Federally Qualified Health Centers: An Introduction

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- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
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Faculty

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Faculty Disclosure

Contributing faculty, Mary Franks, MSN, APRN, FNP-C, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for physicians, physician assistants, nurses, and other healthcare providers who may be providing services in federally qualified health centers (FQHCs).

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Course Objective

Federally qualified health centers are pivotal in the healthcare industry today and in the intentional delivery of primary care services in underserved communities. The purpose of this course is to provide an overview of how federally qualified health centers function and impact the delivery of care.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define federally qualified health centers.
2. Outline services provided at federally qualified health centers.
3. Identify how payer processes are utilized in federally qualified health centers.
4. Describe requirements for certification as a federally qualified health center along with protocols for site visits.
5. Evaluate how to uphold patient satisfaction within federally qualified health centers.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Federally qualified health centers (FQHC) are federally funded nonprofit health centers or clinics that provide care to medically underserved areas and residents. FQHCs support the community by providing primary care services regardless of one's ability to pay [1]. These types of programs are intended to help decrease healthcare costs, emergency room visits, and hospitalizations in underserved communities, ultimately reducing costs for state Medicaid programs [2]. This course will provide an overview of FQHCs as a model of delivering and preserving health care. There are three types of centers: health centers, FQHC look-alikes, and FQHC clinics. For the purpose of this course, the focus will be on FQHC clinics.

FEDERALLY QUALIFIED HEALTH CENTERS

As noted, FQHCs are available to specifically benefit those in underserved populations. These clinics can provide a broad range of services that may typically not be covered or offered in standard practice settings [3]. These coverages are specific to those who are uninsured or who have high Medicare deductibles.

The first FQHC was established in 1965 as part of President Johnson's "War on Poverty." Nearly $11 billion has been allocated to the FHQC Trust Fund as part of the Affordable Care Act since its inception [3]. Approximately 60% of patients being served by FQHCs are 18 to 64 years of age, 31% are younger than 18 years of age, and 7.4% are 65 years of age or older. Nearly 92% of those served are at an income level of at or below 200% of the federal poverty level [2]. As of 2024, there are 9,754 FQHCs in the United States, serving more than 24 million individuals [4].

The following services are provided at FQHCs [5; 6]:

- Preventive health services
- Hospital and specialty care
- Dental services
- Mental health and substance abuse services
- Transportation services necessary for adequate patient care
- Translation services for patients with limited English proficiency
- Health education (e.g., diabetes management, medical nutrition therapy)
- Pharmacotherapy
- Hospice services (when the physician, nurse practitioner [NP], or physician assistant/associate [PA] who is employed or under contract for an FQHC but is not employed by a hospice program provides the services)
- Obstetrics/gynecology services
- Telehealth services, as applicable

All FQHC visits must be medically necessary. If services cannot be provided on-site, FQHCs make arrangements for referral to another provider.

Visits should typically be face-to-face for medical or mental health visits, including preventative visits. Diabetes self-management training and medical nutrition therapy must meet certain qualifications and conditions for the FQHC to provide these services, specifically with qualified practitioners.

Visits can take place at the FQHC, an assisted living facility, Medicare Part A-covered skilled nursing facility, the scene of an accident, or a hospice facility. Patients who are homebound qualify for home visits with a registered nurse or licensed practical nurse. FQHC visits cannot take place in inpatient or outpatient hospitals, including critical access hospitals or facilities that specifically exclude FQHC visits. There can be multiple visits in one day; however, they will be counted as a single visit. The exception to this rule is a return visit for illness or injury that occurred after the initial visit or a qualified medical or mental health visit on the same day [7].

