WHITE PAPER

Strengthening California's Free and Charitable Clinics:

The Role of CAFCC in a Changing Medi-Cal, Medicaid, and CalFresh Landscape

Policy Analysis and Recommendations for California's Free and Charitable Clinic Safety Net

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Executive Summary

California's free and charitable clinics are expected to face increasing pressure as state and federal changes to Medi-Cal, Medicaid, and CalFresh reduce access to health coverage and nutrition assistance for low-income residents. These changes are likely to increase unmet need and may increase demand for free and charitable clinics, particularly in communities where clinics are trusted access points for uninsured, underinsured, immigrant, unhoused, food-insecure, and medically underserved patients.

Medi-Cal, California's Medicaid program, is the largest health coverage program in the state and serves as a central part of California's healthcare safety net. The Legislative Analyst's Office (LAO, 2026a) estimates that Medi-Cal will serve an average monthly caseload of approximately 14.5 million people in fiscal year 2025-26, or about one-third of Californians. Medi-Cal covers a broad range of services, including physician visits, hospital care, prescription drugs, behavioral health, long-term care, and dental services (LAO, 2026a).

CAFCC represents and supports California's free and charitable clinic sector. CAFCC member clinics provide care to patients who are uninsured, underinsured, low-income, or otherwise unable to access traditional healthcare systems (California Association of Free and Charitable Clinics [CAFCC], n.d.-a). These clinics are often described as the "safety net of the safety net" because they care for people who remain outside public coverage programs, lose coverage because of administrative barriers, cannot afford care, fear using government-connected systems, or cannot successfully navigate complex healthcare systems.

Free and charitable clinics should not be viewed as a replacement for Medi-Cal, FQHCs, public hospitals, or county health systems. Instead, they are a complementary and essential layer of California's healthcare safety net. Their role is especially important for patients who remain uninsured, lose coverage because of procedural barriers, cannot afford care, fear using government-connected systems, or need services that are difficult to access through traditional reimbursement structures.

Using LAO's 2025-26 Medi-Cal total spending estimate of $196.7 billion and the projected 14.5 million average monthly caseload, a rough illustrative estimate of Medi-Cal spending is approximately $13,565 per enrollee per year (LAO, 2026a). This comparison should not be interpreted to mean that free clinics replace Medi-Cal. Medi-Cal finances a comprehensive insurance benefit, while free clinics provide targeted, community-based care for patients who remain outside or fall through the cracks of the coverage system. However, the comparison illustrates that free clinics deliver substantial value at a low operating cost and should be included in safety-net investment strategies.

Recent federal and state policy changes are expected to place significant pressure on California's safety net. LAO (2026b) reports that California's uninsured rate fell from more than 14% in 2012 to about 5% by 2024 because of major coverage expansions, including Medi-Cal expansion, Covered California policies, and state actions expanding comprehensive Medi-Cal coverage to undocumented immigrants. However, LAO (2026b) also notes that California's budget situation has tightened, Medi-Cal costs have risen, the Legislature enacted several Medi-Cal reductions in 2025, and Congress enacted H.R. 1 in July 2025, which made significant changes to federal Medicaid and marketplace policy.

At the same time, changes to CalFresh, California's Supplemental Nutrition Assistance Program, are expected to reduce food assistance for some low-income residents, increase work or community engagement requirements, and eliminate eligibility for many lawfully present immigrants. The California Department of Social Services (CDSS, 2026) states that some CalFresh recipients may receive less money for food, more recipients will need to participate in work or community engagement activities beginning June 1, 2026, and many lawfully present immigrants will no longer qualify for CalFresh beginning April 1, 2026.

Without targeted investment and coordinated policy support, California risks overwhelming the organizations that provide care to residents who have nowhere else to turn. CAFCC is well positioned to help document the

impact of these changes, strengthen clinic collaboration, advocate for flexible operating support, improve statewide data collection, and ensure that free and charitable clinics are included in California's policy response.

