CHAPTER 6

Federally qualified health centers

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Chapter summary

Federally qualified health centers (FQHCs) provide access to primary care in areas where primary care resources are constrained. In 2009, FQHCs that received federal grant funding (which comprise over 80 percent of all FQHCs) served 18.8 million people, including 1.4 million Medicare beneficiaries. Total operating revenue for these FQHCs in 2009 was $11.5 billion, with 6 percent from Medicare ($674 million).

FQHCs are required to be community-centered and either not-for-profit or public organizations that emphasize coordination of care. They make use of physician assistants, advanced practice nurses, and clinical nurse midwives where appropriate. Patients at FQHCs are predominantly low income and largely uninsured or covered by Medicaid.

The Medicare FQHC benefit provides primary and preventive care to Medicare beneficiaries. Historically, the Medicare program has reimbursed FQHCs according to an all-inclusive per visit payment rate based on the reasonable costs reported by the centers, subject to productivity targets for medical practitioners and a dollar limit on the per visit payment.

The Patient Protection and Affordable Care Act of 2010 establishes a Medicare prospective payment system (PPS) for FQHCs starting October 1, 2014. In the first year of the PPS, aggregate payments under the PPS

In this chapter

must equal the estimated payments that would have occurred under the current reasonable cost payment system without regard to the productivity target or the per visit upper payment limit. The result will likely be higher total payments on average. A great deal of flexibility is afforded to the Secretary of the Department of Health and Human Services in the design of a Medicare FQHC PPS, including the ability to create a system with differentiation of payment rates by service and intensity.

This chapter focuses on FQHCs for three reasons. First, FQHCs are illustrative of a team-based approach to primary care, relying on advanced practice nurses, physician assistants, and other nonphysician practitioners as well as physicians. Second, FQHCs are required to provide care in medically underserved areas or to treat medically underserved populations and play a role in meeting primary care capacity challenges in low-density rural areas. Third, the change in Medicare's payment system from a per visit cost-based reimbursement to a PPS will likely result in higher payments to FQHCs, thus encouraging these providers to serve more Medicare beneficiaries. ■

Introduction

Federally qualified health centers (FQHCs) provide a resource for primary and preventive care outside the private practice physician's office. In meeting federal requirements for FQHCs, these clinics provide an integrated model of health care delivery emphasizing a team-based approach.

Community health centers started as locally run institutions providing care to indigent and underserved people in the early 1960s; in 1965, the federal government created a demonstration program that funded these community health centers as part of the Office of Economic Opportunity, which ran many of the War on Poverty programs. The current model of providing grants to FQHCs was established in 1975; in 1996, three different funding streams were merged to create the consolidated health center grant program under Section 330 of the Public Health Act. Currently, the Health Resources and Services Administration (HRSA) is responsible for distributing grants to FQHCs.

In 1990, the FQHC benefit under Medicare and the FQHC benefit under Medicaid were established (Taylor 2004). Most grant-funded health centers are classified as general community health centers that serve all populations; however, some centers target specific populations, such as residents of public housing and homeless and migrant farmworker communities.

Three types of entities are eligible to become FQHCs under Medicare and Medicaid: health centers that receive federal grant funds under Section 330 of the Public Health Service Act (PHSA), known as health center grantees; health centers that do not receive a federal grant but meet all the requirements of the grant program, known as look-alikes; and certain outpatient clinics operated by the Indian Health Service.[1] Health center grantees constitute the vast majority—over 80 percent—of all FQHCs. After receiving a grant under Section 330 or a designation as a look-alike, health centers must request that CMS designate them as an FQHC to receive payment for delivering Medicare and Medicaid benefits. The Medicare FQHC certification process requires each FQHC site to be separately approved for Medicare participation.