FQHCs qualify for funding under Section 330 of the Public Health Service Act. This Act enables the Bureau of Primary Health Care (BPHC) to grant funding to FQHCs that have met specified requirements [8]. In general, FQHCs are required to have services of primary care capability, such as those related to family practice services for all ages, obstetrics, and gynecology, along with laboratory and diagnostic services. There should also be access to emergency medical services and pharmacy services [9]. To certify as an FQHC, a facility may also operate as an outpatient health program of a tribal organization under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act of October 1991. All requirements of Section 330 of the PHA must be met, including [10]:

- Serving a designated medically underserved area or medically underserved population
- Offer a sliding fee scale to persons with incomes below 200% of the federal poverty guidelines
- Government by a board of directors, composed of a majority of members who get care at the FQHC

FQHCs are required to participate in Medicare and Medicaid reimbursement, and specific forms must be completed for enrollment. An attestation statement is included in the initial application process that states that the entity applying for FQHC complies with federal requirements [11; 12]. In addition, the entity applying for FQHC status must also have the following health and safety requirement policies established [13]:

- Compliance with applicable federal, state, and local laws and regulations
- Clear written policies and lines of authority and responsibilities
- Provision of medical direction to the FQHC by a physician
- Clinical staff and staff responsibilities
- Provision of services and patient care policies
- Patient health records
- Program quality assessment/improvement
- The construction and maintenance of the FQHC's physical plant
- Handling of nonmedical emergencies in the FQHC

A facility certified as FQHC cannot concurrently be approved as a rural health clinic [13].

BENEFITS

There are many benefits FQHC certification related to community involvement and serving the under- or uninsured. In addition to federal funding, a certified FQHC clinic can receive [14; 15]:

- Enhanced program in Medicare and Medicaid reimbursement
- New center start-up, up to $650,000
- Medical malpractice insurance coverage through the Federal Tort Claims Act (FTCA)
- Participation in the 340B Federal Drug Pricing Program, which allows outpatient purchasing of non-prescription and prescription medications
- Access to National Health Service Corps (NHSC) dental, medical, and mental health providers
- Access to the Vaccine for Children (VFC) program, providing children who are receiving state assistance or who are uninsured with access to vaccinations
- Eligibility for numerous other federal programs and grants
- Access to on-site eligibility workers to provide Medicaid and Children's Health Insurance Program enrollment services

FQHCs also meet nationally accepted evidence-based practice standards when it comes to managing chronic illnesses and the decrease of health disparities. The Institute of Medicine (IOM) and the Government Accountability Office recognize FQHC's standards of practice when it comes to health screenings and chronic condition management [14].

Federal Tort Claims Act (FTCA)

The FTCA was enacted in 1946 to arrange for a legal means of compensation to be provided to individuals who have experienced personal injury, death, or property loss or damage caused by the negligent or wrongful act or omission of an employee of the federal government. The FTCA allows persons to recuperate financial damages from the United States under circumstances in which the United States, if a private person, would be accountable in accordance with the law of the place of practice where the act occurred [16; 17].

CERTIFYING REQUIREMENTS

Certification to qualify as an FQHC takes time and diligence. There are a total of 19 program requirements for FQHC compliance [18].

NEEDS ASSESSMENT

A needs assessment is a process for determining the needs or "gaps" between existing and desired results. If a needs assessment is conducted properly, it can provide valuable insights into areas of program improvement or enhanced efficiency [12]. The health center applying for FQHC status must demonstrate and document the needs of the target population. They must also update the service area, as applicable [18].

REQUIRED SERVICES AND STAFFING

As previously discussed, centers identified as FQHCs must be able to provide all primary care, preventative care, and additional services, as appropriate and necessary. These services can be completed through direct care or via arrangements and referrals. All staff must be licensed, credentialed, and privileged to practice within the care setting [18].

FQHCs can house NP, PA, certified nurse-midwife (CNM), clinical psychologist, and clinical social worker services. Supplies incident to the services of these clinicians will also be available [19].

Of note, if a center requests to offer services to unhoused individuals and their families, the FQHC must also provide substance abuse services in addition to the other required services. The health center should maintain a completely staffed management team suitable for the size and needs of the center. Any change in the Project Director/Executive Director/CEO position is required to have Health Resources and Service Administration (HRSA) approval before the change is made [18].