Background: California's Healthcare Safety Net

California's healthcare safety net is made up of diverse organizations that provide care to individuals who might otherwise go without services. These include public hospitals, county indigent health programs, community clinics, FQHCs, free clinics, mobile clinics, charitable pharmacies, and community-based organizations. The Public Policy Institute of California (PPIC, 2024) describes the safety net as a patchwork of programs and providers that deliver coverage and care to people with low incomes, no private insurance, and special medical needs.

Free and charitable clinics play a distinct role within this system because they often serve patients who remain outside traditional coverage and reimbursement structures. These patients may include uninsured workers, immigrant communities, people experiencing homelessness, patients with language barriers, individuals with unstable housing, and patients who cannot access timely primary care, specialty care, dental care, behavioral health services, medications, or social support services.

Many free clinics provide care regardless of insurance status, immigration status, income level, or ability to pay. This makes them essential for patients who are excluded from other systems or who cannot successfully navigate traditional healthcare pathways. However, free clinics cannot absorb coverage losses alone and should not be treated as a substitute for insurance coverage, FQHCs, county systems, or hospitals. They are an essential complementary part of the safety net, but they require investment, referral pathways, workforce support, and quality infrastructure to expand safely.

Distinguishing Free Clinics, Charitable Clinics, Community Clinics, and FQHCs

A major policy challenge is that free clinics, charitable clinics, community clinics, and FQHCs are sometimes discussed as though they are the same. They are not. FQHCs are essential safety-net providers that operate under federal requirements, receive federal Section 330 funding, bill Medicaid and other payers, and provide care regardless of ability to pay. Nationally, community health centers served 32.4 million patients in 2024. About half of health center patients were covered by Medicaid, 18% were uninsured, and Medicaid accounted for 45% of total health center revenue in 2024 (KFF, 2026).

Free and charitable clinics differ because many operate outside the traditional reimbursement system, rely heavily on volunteers and donated services, and often serve patients who are uninsured, ineligible for coverage, unable to pay, afraid to use government-connected systems, or unable to access reimbursable care. FQHCs are essential safety-net providers, but free clinics fill gaps for patients and services that remain outside FQHC capacity or reimbursement structures.

This distinction matters for policy. Strengthening free clinics should not be viewed as an alternative to preserving Medi-Cal coverage, supporting FQHCs, or funding county health systems. Rather, free clinics should be funded as a complementary safety-net resource for patients who remain outside those systems.

California Association of Free and Charitable Clinics' Role in the Safety Net

CAFCC is an important statewide association supporting clinics that provide care to patients who are uninsured, underinsured, low-income, or otherwise unable to access traditional healthcare systems. Through advocacy, networking, funding support, data collection, and information sharing, CAFCC strengthens California's free clinic sector and elevates the needs of uninsured and underserved populations (CAFCC, n.d.-a).

CAFCC member clinics vary widely in size, scope, and service mix. Depending on local capacity, clinics may provide primary care, chronic disease management, behavioral health, dental care, vision services, specialty referrals, pharmacy support, preventive screenings, health education, social needs screening, care coordination, mobile care, street medicine, or navigation assistance. CAFCC's member clinic directory identifies clinics across regions of California, including Northern California, Southern California, the Central Coast, the Inland Empire, Los Angeles County, Orange County, and San Diego County (CAFCC, n.d.-b).

CAFCC is especially important because free clinics are often small, community-based organizations with limited administrative capacity, heavy reliance on volunteers, and limited access to stable reimbursement. Many free clinics depend on grants, philanthropy, donated services, volunteers, and partnerships. A statewide association helps strengthen this fragmented network by creating connections among clinics, supporting collaboration, elevating shared needs, and helping free clinics participate in broader safety-net discussions.