At present, 1,131 centers receive grants under Section 330 of the PHSA. These grantees deliver care at approximately 7,800 sites; in addition to the 1,131 central grantee locations, there are nearly 6,700 sites ranging from full clinics to satellite sites open a few days a week to mobile vans. In addition to the 1,131 grant-funded centers, 106 centers are certified as FQHC look-alikes. In comparison to the 7,800 federally funded health center sites, there are roughly 4,900 Medicare-participating FQHC sites as of April 2011. To be certified as an FQHC, each center location must be certified separately, whereas a grant-funded health center may operate multiple sites under the same program. We use the term FQHC in this chapter to refer to health centers that are certified by CMS to deliver the Medicare and Medicaid FQHC benefit.

FQHCs are federally qualified nonprofit organizations delivering primary care

FQHCs offer primary and preventive medical care and enabling services (such as translation, transportation, and care management) that help individuals access care (Government Accountability Office 2010). About three-quarters of FQHCs offer preventive dental and mental health treatment on site, while about half of FQHCs offer substance abuse treatment on site (Shi et al. 2010). Most FQHCs also have laboratory services on site or by arrangement and may also perform minor procedures. In a 2009 survey of FQHCs, 40 percent of centers indicated that they used electronic medical records (Commonwealth Fund 2010). This number is comparable to the adoption rate for physician offices (48 percent) and is significantly higher than the adoption rate in hospitals (12 percent) (Jha et al. 2010, National Center for Health Statistics 2010). FQHCs are not eligible for Medicare electronic health record (EHR) incentive payments, although the individual clinical professionals who practice in an FQHC may be eligible for either the Medicare or the Medicaid EHR payments if they meet certain eligibility criteria (Centers for Medicare & Medicaid Services 2011c).

Providers may deliver FQHC services at approved locations that are not health center sites, such as providing medical rounds at a hospital or visits at a patient's home. If an FQHC is in an area with a designated shortage of home health agencies, it may also provide visiting nurse services (Health Resources and Services Administration 2006).

FQHCs receive federal benefits that supplement grants and payments from federal health programs

FQHCs are eligible for certain benefits beyond the federal grant. All FQHCs can participate in the Health Resources and Services Administration's 340B drug discount

program, which can help centers save from 20 percent to 50 percent on the cost of pharmaceuticals (Health Resources and Services Administration 2011c). Grantees and their practitioners, staff, and board members can be covered under the Federal Tort Claims Act program, which eliminates the need for these individuals and the health center to obtain private malpractice insurance (Health Resources and Services Administration 2006). FQHC grantees are also eligible for federal loan guarantees for capital improvements.

FQHCs deliver accessible care to underserved populations and incorporate community representation

HRSA runs the FQHC grant program under Section 330 of the PHSA. An organization applying for an FQHC grant can deliver care at one or more service sites that are most appropriate for the center's target population. The Section 330 statute specifies the services that health center grantees are required to provide (for more detail, see the section on Medicare's FQHC benefit and payment mechanism). These requirements apply at the grantee level—not at the level of individual service sites. As a result, not all required services are provided at every grantee service site, and each service site does not necessarily have to provide care year-round or cover all working hours. The HRSA requirements for FQHCs state that the patient "must have reasonable access to the full complement of services offered by the center as a whole" (Health Resources and Services Administration 2007). This requirement could result in a site offering a limited set of services, provided that the main grantee location offers reasonable access to other services the FQHC is required to provide.

Service sites include permanent sites, which are open year-round in a defined location, seasonal sites, mobile van sites, and other intermittent sites. For example, an FQHC focusing on delivering care to the homeless could provide year-round care at a permanent site as well as operating a van at locations the homeless population uses during certain times of the year. FQHCs must also provide off-hours coverage (e.g., through providers on call) and have admitting privileges at local hospitals.

FQHCs must have a board that is representative of the population they serve

Given their role as community-based safety net providers, FQHCs are subject to fairly extensive governance requirements. They are required to have a board of between 9 and 25 people, with a majority of the members being patients receiving services from the FQHC. The remaining members must be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, commercial and industrial concerns, or social service agencies (Health Resources and Services Administration 2011a). The board is required to meet monthly and cannot have any members who are employed by the center. No more than half of the consumer board members can derive more than 10 percent of their income from the health care industry, and the center must have a conflict of interest policy for board members.

