An FQHC Primer

Overview of Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC) - which include all federally assisted Community, Migrant, Public Housing Primary Care and Homeless Health Centers, as well as Urban Indian and Tribal Health clinics and other qualified community-based health centers - represent four decades of federal, state and local community investment in primary care infrastructure. Nationwide, approximately 1,200 health centers currently serve in urban and rural underserved communities, delivering preventive and primary health care to over 20 million children and adults through more than 7,500 service delivery sites.1 Of this population, more than 903,586 individuals received primary and preventive health care, dental, WIC, Head Start and other social services from the more than 330 community health center sites located in Texas in 2009.2

The underlying goal of the health center program is to provide communities the opportunity to respond to community-based healthcare needs while driving economic development. Toward that end, the programs have facilitated the flow of public and private resources, enabling local communities to establish and operate health centers and to develop innovative programs to meet their health and community needs.

Nationally, the 20 million individuals served by FQHCs and FQHC Look-Alikes (both are also known as community health centers), are predominately low-income people who are uninsured, working poor, and minority.3 Data indicate that 7.2 million of the individuals served by health centers across the nation are uninsured; Texas centers served over 506,400 uninsured patients in 2009.4 In Texas, 28 percent of the population served by health centers are women of childbearing age, 37.5 percent are children below the age of 20, 66 percent identify as Hispanic, 66 percent identify as Caucasian, 11 percent as African American and 1 percent as Asian. In 2009, community health centers in Texas served 4 percent of the total population, 8 percent of the Texas uninsured population, and 7 percent of all non-elderly Medicaid beneficiaries.5

Today, across the nation, community health centers serve more than 14 percent of the nation’s uninsured population, or over 7.2 million people.6 Nationally, health centers also serve approximately 865,000 migrant and seasonal farmworkers and 1,018,000 homeless people.7 In these locations and for these populations, community health centers are often the only available and accessible primary care providers. The important role of health centers as “safety-net” providers has become even more critical as cost pressures from managed care, rising numbers of uninsured Americans, and skyrocketing health care costs have forced other providers to reduce the services they deliver to the uninsured and other medically underserved populations.

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Federally Qualified Health Center Designation

There are 68 FQHCs including four FQHC Look-Alikes serving populations in 115 counties in Texas. Of this number, the 64 funded centers receive federal funding under section 330 of the Public Health Service Act through the U.S. Department of Health and Human Services. The four Texas centers that have been certified as Look-Alikes meet all requirements for FQHC status and are reimbursed in Medicaid and CHIP under the Prospective Payment System which provides reimbursement according to care costs for those patients, but these centers do not receive federal 330 grant funds. To receive FQHC status, these centers are mandated by the Public Health Service to meet all of the governance and service delivery requirements of funded FQHCs.

To be eligible for federal dollars under section 330 or to be certified as a Look-Alike, health centers must have a consumer-based governance structure, provide a comprehensive set of services, be a private, not-for-profit organization or a public entity, and must be located in a medically underserved area, defined as an area with a shortage of personal health services or a population group designated by the Secretary of Health and Human Services as having a shortage of such services. Some of the benefits to FQHC status are reimbursement under the Prospective Payment System for Medicaid, the Children’s Health Insurance Program (CHIP), and Medicare clients, 340B pharmaceutical discounts, National Health Service Corps placements and Federal Tort Claims Act coverage (for funded centers only).

Services Provided by Federally Qualified Health Centers

As required by federal law, all community health centers, through their health services staff or through cooperative agreements, arrange for primary and preventive health services. These include, but are not limited to:

- Physician, Physician Assistants and Nurse clinician services;
- Diagnostic laboratory and radiological services;
- Preventive health services including children’s eye and ear examinations, prenatal and perinatal services, screening for breast and cervical cancer, well child services, adult primary care services, immunizations and family planning services;
- Transportation services as required for adequate patient care;
- Dental services;
- Pharmaceutical services;
- Mental health and substance abuse services;
- Patient case management services and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, educational or other related services;
- Health Education (including nutritional education); and
- Outreach to uninsured and underserved populations.