CAFCC's history reflects the evolution of the free clinic movement in California. CAFCC states that the organization transitioned in 2011 from the Free Clinics of the Western Region into a California-based association focused on building strong and meaningful links among free and charitable clinics in the state. CAFCC also states that in November 2021, the association began receiving an annual $2 million grant from the State of California to distribute to member clinics, demonstrating state recognition that free clinics are an important part of the healthcare safety net (CAFCC, n.d.-c).

CAFCC is also important for advocacy and visibility. Free clinics are sometimes left out of policy discussions because they are not hospitals, FQHCs, or county-operated systems. However, they care for patients who often have nowhere else to go. CAFCC helps represent these clinics as a distinct part of the safety net and can help policymakers understand how Medi-Cal changes, CalFresh reductions, workforce shortages, behavioral health needs, specialty care gaps, and immigration-related barriers affect free clinic patients.

Additional support for CAFCC could strengthen statewide data collection, regional clinic coordination, technical assistance, emergency response capacity, documentation of service gaps, volunteer recruitment infrastructure, and distribution of flexible operating funds to clinics serving uninsured and underinsured patients.

Medi-Cal Reductions, Coverage Losses, and Unmet Need

Medi-Cal is central to California's healthcare financing system. LAO (2026a) reports that Medi-Cal provides health coverage for low-income Californians and covers services including doctor visits, hospital stays, prescription drugs, behavioral health services, long-term care, and dental care. LAO (2026a) also estimates that Medi-Cal will serve an average monthly caseload of 14.5 million people in 2025-26, about one-third of Californians.

LAO (2026a) estimates total Medi-Cal spending of $196.7 billion in 2025-26 and $222.4 billion in 2026-27. Dividing the 2025-26 spending estimate by the projected 14.5 million average monthly caseload produces a rough illustrative estimate of approximately $13,565 per enrollee per year. This is not a formal actuarial estimate and should not be compared directly with free clinic cost per patient as though the benefits are

equivalent. Medi-Cal finances a comprehensive health coverage program; free clinics provide targeted, community-based care for patients who remain outside or fall through the cracks of coverage systems.

Recent federal and state policy changes are expected to increase unmet need. LAO (2026b) reports that California's uninsured rate improved from 14% in 2012 to about 5% in 2024 following major coverage expansions. However, LAO (2026b) also states that California's budget situation has tightened, Medi-Cal costs have risen, the Legislature enacted several Medi-Cal reductions in 2025, and H.R. 1 made significant changes to federal Medicaid and marketplace policy.

These changes may increase uncompensated care for hospitals, FQHCs, county systems, and free clinics. For free clinics, the concern is not simply that patients may lose coverage. It is that many patients who lose coverage may still need medications, chronic disease care, behavioral health support, dental care, specialty referrals, and help navigating systems that have become more difficult to access.

The strongest argument is not that free clinics can absorb all coverage losses. They cannot. The stronger argument is that free clinics are a highly valuable and underfunded part of the safety net that will face increased pressure as more patients experience coverage loss, administrative barriers, fear, or delayed access to care.

Medicaid Work Requirements and Administrative Barriers

Federal policy changes are expected to increase administrative requirements for some Medicaid enrollees, including work or community engagement reporting requirements and more frequent eligibility checks. Orange County Social Services Agency (2026) states that starting January 2027, certain Medi-Cal recipients will be asked to prove they are working or volunteering during renewal periods.

Administrative barriers are particularly concerning for patients served by free clinics. Many patients face unstable housing, limited internet access, limited English proficiency, behavioral health conditions, transportation barriers, inconsistent work schedules, low literacy, or difficulty obtaining documents. These barriers make patients more likely to lose coverage because of missing paperwork, confusion about renewals, technology barriers, or an inability to document compliance.

Many patients who lose coverage may still be eligible but become disconnected because of administrative complexity. This kind of procedural coverage loss increases unmet need without reducing underlying medical risk. When patients lose coverage for procedural reasons, their health needs do not disappear. They often return to the safety net in worse condition.