The board must have responsibility for setting personnel policies; overseeing the center's financial management and budget; ensuring compliance with state, federal, and local laws; approving the selection of the director or chief executive officer of the center; and defining the health benefits delivered by the center, including the scope of services, the location, and hours of service delivery (Centers for Medicare & Medicaid Services 2011a).

FQHCs must be located in medical shortage areas or treat medically underserved populations

Medically underserved areas (MUAs) and medically underserved populations (MUPs) are designations made by HRSA and identify areas or populations with insufficient access to primary care and a high infant mortality rate, a high poverty rate, or a high share of the population that is elderly (Health Resources and Services Administration 2011a). FQHCs must be located in MUAs or serve MUPs and document the needs of its target population (Health Resources and Services Administration 2011a).

MUAs and MUPs are similar but not identical to health professional shortage areas (HPSAs), which are areas that have a shortage of primary, dental, or mental health care. All FQHCs receive an automatic designation as an HPSA facility, which permits them to hire clinical staff through the National Health Service Corps (NHSC) program.

There are similarities between FQHCs and rural health clinics, although differences remain

Given the presence of FQHCs in rural areas, a brief discussion of rural health clinics (RHCs) is warranted. In 1977, the Congress created RHCs to deliver primary care in rural areas to Medicare and Medicaid beneficiaries. CMS approves RHCs as eligible for participation in the Medicare and Medicaid programs (Centers for Medicare & Medicaid Services 2010b). As of September 2010, there were 3,820 RHCs in 45 states. RHCs can be provider

based or freestanding, and they can be nonprofit, for profit, or operated by a state or local government. RHCs can be established by physician offices that include specialty care as long as the physician office can establish that the goal of the practice is primary care (Health Resources and Services Administration 2006).

Section 1861(aa)(2) of the Social Security Act requires that, when applying for determination as an RHC for the purpose of Medicare payment, RHCs must be in a nonurbanized area. For the purposes of the RHC program, a nonurbanized area is an area outside of an urban area, which is defined as a densely settled area with at least 50,000 residents. Upon establishment, RHCs must also be located in an area that within the previous four years was designated as a shortage area. Under Section 1861(aa)(2), shortage areas for the purposes of RHC designation include MUAs, HPSAs, and a shortage area as designated by the state governor. The Secretary of the Department of Health and Human Services must certify the shortage designation.

The Medicare RHC benefit includes services delivered by physicians, nurse practitioners, physician assistants, and other medical professionals as well as services and supplies incident to such services, visiting nurse services, services of registered dieticians or nutritional professionals, and otherwise covered drugs furnished by physicians and other practitioners (Centers for Medicare & Medicaid Services 2009). Preventive care under the RHC benefit is limited to those services that otherwise would be covered under Medicare Part B, whereas the Medicare FQHC benefit includes the primary care services that FQHCs are required to provide under the conditions of their Section 330 grant (Centers for Medicare & Medicaid Services 2009).

Medicare's method of reimbursing RHCs is similar to the reimbursement method for FQHCs—an all-inclusive payment rate that incorporates per visit payment limits and provider productivity caps. The per visit payment limit for RHCs is $78.07 in 2011, and RHCs based in hospitals with fewer than 50 beds receive cost-based reimbursement without respect to the per visit payment limit (Centers for Medicare & Medicaid Services 2009, Centers for Medicare & Medicaid Services 2010a). The per visit payment amount for RHCs is less than the per visit payment amount for FQHCs—which is $109.24 for rural FQHCs and $126.22 for urban FQHCs in 2011 (Centers for Medicare & Medicaid Services 2010a). To receive payment from Medicare, RHCs and FQHCs file cost reports that indicate the type of visit and the cost of providing services. Starting in January 2011, FQHCs will report HCPCS codes for their patients to facilitate CMS's development of the new FQHC prospective payment system (PPS). However, RHCs will not report HCPCS codes for their patients, as they will continue to be paid based on an all-inclusive payment rate.

