

Overview of Federally Qualified Health Centers

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Background

- ❑ **1962 – Federal support under the Migrant Health Act**
- ❑ **1964 – Economic Opportunity Act provided funds for two “neighborhood health centers”**
- ❑ **1965 – Neighborhood health centers launched by two MDs from Tufts University**
 - Community-based, promoted patients involvement in the operation of the center
 - Comprehensive primary care
 - Focused on outreach, disease prevention and pt education
 - Promoted local economic development, job training, social services and nutritional counseling

Background II

- ❑ **1970 – Congress authorized the community health centers (330) and migrant health centers (329) under the Public Health Service Act**
- ❑ **1987 - Health Care for the homeless**
- ❑ **1990 – Public Housing Primary Care program**
- ❑ **1996 - All programs were consolidated under section 330 of the PHSA as the Consolidated Health Center Program**
- ❑ **2008 – Health Care Safety Net Act (reauthorizes program)**
 - Supports expansion (number of centers and patients)
 - Expands quality improvement efforts
 - **Requires integration between health centers and health care system**

Consolidated Health Center Program

- Over 1,100 health centers with over 6,000 clinical sites operating in every state and territory
- Most sites also offer oral health, mental health, substance abuse and pharmacy services
- ~ 48% of health centers in urban areas
- More than 18 million patients served in 2009 with 63 million encounters, (more than 9,100 MDs: 5,800 nurses, PAs and NMs)
- Current HRSA funding is +\$2 billion
 - +\$2 bill ARRA dollars appropriated in 2009 \$1.5 capital improvements and \$500 million for new access points
- **Depend on reimbursement from other Federal grants**, Medicaid, Medicare, SCHIP, health plans, self pay collections, and State/local/other resources
- **HRSA grant covers about 19% of average health center's budget**

Federally Qualified Health Centers

- ❑ **Created by Congress in 1989**
- ❑ ****Establishes preferential payment policy for HC**
 - ❑ Policy managed by CMS but HRSA determines eligibility
 - ❑ Rural health clinics have preferential payment policy but are not FQHCs
- ❑ **3 categories for FQHC designation:**
 - receiving a grant under Section 330 of the PHSA (80%)
 - meeting all the requirements for receiving such a grant but do not receive grant funding (commonly called “look-alikes”) (10%)
 - *centers operated by a tribe or tribal organization or by an urban Indian organization* (10%)

Federally Qualified Health Centers

❑ Must provide care to:

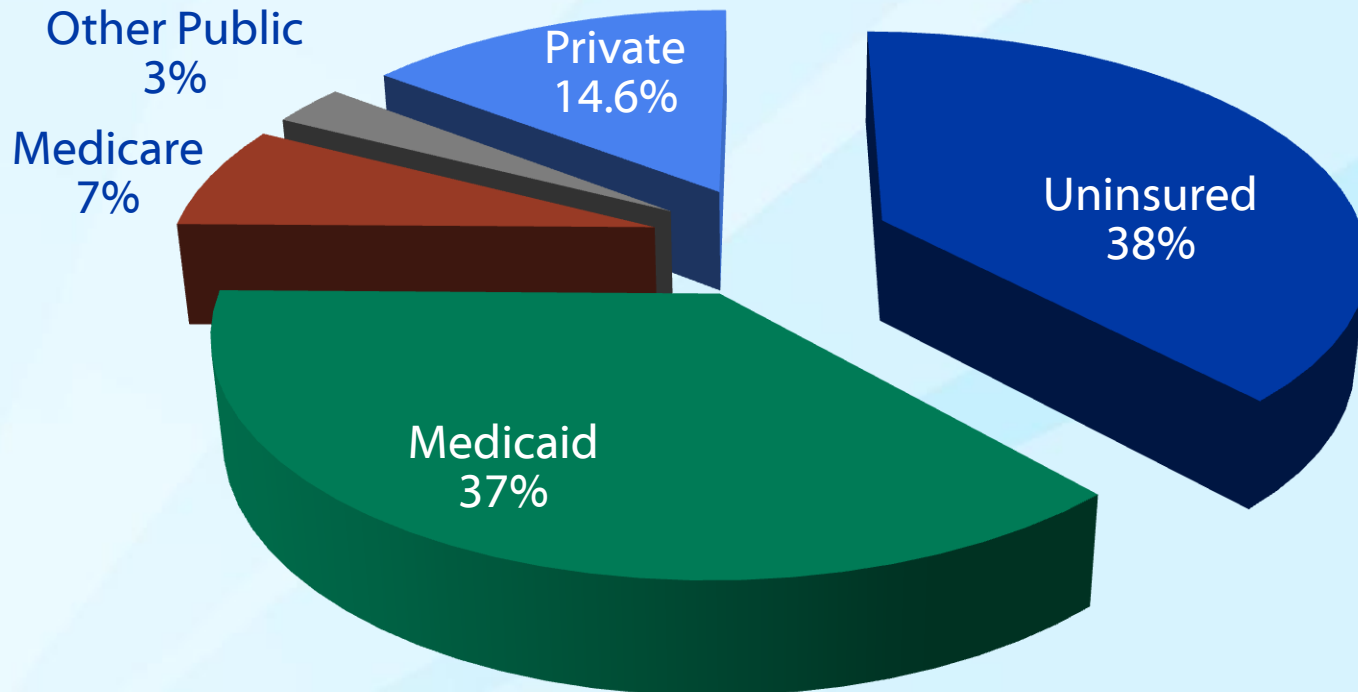
- Federally designated Medically Underserved Area (MUA)
 - **Ratio of primary medical care physicians per 1,000 population**
 - Infant mortality rate
 - *Percentage of the population living below the federal poverty level*
 - *Percentage of the population aged 65 and over*
- *Medically underserved population*
 - *Needs of specific population*
 - *Racial/ethnic minorities (may include language barriers)*
 - *Health conditions (HIV/AIDS)*
 - *Other social conditions (LGBT, school-based centers)*

