' for a single funding amount and funding process. At present, recurring state funds are distributed through a competitive grant application process. Grants are considered favorably if a collaborative relationship exists between a free clinic and an FQHC or other safety net providers. Instead of medical homes for safety net populations, the state encourages vertically integrated "Medical Neighborhoods" that ensure a continuum of healthcare and human services.

Conclusions

The rural safety net has proportionately fewer free clinics than urban communities, with seventeen states having no free clinics located in rural counties. The initial impact of ACA on free clinics, as reported in Fall, 2014, has not been a reduction in demand for services While there have been a few free clinic closures nationally, respondents at state free clinic associations report that demand for services remains high.

Most free clinic associations reported that their member clinics were taking a 'wait and see' approach to modifying their business models in response to the ACA. At the time respondents were interviewed in late 2014, multiple states had refused to participate in Medicaid expansion and the Supreme Court had not yet ruled regarding the constitutionality of subsidies for low-income persons signing up for health insurance using Federal exchanges, perhaps accounting for a feeling of caution. While many associations reported that their participating clinics are open to alternative business models, very few have changed their operations at this point in time. Free clinics draw upon multiple sources for funding, including philanthropic partners, state governments, faith communities, and local healthcare providers.

Funding Acknowledgement:

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1CRH03711, Rural Health Research Grant Program Cooperative Agreement. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Appendix A. Technical Notes

Two complementary study designs were used: a quantitative assessment of free clinic locations and a qualitative assessment of the perceptions of free clinic association executives.

Quantitative assessment of free clinic locations: The website of the National Association of Free and Charitable Clinics (NAFC) offers a clinic locator that provides the address, hours, and services provided by each participating free clinic across the U.S. We manually extracted and coded locations of all free and charitable clinics. Data on hours and services were available for only 53% (n=417 of 779) of these free clinics and thus was not analyzed. Free clinic addresses were mapped to counties using address when available, otherwise by ZIP Code.

Rurality was measured at the county level. Counties were characterized using 2013 Urban Influence Codes, as follows: metropolitan or urban (UIC 1-2) and rural (UIC 3-12).

Qualitative work: Contact information for executives from 25 state/regional free clinic associations was obtained from the NAFC website. The original source was http://nafcclinics.org/about-us/stateregional-associations and is no longer active. States with individual associations include: Arkansas, California, Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Washington, and West Virginia. The two regional associations include the Great Lakes Region and Western Region. We were able to schedule telephone interviews with 15 of these associations: Colorado, Florida, Georgia, Illinois, Kentucky, Missouri, North Carolina, Ohio, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, and Western Region. Due to association restructuring between the Western Region and California, the telephone interview with the Western Region was excluded from this policy brief.

Telephone interviews were recorded. They averaged 45 minutes in length. Three researchers listened to the recordings separately and coded the content individually. The three (Martin, Bhavsar, and Workman) reconciled their coding for agreement. When there was disagreement, the recording was retrieved and the three researchers discussed with consensus being achieved in each instance.

Key informant interview questions included:

1. Tell us about business strategies or model adaptations free clinics in your state are using as ACA is implemented and the needs and demography of uninsured change.
2. Tell us about state policies that are positively or negatively impacting the operations of free clinics in your state/region, including standardization/certification of free clinics.
3. Other than the Free Clinic Association in your state or region, what other organizations are considered resources or advocates for uninsured and free clinics, especially among those in rural communities?
4. Tell us about 'model' free clinics serving rural communities in your state. What lessons are there to be learned about these models. May we contact them to document their model? [This question yielded few responses; thus, there is no section devoted to it in the Findings Brief.]

Telephone interview data were examined for key themes and concepts that allowed us to understand how free clinics and their associations engage partners, address rural populations, and plan for post-ACA activities.

Both parts of study were submitted to the University of South Carolina Institutional Review Board simultaneously with the proposal, in accordance with University policy. The study was classified as "exempt."