Free clinics will likely see increased need for coverage navigation, medication refills, chronic disease management, urgent evaluations, behavioral health support, and specialty referrals. Policymakers should fund navigation support at free clinics and community-based organizations to help patients understand notices, complete renewals, document exemptions, respond to eligibility changes, and avoid unnecessary loss of coverage.

Immigration-Related Fear and Chilling Effects

Coverage eligibility is only part of the issue. Even when patients remain technically eligible for services, fear and confusion related to immigration enforcement, public benefit rules, changing eligibility standards, and government systems may discourage patients from seeking care or nutrition assistance.

KFF (2026) reports that increased immigration enforcement in healthcare settings and proposed changes to federal immigration policies may create confusion and fear among immigrant patients using health center services. Free clinics are often trusted community-based settings where patients may feel safer asking for help. This trust is especially important for patients who are undocumented, mixed-status families, refugees, asylees,

lawfully present immigrants affected by benefit changes, or individuals who fear that seeking care could create personal or family risk.

CAFCC and its member clinics can help reduce confusion by supporting culturally appropriate outreach, language access, benefits navigation, and trusted community education. However, these activities require staffing, training, and funding. They should not become unfunded expectations placed on already stretched clinics.

Impact on Federally Qualified Health Centers

FQHCs will also be significantly affected by Medicaid changes because Medicaid is one of their primary funding sources. Nationally, community health centers served 32.4 million patients in 2024. About half of health center patients were covered by Medicaid, and Medicaid accounted for 45% of total health center revenue in 2024. KFF (2026) also reports that health centers had negative net margins nationally in 2024 and face financial pressure from Medicaid and marketplace changes, increased uninsured patients, immigration-related fear, and funding uncertainty.

The Commonwealth Fund (2025) estimates that Medicaid work requirements could cause nearly 5.6 million community health center Medicaid patients in expansion states to lose coverage over five years, resulting in nearly $32 billion in lost community health center revenue.

Because FQHCs are required to provide services regardless of ability to pay, reductions in Medicaid coverage and reimbursement may result in lower revenue, increased uncompensated care, longer wait times, reduced staffing flexibility, fewer appointments, and increased referrals to free clinics and charitable care organizations.

This matters for CAFCC and its member clinics because free clinics often receive patients who cannot be seen quickly elsewhere, who do not qualify for coverage, who are afraid to engage with government-connected systems, or who need services that are not easily available through other safety-net providers. As FQHCs and public systems become more strained, free clinics may see more patients who have delayed care, lost coverage, or exhausted other options.

Impact on Free and Charitable Clinics

As Medi-Cal coverage contracts and FQHCs experience increased financial pressure, free clinics are likely to absorb a greater share of unmet healthcare needs. Nationally, NAFC reports that free and charitable clinics provided approximately 6 million patient visits in 2024, up from 5.7 million visits in 2023. NAFC also reports that 84% of patients were uninsured, 76% lived at or below 200% of the federal poverty level, 81% of clinics reported increased demand, 27% had waitlists, and 92% of the workforce was made up of volunteers (NAFC, 2025a, 2025b).

These statistics highlight both the value and the vulnerability of the free clinic model. Free clinics provide care to high-need patients with limited resources, but they cannot absorb sudden increases in patient volume without additional funding, staffing, volunteer support, and referral infrastructure.

To address these challenges, California should invest in capacity-building strategies for free and charitable clinics. Potential approaches include targeted operational grants, workforce development programs that encourage providers and specialists to volunteer or work in free clinics, public-private partnerships with hospitals and universities, training and retention of bilingual staff, stipends or incentives for high-demand specialties, and telehealth expansion where clinically appropriate.

Free clinics also serve patients with complex medical and social needs. NAFC reports that 80% of free clinics offer mental health services, reflecting the growing behavioral health needs among patients who lack access to

traditional care (NAFC, 2025a, 2025b). Many free clinic patients need ongoing monitoring, medications, preventive care, patient education, behavioral health support, and continuity of care. These needs become more difficult to address when patients lose insurance coverage or experience worsening food and housing insecurity.