❑ Federal government also provides special malpractice coverage through the Federal Tort Claims Act

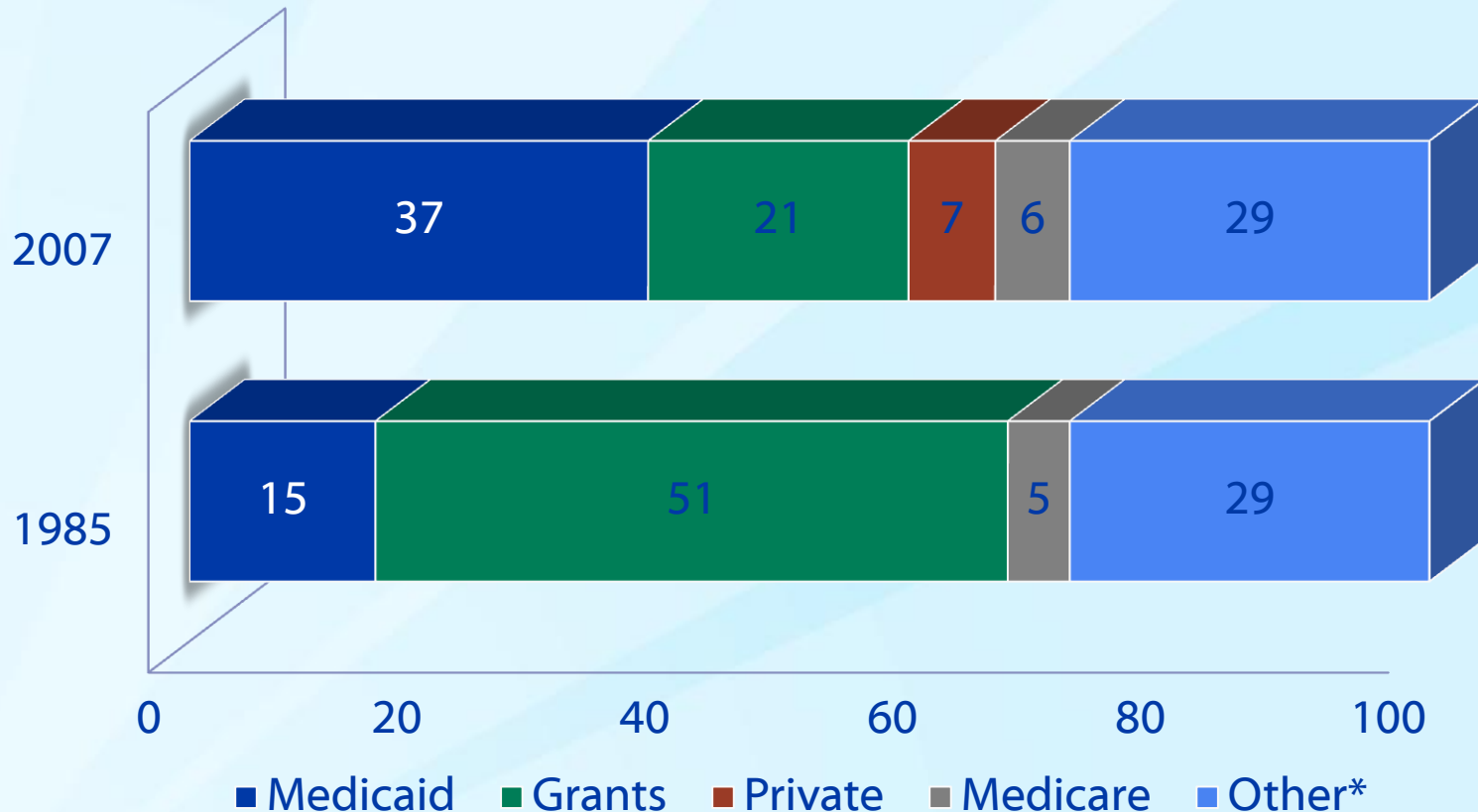
Requirements

- ❑ **All health centers (FQHCs and look-alikes), whether or not they receive 330 grants must**
 - Be located in (or serve) medically underserved communities or areas that experience shortage of primary care providers
 - Have nonprofit, public, or tax exempt status
 - Provide comprehensive, quality primary health care services
 - Must participate in government insurance programs (Medicaid, Medicare and SCHIP)
 - Must establish fee sliding scales based on patients' ability to pay (they discount the cost of care up front rather than writing off bad debt)
 - Report key performance measures as a condition of federal funding
 - **Be governed by community boards, 51% or more must be patients**

Patients by Type of Insurance, 2009



Health Center Revenue, 1985 and 2007



- Grant dollars cover services for the uninsured; Other may also include private insurance
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2007

CHC Users, 2009

□ **By age**

- 19% aged 13-24
- 27% aged 25-44

□ **Race/Ethnicity**

- About 2/3 are racial/ethnic minorities
 - 26.8% African American
 - 34.9% Hispanic/Latino

□ **Poverty status**

- 1 in 7 individuals living below 200 percent of the Federal poverty level; and
- 1 in 4 homeless individuals and migrant/seasonal farmworkers.
- Many patients experience frequent changes in poverty status

Assuring Quality

- ❑ **HRSA conducts Primary Care Effectiveness Reviews**
- ❑ **About 1/3 have JCAHO accreditation**
- ❑ **Implementation of health disparities collaboratives to reduce disparities and improve health outcomes (in collaboration with IHI)**
 - Diabetes, asthma, depression, cardiovascular disease, cancer, and HIV/AIDS, prevention, redesigning office practice, perinatal care
 - HRSA defrays costs of participating on a collaborative
 - HRSA is proposing a new collaborative on primary care –public health collaboration: Healthy Communities Collaborative designed to improve health outcomes of specific sub-populations.

Scope of Project

- Defines approved service sites, services, providers service areas and target populations(s) supported (wholly or in part) under the total grant-related budget**

Specialty Services

- ❑ **Not prohibited under the statute authorizing health center program**
 - New services added to scope of project require prior approval
 - Necessary for the adequate support of primary health services
 - Appropriate to meet the health needs of the population served by the health center
 - In most cases, HRSA will consider diagnostic/screening procedures, as well as some treatment procedures to be within the scope of the health center's project as "additional" health services