Due to the hard-to-reach and often mobile populations served by health centers, all centers offer outreach services to provide health education materials as well as health insurance eligibility and enrollment information to uninsured families and other special populations in their communities. Many of the centers also provide on-site eligibility determination for the Medicaid program. Currently, there are 40 state eligibility workers “outstationed” in health centers around the state of Texas to make Medicaid enrollment more accessible to working families. Successful outreach programs implemented by community health centers are vital in TACHC’s efforts to link as many uninsured families as possible to existing health coverage programs and other available resources. To assist the uninsured families in communities served by health centers, some health centers receive contracts from the Texas Health and Human Services Commission to...
serve as the lead community based organization to promote and enroll eligible children into Medicaid and the state Children’s Health Insurance Program (CHIP). The remaining health centers serve as active participants in community coalitions to promote Medicaid and CHIP coverage to eligible families.

Community-Based Governance

Although health centers have a broad, prevention-focused perspective on many health problems, they are much like private medical practices, staffed by physicians, nurses and other health care professionals. They differ from private medical practices, however, by their broader range of services such as social services, transportation, translation services, health education, and by their management structure.

Health centers are owned and operated by communities through volunteer governing boards composed of leaders and residents of the communities they serve. They function as nonprofit businesses with professional managers. Each FQHC is under the supervision of its own board of directors. By law, at least 51 percent of the board membership must be consumers of health center services. Furthermore, the constituency of the board must reflect the demographics of the patient population served and the community in which those services are provided. The size of the board ranges from 9 to 25 members depending on the center’s bylaws. Consumer-based board governance is a unique feature of FQHCs that ensures centers provide health care and enabling services that meet the needs of patients and their communities. Additionally, a management team typically composed of an Executive Director, Medical Director, Chief Financial Officer, and Chief Operating Officer is responsible for the day-to-day administrative and clinical operations.

Community Partnerships

To maximize limited resources, these private, nonprofit community practices have developed community linkages with specialty providers, local health departments, hospitals, nursing homes, pharmacies, and other community organizations to ensure services are coordinated and to eliminate duplication of effort. Although some services may not be available on-site, the health center does coordinate care and referrals to other providers in a way that assures comprehensive and convenient “one-stop caring” for its patients.

In addition to making a difference in the health of people, community health centers contribute to the strength and well being of the economy by employing community residents. They also contribute to other local businesses and stabilize neighborhoods by bringing in other forms of community or economic development. Indeed, in some smaller communities, health centers are often one of the largest employers. Health centers in Texas are also important contributors to the statewide economy. The overall economic impact of Texas health centers to local economies in the state is over $560 million with health centers employing almost 6,500 Texans across the state.\(^8\)

Community Health Center Revenue Sources

Because they exist to serve their communities, health centers are committed to seeking out and combining resources from a variety of sources to ensure that access to primary health care services is reliably available to all community residents, regardless of their financial or insurance status. However, patients who can afford to pay are expected to pay.

All FQHCs have a fee schedule for services. A sliding scale is applied based on the patient’s annual income and family size. This sliding fee schedule is voted on and approved by each center’s governing board. Full discounts are applied to individuals and families with incomes at or below 100 percent of the Federal Poverty Level (FPL) with a nominal co-pay attached to their visits. Full charge for services is applied for individuals or families with incomes at or above 200 percent of FPL. Therefore, the sliding scale discount on FQHC services is available for patients whose incomes range from 101 to 199 percent of the FPL.

Medicare, Medicaid, and CHIP recipients are always welcomed at FQHCs. In 2009, FQHCs in Texas provided services to 54,215 Medicare, 225,897 Medicaid, and 18,072 CHIP recipients. Community health centers also bill private insurance companies for those clients with commercial insurance.

A health center’s board and staff must continually work to obtain support from other sources, such as federal, state, and local governments and foundations, to ensure that care is available for all patients. In addition to more than $144 million in one-time and ongoing Federal grants received by FQHCs in Texas during 2009, FQHCs received approximately $18 million from private insurance, over $154 million from Medicaid and Medicare reimbursements, over $87 million in state and local funds, and over $48 million in patient fees. The $10 million appropriated to Texas FQHCs by the 78th legislature for the FQHC Incubator program provided planning and other start up grants to organizations working to receive federal funding in the future. This allocation of $10 million was continued by the 79th, 80th, and 81st Legislatures to continue funding to new and expanding organizations.