HOURS OF OPERATION

The FQHC must provide services at times and locations that will be guaranteed to meet the needs of the population served or requested to be served. Professional coverage for after-hours emergencies is required [18]. There are set minimum hours for providers to receive FTCA coverage along with minimum patient care hours set by the NHSC [6]. The FTCA requires that clinicians who are practicing full-time must work a minimum of 40 hours per week for a minimum of 45 weeks per year. The 40 hours should occur over no fewer than four days per week and no more than 12 hours in 24 hours. For providers and clinicians working half-time, 20 to 39 hours should be upheld, for a minimum of 45 weeks per year. These hours of work should be condensed into no less than two days per week and no more than 12 hours of work within 24 hours [20].

CONTINUUM OF CARE

Health center physicians are required to have admitting privileges at one or more referral hospitals. If a physician is unable to obtain said privileges, other arrangements must be obtained to ensure continuity of care for all patients. Whether the FQHC provider has admitting privileges or not, the health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. In addition, affiliate agreements and contractual services must also meet the FQHC requirements [18].

FINANCIALS

As discussed, funding for FQHC is based on Section 330 of the PHA. The Patient Protection and Affordable Care Act of 2010 reformed how payments were made for services at FQHCs. The prospective payment system (PPS) was initiated with FQHC for payments, which sets payments on a national rate adjusted based on the location of services furnished [21]. Upon billing, the FQHC site-specific G-code must be used in billing of the visit to properly submit the claim [22]. As of 2024, the base rate nationally for a visit without price rate changes on a sliding fee schedule is $181.19, which is 3.9% higher than the base rate in 2022 [23].

To properly ensure reimbursement and avoid the risk of losing the FQHC certification, the requirements for sliding fee schedules must be adhered to strictly. No patient can be turned away due to an inability to pay. These fee schedules are developed based on local rates and the minimums necessary to cover the costs of organizational operations. The eligibility determination should be established with each FQHC. A full discount is provided for those with incomes at or below the 100% of the federal poverty guideline; individuals with incomes greater than twice the federal poverty guideline do not qualify for discounts [24].

FQHCs are expected to offer a sliding fee scale for payment of services along with a quality assurance program [5; 25]. Compliance with the sliding fee schedule is imperative for a facility to continue receiving reimbursement. Frequent reassessment of patient income and family size are needed, except in situations in which the patient has declined or refused to provide updated information. The health center can establish this reassessment interval. The sliding fee schedule is re-evaluated at least once every three years to assess the need to increase, decrease, or maintain the current schedule. The ability to demonstrate these data and process is required during site visits in order to maintain FQHC certification [24].

The health center must also maintain accounting and internal control systems appropriate to the size and complexity of the organization, as reflected in generally accepted accounting principles. The health center is required to complete an annual independent financial audit performed in accordance with federal audit requirements, including the suggestion of a corrective action plan tackling all findings, questioned costs, reportable conditions, and material weaknesses quoted within the report [18].

FQHCs have a responsibility to maintain adequate billing and collections, with systems in place to maximize the collection of fees along with reimbursement of costs. These systems should include written billing options and policies on collection and credit procedures. The budget on which the FQHC operates reflects the overhead and revenue, including grants that are necessary to achieve the operating delivery plan. This plan also includes the number of patients that are to be served [18].

QUALITY IMPROVEMENT

A certified FQHC clinic is required to maintain a quality improvement/assurance system (QI/QA) to assess clinical management and ensure confidentiality of patient records. The QI/QA program must address [26]:

- The quality and utilization of health center services
- Patient satisfaction and patient grievance processes
- Patient safety, including adverse events

Patient satisfaction is an essential component of care in FQHC clinics, just as with any other organization. Documentation of satisfaction assessments, including receipt and resolution of any patient grievances, is a requirement to maintain FQHC certification [26]. One or more individuals should be designated to oversee the QI/QA program. Assessment of the QI/QA program is conducted by physicians or another licensed health professionals under the direct supervision of a physician. Necessities for change can be identified and documented by the health center along with the process to institute change [18].

DATA REPORTING

While QI/QA is important in terms of patient satisfaction and care delivery, FQHCs should also have programs and systems in place to collect and organize data to support management decision-making opportunities. Potential data points include wait times, callbacks, treatment plans, smoking cessation opportunities, re-admissions, and no-shows [18].