In considering the difference in the upper payment limit for FQHCs and RHCs, it is worth noting the differences between the services provided, and the population served, by FQHCs and RHCs. First, FQHCs must provide preventive primary health services as required by Section 330 of the PHSA, while the preventive health services provided by RHCs is limited to those who would otherwise be covered under the Medicare Part B benefit (discussed in more detail in the section on Medicare's FQHC benefit and payment mechanism). Second, FQHCs are required to accept patients without regard to their ability to pay. While some RHCs do offer a sliding scale of charges or accept patients without regard to their ability to pay, they are not required to do so. RHCs that establish a sliding scale of patient charges and accept all patients without regard to their ability to pay can be designated as an HPSA facility, which allows them to hire from the NHSC.

Given the differences in payments, services, and patient populations, it will be important to fully understand the complement of services provided by FQHCs and RHCs, as well as physician offices and other Medicare providers, particularly in anticipation of the upcoming changes in Medicare's reimbursement to FQHCs from a cost-based per visit payment amount to a PPS. This change could further widen the differences in reimbursement across settings, making it more critical that policymakers understand the differences in the benefit package, intensity, and patient mix across different primary care providers.

FQHCs rely on a range of clinical staff to deliver care

Among the 43,000 medical professionals employed at FQHCs, more than 9,100 are physicians; 5,800 are nurse practitioners, physician assistants, or clinical nurse midwives; and the balance are nurses and other medical personnel (Health Resources and Services Administration 2010). Medicare pays the same rate for an FQHC visit

whether it is provided by a physician or an advanced practice nurse, physician assistant, or clinical nurse midwife.[2] This reliance on advanced practice nurses, physician assistants, and clinical nurse midwives to deliver care where appropriate is one of the original principles behind establishment of the FQHC Medicare benefit. An FQHC run by a physician assistant, nurse practitioner, or other health professional must have an arrangement with a physician to supervise these staff.[3] Work done by all practitioners at an FQHC must comply with state law regarding scope of practice (Centers for Medicare & Medicaid Services 2009).

FQHCs face challenges in recruiting and retaining health professionals and obtaining specialty referrals

FQHCs experience some difficulty recruiting and retaining clinical staff, particularly specialty providers (mental health, dental, and obstetrician or gynecologist practitioners). A 2006 study by Rosenblatt and colleagues found that 13 percent of family physician or general practitioner slots at FQHCs were vacant, and certain specialties had even higher vacancy rates—21 percent of obstetrician or gynecologist slots were vacant and 23 percent of psychiatrist slots were vacant (Rosenblatt et al. 2006).

Federal hiring and loan repayment programs help FQHCs recruit health professionals

All FQHCs—because of their designation as health professional shortage facilities—are permitted to hire from the NHSC, which provides grants to students applying to medical or professional schools if they agree to work at FQHCs or other designated safety net providers. The NHSC also runs a loan repayment program for practitioners who have already completed their training. FQHCs make up the largest single placement site for NHSC health professionals (Kaiser Commission on Medicaid and the Uninsured 2010). FQHCs also hire staff through the Conrad 30 (J-1 waiver) visa program for foreign medical graduates. Among a survey of FQHC grantees, 24 percent used the NHSC scholarship program, 36 percent used the NHSC loan repayment program, and 32 percent used the J-1 visa program to fill at least one physician position (Rosenblatt et al. 2006).