**Emphasis on Quality of Care**

In Texas, there are 364.08 Primary Care Physician, a combined 277.41 Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife, 122.12 Dentist, 60.87 Dental Hygienist and 91.36 Mental Health Provider Full Time Equivalents (FTEs) employed by FQHCs to provide preventive and primary health care services in medically underserved areas of the state. To assure each patient receives comprehensive services, most Texas FQHCs have on-site lab, x-ray, and pharmacy services. If these services are not available at the center, referral mechanisms that ensure these services are available to all health center clients are arranged with other providers.

The Bureau of Primary Health Care (BPHC) in the federal Health Resources and Services Administration (HRSA), the organization that administers the health center program, requires that health centers attain the highest possible standard of care. To ensure high quality care that meets the needs of the patients and their community, each health center must have an ongoing compliance and performance improvement (CPI) program. TACHC developed a CPI program called the Optimizing Comprehensive Clinical Care (OC³) that can be adapted to meet each center's needs and is currently being used by the majority of health centers in Texas. Several clinical areas of care must be reviewed within a center's CPI program, and through the OC³, an FQHC can assess the utilization, quality, and efficacy of patient services.

Texas health centers meet rigorous standards for quality of care. As of October 2010, twenty-four Texas centers were accredited by The Joint Commission. Centers also have a proven track record in quality service to patients with chronic disease. As an example, in 2009, according to data from an audited sample of Texas health center

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10 Ibid.
11 Ibid.
patients with diabetes, 65 percent of these patients had their disease under average or good control compared to 44 percent of the general Texas population whose care is managed by Texas HMOs.\textsuperscript{12}

**Optimizing Comprehensive Clinical Care (OC\textsuperscript{3}) and Performance Improvement Systems**

As a commitment to quality healthcare delivery, many Texas health centers are engaged in the Optimizing Comprehensive Clinical Care (OC\textsuperscript{3}) and Performance Improvement Systems learning process, or the OC\textsuperscript{3}. This total system approach to care was sparked by the Bureau’s Health Disparities Collaboratives (HDC) program. The aim of the HDC program was to eliminate health disparities by incorporating an innovative chronic care model into systems of care. However, it is a fact that our current healthcare system is burdened by delays. Patients often wait to get an appointment, and then they wait again at the appointment. These waits mean that patients may not be able to get the care they need when they need it. Thus, the principles of Access and Redesign were added to the learning process of the Chronic Care Model, and as a result, the OC\textsuperscript{3} was born.

The OC\textsuperscript{3} program is designed to help health centers reduce or even eliminate waits for and at appointments. The program is based on a fundamental understanding of patient and provider desire for continuity of care, the need to balance the demand for service with the provider supply available, and the importance of measurement to move toward an improved system of care. Reducing delays for healthcare has been shown to lead to improved adherence to treatment, improved care for patients with chronic illness, and enhanced early detection of serious illness.

To assist the centers in implementing the OC\textsuperscript{3} system, TACHC, through its affiliate TACHC Purchasing Group, developed a four volume set of manuals (the OC\textsuperscript{3} Manuals). The OC\textsuperscript{3} manuals represent a master plan to provide guidance to health centers on compliance issues. In using these manuals and the sample policies and procedures contained within them, centers draw on evidence-based guidelines for designing, implementing and evaluating health care services. OC\textsuperscript{3} requires multifaceted monitors with a wide variety of indicators to track and trend access and case management and patient services and outcomes, as well as operations, and the environment of care that are part of an annual CPI review plan.

**Conclusions**

The empowerment and involvement of local citizens in planning and governance have been the essential characteristics that have made it possible for FQHCs to make a real difference in underserved communities, in terms of both the sense of ownership they help foster and the tangible benefits they yield. In recent years, the role of community governance has achieved increased recognition and respect, especially because it promotes direct involvement by local residents in developing the services they use and need. Because of their commitment to their local communities, FQHCs have become an effective solution for primary health care access in hundreds of communities in Texas and thousands of communities across the nation, affirming their vital role in America's future health care system.

\textsuperscript{12} Texas UDS Rollup Report, 2009; “Guide to Texas HMO Quality, 2009.” State of Texas Public Insurance Council and the Department of State Health Services, Center for Health Statistics, November 2009. http://www.opic.state.tx.us/docs/611_guidetotexashmoquality2009.pdf. Average control is defined as HbA1c between 7% and 9%. Good control is defined as HbA1c under 7%.