Capacity Limits and the Need for Realistic Expectations

Free clinics are essential, but they are not unlimited. Many free clinics are volunteer-based, part-time, specialty-limited, appointment-limited, or dependent on donated services. Some provide comprehensive primary care, while others focus on episodic care, specialty care, dental care, vision services, behavioral health, pharmacy services, health fairs, or mobile services.

California should not assume that free clinics can absorb large coverage losses without investment. Free clinics need paid staff, volunteer coordination, administrative systems, quality infrastructure, clinical protocols, credentialing processes, malpractice support, referral networks, language access, technology, and data systems.

Free clinics should therefore be understood as a critical but capacity-limited layer of the safety net. They can help prevent patients from falling through the cracks, but they cannot replace Medi-Cal, FQHCs, hospitals, county programs, or specialty networks.

Quality, Safety, and Clinical Infrastructure

As free clinics expand, quality and safety infrastructure must grow with them. Clinics need support for credentialing, training, documentation, clinical protocols, referral tracking, medication safety, infection prevention, language access, emergency response, privacy compliance, and quality improvement.

Funding should support not only more visits, but also the systems needed to provide safe, reliable, and coordinated care. This is especially important because many free clinics rely heavily on volunteers. Volunteers are a major strength of the model, but safe volunteer-based care requires structure, supervision, training, and accountability.

CAFCC can help support quality and safety by providing technical assistance, shared templates, training resources, peer learning opportunities, and statewide guidance. However, policymakers should avoid creating unfunded administrative mandates. Data collection, navigation support, expanded reporting, and quality expectations should be paired with funding for staff time, technology, training, and technical assistance.

Behavioral Health Impact

Behavioral health services are expected to face severe pressure as coverage reductions increase the number of uninsured and underinsured patients. NAFC reports that 80% of free clinics offer mental health services, showing that free clinics are already part of the behavioral health safety net (NAFC, 2025a, 2025b).

Coverage losses may interrupt access to psychiatric medications, counseling, substance use treatment, crisis intervention, and care coordination. Patients experiencing immigration-related stress, housing instability, food insecurity, chronic disease, trauma, or job insecurity may have increased behavioral health needs at the same time clinic capacity becomes more limited.

Behavioral health expansion in free clinics requires more than screening. Clinics need licensed supervision, referral pathways, psychiatric consultation, crisis protocols, culturally appropriate services, privacy protections, and sustainable funding for follow-up care. Without these supports, clinics may identify needs they cannot adequately treat or refer.

Free clinics are often trusted spaces where patients feel safe asking for help. That trust will become even more important as policy changes create additional fear, confusion, and instability for vulnerable communities.

CalFresh and SNAP Reductions as Social Drivers of Health

Reductions in SNAP benefits, known in California as CalFresh, are also expected to increase pressure on California's healthcare safety net. CalFresh provides monthly food assistance to qualifying low-income households.

CDSS (2026) states that because of H.R. 1, some CalFresh recipients may get less money for food, more recipients will need to participate in work or community engagement activities beginning June 1, 2026, and many lawfully present immigrants will no longer qualify beginning April 1, 2026. Orange County Social Services Agency (2026) similarly states that starting April 1, 2026, certain noncitizens previously eligible for CalFresh will no longer qualify, including asylees, refugees, parolees, battered noncitizens, trafficking victims, and individuals with deportation or removal withheld. The same source notes that clients in those groups will keep benefits until their next annual renewal period (Orange County Social Services Agency, 2026).

For free clinics, food insecurity becomes a clinical issue when patients cannot manage diabetes, hypertension, pregnancy, medication schedules, wound healing, or behavioral health conditions because they lack stable access to food. A patient with diabetes cannot successfully manage blood sugar without reliable access to food. A patient with hypertension may struggle to follow dietary recommendations when food choices are limited. A patient taking medications may skip doses if they must choose between food, transportation, rent, and prescriptions.