FQHCs sometimes face difficulty in securing specialty referrals, which is often related to the patient's insurance status

A successful referral from an FQHC to a specialist often depends on the insurance status of the patient and the patient's ability to absorb the cost of specialty care if the patient's insurance does not cover it (Gusmano et al. 2002, Shi et al. 2010). A study of the 2006 National Ambulatory Medical Care Survey (NAMCS) did not find a large difference in the rate of FQHCs (14 percent) and physician offices (10 percent) saying they had "a lot of difficulty" or "some difficulty" in referring Medicare patients to specialists. However, more FQHCs and physician offices reported "a lot of difficulty" referring Medicaid patients (16 percent for FQHCs, 22 percent for physician offices) and uninsured patients (46 percent for FQHCs, 24 percent for physician offices) to specialists (Shi et al. 2010). In a survey of 20 FQHC directors across the country, 35 percent of respondents said they often try to negotiate lower prices with specialists if the cost of specialty care would be prohibitive for the patient (Gusmano et al. 2002).

FQHCs may play a larger role in medical education as a result of recent legislative changes

FQHCs offer an opportunity for medical residents to experience care delivery in an ambulatory setting. To facilitate these connections, two provisions in the Patient Protection and Affordable Care Act of 2010 (PPACA) establish funding sources for development of, and payment to, teaching health centers. Teaching health centers are community-based ambulatory care sites that operate a primary care residency program and can include FQHCs, RHCs, and other entities. PPACA authorized (but did not appropriate) HRSA grants to help eligible establishments start up teaching health center residency programs. Separately, PPACA appropriated $230 million over the next five years to support the costs of operating residency programs in teaching health centers. HRSA will administer this funding process. On January 25, 2011, the Secretary of Health and Human Services announced that $1.9 million had been awarded to 11 teaching health centers under the Teaching Health Centers Graduate Medical Education Program (Health Resources and Services Administration 2011b).

Separate from these provisions, FQHCs are eligible to receive Medicare payments for graduate medical education, either directly from Medicare or more commonly through arrangements with teaching hospitals. Medicare can make direct graduate medical education payments for specified teaching-related expenses to FQHCs that sponsor their own accredited residency training program. Because very few FQHCs sponsor

their own residency programs, these direct payments are relatively rare. It is more common, however, for FQHCs to receive payments through an arrangement to provide a rotation for a hospital-based residency program. Unlike teaching hospitals, FQHCs cannot receive Medicare indirect medical education payments for the higher costs associated with being a teaching institution. However, if an FQHC enters an arrangement with a hospital-based residency program to provide an ambulatory rotation, it may negotiate reimbursement from the hospital that could include the indirect costs of having the residents rotate through the FQHC. Although PPACA eliminated some regulatory burdens that discouraged residency rotation to these nonhospital settings, financial disincentives remain (Medicare Payment Advisory Commission 2010).

The largest source of FQHC revenue is Medicaid, with federal grants contributing a significant share

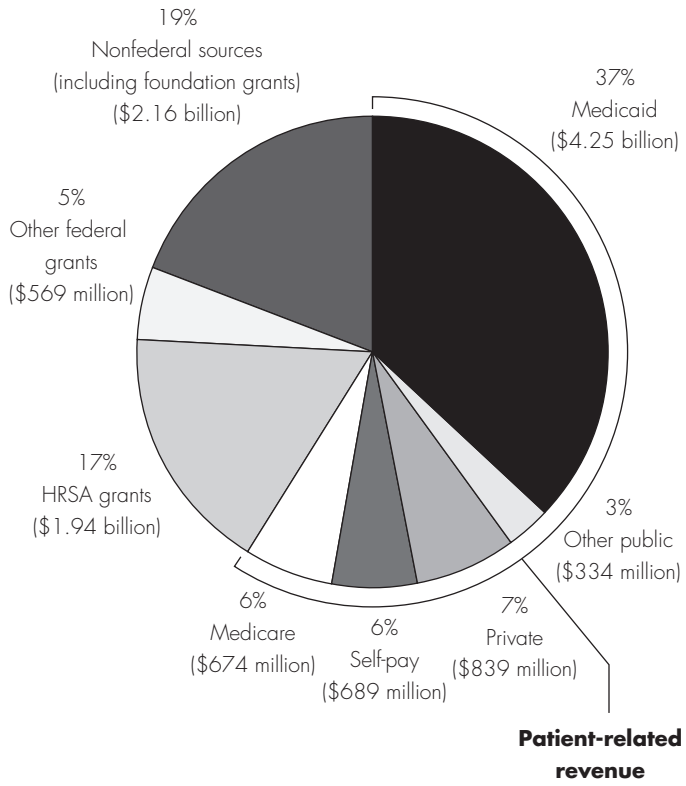
Among all sources of revenue, Medicaid makes up 37 percent of total revenue and 63 percent of patient-related revenue for health center grantees (Figure 6-1). In 2009, Medicaid paid $4.25 billion to FQHCs. In contrast, Medicare paid $674 million to federally funded FQHCs, or 6 percent of their total revenue.