There are specific requirements to ensure data reporting and program monitoring are optimal. FQHCs should establish a system for program performance to ensure the oversight of the operations, ensure program expectations are being achieved as planned, and areas for improvement are identified related to outcomes and productivity. FQHCs must also collect and report data required by HRSA related to overhead for operations, patterns in the utilization of the center, and the availability, accessibility, and acceptability of FQHC services. Compliance can be demonstrated through these reporting systems. In most cases, data originates from the electronic medical record system abstracted for service utilization [27].

THE BOARD

The FQHC board members include non-consumers, non-representative consumers, and representative consumers. As noted, at least 51% of the governing board must consist of consumers, (i.e., those who utilize the services of the center). This requirement originated during the 1960s with the intent of empowering those who are served by the center [3].

At a minimum, the board must have 9 members; it may have no more than 25 members. The board should also be representative of the patient population, with consideration to demographic characteristics such as race, ethnicity, and sex/gender. Non-consumer members of the board should represent the community in which the FQHC service area is established and should be designated for their knowledge and proficiency in community affairs, local government, finance and banking, legal affairs, trade unions, and/or other commercial and industrial concerns or social service agencies within the community. Appointed non-consumer governing board members are not allowed to receive more than 10% of their annual income from the healthcare industry [18; 28; 32].

The FQHC board is responsible for overseeing the operations of the health center in conjunction with the leadership of the center. The board must hold monthly meetings. It is liable for [18; 28]:

- The center's grant application and annual budget; selection and or dismissal of the Chief Executive Officer (CEO), including the performance evaluation of said subject
- Selection of the organization's services, including the hours of operation
- Measurement and annual evaluation of the FQHC's progress related to program and financial goals
- Review of the mission and by-laws of the organization
- Evaluation of patient satisfaction and the handling of grievances
- Development of general policies for center

CONFLICTS OF INTEREST

All governing members of the FQHC board are required to be free to conflicts of interest. For example, no board member is allowed to serve if they are a direct employee of the health center or the immediate family member of an employee. One exception is the CEO, who may serve as a non-voting member of the board. By-laws and policies of an FQHC prohibit conflicts of interest by any board members, employees, or those who provide consulting services and furnish goods to the health center [18].

THE SITE VISIT

FQHCs must demonstrate many items to maintain certification, and this is done via an HRSA site visit. Site visits are typically conducted every 12 to 16 months, with renewal periods of one and three years, depending on compliance concerns. If compliance is of concern and a facility receives a one-year renewal period, a site visit will typically take place within two to four months of the new performance review timeframe [10; 29; 30; 31]. A full explanation of the site visit protocol is available online at https://bphc.hrsa.gov/compliance/site-visits/site-visit-protocol.

CONCLUSION

The development of the FQHC within the United States has resulted in significant improvements in accessibility to health care. FQHCs provide a safety net for underserved patients who may have no other care options. The services provided to those on public insurance, with low income, or who are uninsured have become imperative in efforts to reduce health disparities in this country. FQHCs have demonstrated the ability to provide high-quality, patient-centered medical care, focusing on care coordination for those in underserved populations.

RESOURCES

FQHC PPS Specific Payment Codes
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

Medicaid and Medicare Reimbursement for the National DPP Lifestyle Change Program
https://coveragetoolkit.org/wp-content/uploads/2022/03/FQHCs-Medicaid-and-Medicare-Reimbursement-for-the-National-DPP-Lifestyle-Change-Program.pdf

Health Center Program Compliance Manual
https://bphc.hrsa.gov/compliance/compliance-manual

CMS Prospective Payment Systems for FQHC
https://www.cms.gov/medicare/payment/prospective-payment-systems/federally-qualified-health-centers-fqhc-center

Federal Tort Claims Act Health Center Policy Manual
https://bphc.hrsa.gov/sites/default/files/bphc/compliance/ftcahc-policy-manual.pdf

Federally Qualified Health Center Statistics
https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers#statistics

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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