For these reasons, CalFresh reductions will likely increase both medical and social needs among patients served by free clinics.

Free Clinics, Food Resources, and Social Drivers of Health

Free clinics increasingly address social drivers of health in addition to providing medical care. However, comprehensive California-specific public data showing the exact number or percentage of California free clinics that offer food resources, CalFresh enrollment assistance, food pantry referrals, transportation support, housing navigation, or other social driver services were not identified in the public sources reviewed for this paper.

Therefore, the most accurate statement is that national free clinic data confirm widespread need among uninsured and low-income patients, while California-specific counts should be obtained directly from CAFCC, individual clinic surveys, Healthcare Payments Data Program or other state datasets where relevant, or a California free clinic member survey before being stated as verified statistics.

The lack of comprehensive California-specific free clinic data is itself a policy problem. Without statewide data, policymakers cannot accurately assess patient volume, service gaps, workforce needs, social needs, specialty care gaps, geographic disparities, or the impact of coverage and nutrition benefit changes on free clinics.

California policymakers, in collaboration with CAFCC and other stakeholders, should support a statewide data collection initiative to document the range of social driver services provided across the state. This effort would clarify the current landscape, identify unmet needs, and guide future resource allocation.

Geographic Variation Across California

California's free clinic capacity is not evenly distributed. Rural areas, inland regions, border communities, high-cost urban areas, and agricultural communities may experience different access gaps, workforce limitations, transportation barriers, and patient needs.

Statewide policy should allow flexible regional responses rather than assuming one model will fit every community. Some regions may need mobile clinics and street medicine. Others may need specialty referral networks, behavioral health partnerships, dental care access, or benefits navigation. CAFCC can help identify these regional differences and support policy responses that reflect local realities.

Specialty Care Gaps

One of the most persistent gaps for uninsured and underinsured patients is specialty care. Even when patients can access primary care, they may face long delays or no realistic pathway for diagnostic testing, procedures, dental care, vision care, or specialist consultation.

Specialty care gaps may include ophthalmology, gastroenterology, cardiology, dermatology, orthopedics, neurology, behavioral health, dental care, imaging, laboratory testing, and ambulatory procedures. These gaps can lead to delayed diagnosis, worsening chronic disease, avoidable emergency department use, preventable complications, and poorer outcomes.

CAFCC and its member clinics can help identify these gaps and build regional referral partnerships with hospitals, FQHCs, county systems, universities, specialty providers, charitable pharmacies, and community organizations. However, specialty referral coordination requires staff time, follow-up systems, documentation, patient navigation, and clinical oversight.

Workforce and Operational Strain

Workforce sustainability is a major concern for California free clinics. NAFC reports that 92% of the free clinic workforce is volunteer-based (NAFC, 2025a, 2025b). Free clinics rely heavily on volunteer physicians, nurses, pharmacists, dentists, behavioral health professionals, interpreters, administrative staff, students, community health workers, and community partners.

As demand increases, clinics may experience volunteer burnout, difficulty recruiting specialists, longer patient wait times, greater administrative burden, increased care coordination needs, and higher demand for bilingual and culturally responsive services. Clinics may also face increased complexity related to eligibility screening, resource navigation, medication assistance, specialty referrals, behavioral health triage, chronic disease management, and data reporting.

Even when providers volunteer their time, the infrastructure needed to support safe, reliable care is not free. Free clinics need paid staff, administrative support, supplies, technology, documentation systems, training, supervision, quality oversight, interpretation services, and referral coordination. As patient volume increases, clinics will need additional investment to maintain access, quality, and continuity of care.

CAFCC can play a key role in helping document these workforce needs, supporting clinic-to-clinic collaboration, advocating for volunteer infrastructure funding, and helping policymakers understand that free care still requires operational support.