 - Once a service is included in the approved Federal scope of project it must be offered on a sliding scale and be available equally to all patients regardless of ability to pay
 - The site or service must be able to generate adequate revenue to cover all expenses

Primary Care Organizations

❑ Primary Care Associations (PCAs)

- State/Regional private, non-profit organizations that **provide training and technical assistance to health centers and other safety-net providers**, support the development of health centers in their state, and enhance the operations and performance of health centers.

❑ State Primary Care Offices (PCOs) –

- Coordinate local, State, territorial, and Federal resources to improve primary care service delivery and workforce availability in the State or territory to meet the needs of underserved populations.
- Work with health centers, professional organizations, public and private entities; and other community-based providers of comprehensive primary care.
- Assess needs for health care and for primary care providers in the state; apply to HRSA to have parts of the state designated as health professional shortage areas (HPSA); and assist with recruitment and retention of primary care providers working in underserved areas.

- 1. Developed between NACHC and NACCHO**
- 2. Includes fundamentals of FQHC and LHDs**
- 3. Essentials of a Successful Partnership**
- 4. Key considerations to develop agreements**
- 5. Legal considerations**

Partnerships between Federally Qualified Health Centers and Local Health Departments for Engaging in the Development of a Community-Based System of Care

Prepared by Feldesman Tucker Leifer Fidell LLP for the National Association of Community Health Centers

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Potential Synergies between Public Health and Primary Care in STD Prevention

- ❑ **Coordination of services:**
 - Integrating DIS services into comprehensive clinical care can improve patient and community health outcomes
 - Health departments can keep primary care providers informed of disease trends and outbreaks in the community
 - Health department can conduct in-service training to improve disease reporting and compliance with treatment guidelines and recommendations
- ❑ **Increased access to quality care:**
 - Both community health clinics and public health specialty (STD, TB) clinics cross refer based on patient need
- ❑ **Improve health of the community/population:**
 - Primary care treat the individual; public health conducts assessment, assurance and policy development
 - Public health coordinates outreach to the community (e.g. partner services including EPT, education)
 - Collaborate to conduct practice-based research or quality improvement initiatives to reduce disparities and improve outcomes

Thank You!
Questions???