Financial Sustainability

Financial sustainability remains a critical concern. Unlike hospitals and FQHCs, free clinics often operate with limited reserves and rely heavily on philanthropy, grants, donated medications, donated supplies, volunteer labor, and community partnerships. NAFC data show that free clinics operate with significant reliance on volunteers while serving patients who are overwhelmingly uninsured and low-income (NAFC, 2025a, 2025b).

At the same time, clinics are expected to meet rising demand for primary care, chronic disease management, behavioral health, dental services, medication access, vision care, food resources, transportation referrals, housing navigation, and other social supports. Without additional financial investment, clinics may be unable to maintain service levels, expand programs, recruit volunteers, support paid staff, or absorb the growing demand created by Medi-Cal and CalFresh changes.

The California free clinic average cost of approximately $399.50 per patient demonstrates the potential efficiency of the free clinic model, but this figure should be cited as unpublished or internal California survey data unless publicly released by CAFCC or NAFC (NAFC, 2025c). Low cost should not be misunderstood as low need. Free clinics are able to stretch limited dollars because of donated care, volunteer labor, partnerships, careful coordination, and mission-driven staff. As demand rises, even highly efficient clinics will need stable funding to prevent service reductions, longer wait times, and increased unmet needs.

Free clinics may help reduce avoidable emergency department use by providing earlier access to primary care, medications, chronic disease management, behavioral health support, dental care, vision services, and referrals. However, California-specific data should be strengthened to measure this impact more directly.

Hospitals, Community Benefit, and Cross-Sector Partnerships

Hospitals and health systems should view partnerships with free clinics as part of a community benefit strategy. Supporting free clinics can help patients access earlier care, reduce preventable deterioration, and strengthen local referral pathways for uninsured and underinsured residents.

No single part of the safety net can absorb the coming demand alone. FQHCs, county health systems, public hospitals, free clinics, food banks, charitable pharmacies, behavioral health providers, universities, and specialty providers will need coordinated referral systems and shared resources.

CAFCC can help strengthen these partnerships by identifying service gaps, convening clinics and partners, documenting regional needs, and advocating for flexible funding that supports care coordination across systems.

Accountability and Measurement

Any new state investment should include reasonable reporting requirements that measure access, service volume, patient need, workforce capacity, and outcomes without creating excessive administrative burden for small clinics. Measures should be designed in partnership with CAFCC and member clinics so that reporting improves accountability without overwhelming small organizations.

Potential measures include unduplicated patients served, visits provided, uninsured and underinsured patients served, patients assisted with Medi-Cal or CalFresh navigation, chronic disease visits, behavioral health visits, dental and vision visits, specialty referrals completed, patient demographics, language needs, social needs identified, volunteer hours, estimated value of donated services, cost per patient, cost per visit, referral completion rates, and patient-reported access measures.

Policymakers should avoid creating unfunded administrative mandates for free clinics. Data collection, navigation support, expanded reporting, and quality expectations should be paired with funding for staff time, technology, training, and technical assistance.

Policy Recommendations

California policymakers, philanthropy, hospital partners, and community stakeholders should consider targeted investments to preserve and strengthen the capacity of free clinics and other safety-net providers. Immediate focus should be given to increasing operational grant funding for free clinics, supporting statewide data collection, and funding navigation assistance for Medi-Cal and CalFresh. These steps will help stabilize service capacity and prevent avoidable coverage and benefit losses.

1. Increase flexible operational grant funding for free clinics serving uninsured and underinsured patients.

Flexible operating support is essential because free clinics need funding for staffing, supplies, care coordination, technology, interpretation, quality oversight, and volunteer infrastructure. Funding should support both direct services and the administrative systems required to provide safe and reliable care.

2. Support CAFCC and California free clinic data collection.

California needs stronger statewide data on free clinic patient volume, service mix, social needs, food resource programs, workforce capacity, specialty care gaps, geographic variation, referral capacity, and unmet needs. CAFCC is well positioned to lead or coordinate this work in partnership with state agencies, philanthropy, and member clinics.

3. Fund Medi-Cal and CalFresh navigation support at free clinics and community-based organizations.

Patients will need help understanding eligibility changes, completing renewals, documenting exemptions, responding to notices, and avoiding unnecessary loss of coverage or benefits. Navigation funding should include staff time, language access, outreach materials, technology support, and training.

4. Expand behavioral health funding for uninsured and underinsured patients.

Coverage loss, food insecurity, immigration stress, housing instability, and chronic disease will increase behavioral health needs. Free clinics need resources to provide screening, counseling, psychiatric consultation, medication support, crisis navigation, and referrals.

5. Support food-as-medicine partnerships and food insecurity screening.

Free clinics should be supported in connecting patients to food banks, medically tailored food programs, nutrition education, CalFresh enrollment help, and community food resources. Food insecurity should be treated as a clinical issue because it directly affects chronic disease management, medication adherence, pregnancy outcomes, behavioral health, and recovery.

6. Strengthen partnerships between hospitals, FQHCs, free clinics, county health systems, food banks, charitable pharmacies, and specialty providers.

No single part of the safety net can absorb the coming demand alone. Coordinated referral systems and shared resources will be essential. Hospitals and health systems should consider free clinic partnerships as part of community benefit strategies.

7. Invest in volunteer recruitment, retention, training, and malpractice coverage support.

Volunteer providers are central to the free clinic model, but they need organized systems, training, supervision, credentialing, documentation support, and administrative infrastructure.

8. Support mobile clinics, street medicine, and community-based outreach.

Patients who face transportation barriers, homelessness, language barriers, fear, or immigration-related concerns often need care delivered in community settings. Flexible funding should support mobile and outreach models where they are appropriate for local needs.

9. Invest in specialty care referral networks.

Specialty care is one of the most difficult gaps for uninsured and underinsured patients. California should support regional partnerships that expand access to specialty consultation, diagnostic testing, dental care, vision care, procedures, and follow-up services.

10. Fund quality, safety, and technical assistance infrastructure.

Free clinics need support for credentialing, clinical protocols, infection prevention, medication safety, referral tracking, emergency response, documentation, quality improvement, privacy compliance, and language access. CAFCC can help provide shared tools, technical assistance, and peer learning opportunities.

Conclusion

California's free and charitable clinics are likely to experience escalating operational, financial, and workforce pressures as Medi-Cal, Medicaid, and CalFresh changes unfold. Current state and national data suggest that many Californians may be affected by coverage restrictions, work requirements, eligibility redeterminations, CalFresh changes, reduced reimbursement for clinics, and declining access to comprehensive healthcare and food assistance (CDSS, 2026; LAO, 2026a, 2026b; Orange County Social Services Agency, 2026).

FQHCs, public hospitals, county systems, and free clinics will all be affected. However, free clinics are uniquely vulnerable because they often serve patients who are excluded from coverage, unable to pay, afraid to use government-connected systems, or unable to access traditional systems of care. These clinics do not have the same reimbursement structure as hospitals or FQHCs, yet they are often asked to care for patients with some of the greatest needs.

Free clinics should not be treated as a replacement for Medi-Cal, FQHCs, public hospitals, or county health systems. They are a complementary and essential layer of the safety net. Their value lies in their flexibility, community trust, volunteerism, local partnerships, and ability to reach patients who often fall through the cracks.

CAFCC gives California's free and charitable clinics a statewide voice. It supports collaboration, advocacy, data collection, funding distribution, technical assistance, and visibility for clinics that are often overlooked in broader healthcare policy discussions. As the "safety net of the safety net," free clinics will become even more essential to California's healthcare infrastructure.

Without targeted investment and coordinated policy support, California risks overwhelming the very organizations that provide care to the state's most vulnerable residents. Strengthening CAFCC and California's free and charitable clinics is not optional. It is a necessary part of protecting California's healthcare safety net.

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