Medicaid payments to FQHCs are made under a prospective payment system

The Benefits Improvement and Protection Act of 2000 established a PPS for Medicaid reimbursement, changing from a cost-based methodology. The law also allowed state Medicaid agencies to establish their own reimbursement rates for FQHCs provided that: (1) the reimbursement would not be less than the payment under the Medicaid PPS, and (2) the center agreed to it (referred to as an alternative payment methodology). In 2005, the Government Accountability Office (GAO) found that about half of states had established an alternative payment methodology for reimbursing FQHCs (Government Accountability Office 2005).[4] In 2009, 56 percent of Medicaid patients at FQHCs were covered by a Medicaid managed care organization (Health Resources and Services Administration 2010). In these situations, the managed care organization pays the FQHC an amount that the two parties negotiated, and the state Medicaid program pays the FQHC a wraparound payment equal to the difference, if any, between the PPS rate and the payment from the managed care organization.

FIGURE 6–1

Of the more than $11 billion in revenue reported by FQHC grantees, Medicaid makes up the largest single share



Note: FQHC (federally qualified health center), HRSA (Health Resources and Services Administration).

Source: 2009 data compiled by MedPAC from the HRSA data warehouse.

Grants to FQHCs are funded through the annual appropriations process

The FQHC grant program is funded through the yearly appropriations process, although recent legislation has also provided mandatory grant funding for FQHCs. The American Recovery and Reinvestment Act appropriated $2 billion for construction, equipment, health information technology, and related improvements to existing FQHCs and establishment of new FQHC sites. Finally, PPACA appropriated $11 billion over the next five years (including $1.5 billion for construction) for FQHCs. In 2009, the average FQHC grant award was $1.7 million (Health Resources and Services Administration 2011d).

Medicare reimburses FQHCs for visits by beneficiaries using an all-inclusive payment

The FQHC benefit under Medicare became effective in October 1991 and was modeled after the Medicare RHC benefit (Government Accountability Office 2010). It generally covers primary and preventive care and related services provided to Medicare beneficiaries. The current Medicare reimbursement is a single payment per covered visit based on the FQHC's costs and subject to a productivity assumption for clinical staff and an upper limit on the per visit payment.

Medicare FQHC benefit covers comprehensive primary and preventive care

The FQHC benefit under Medicare generally covers:

- ***Primary care:*** Treatment of acute or chronic medical problems furnished under the supervision of a physician, nurse practitioner, physician assistant, clinical psychologist, clinical nurse midwife, visiting nurse, or clinical social worker (Health Resources and Services Administration 2006).
- ***Preventive care:*** Screening services furnished under the supervision of a medical professional. Initially, these services included broad risk-targeted services such as physical exams, blood pressure management, and nutritional assessments. Over time, preventive services under the Medicare FQHC benefit have been expanded to include mammography, Pap tests and pelvic exams, prostate and colorectal cancer screening, diabetes self-management training, bone mass measurement, glaucoma screening, cardiovascular screening, medical nutrition therapy, and tobacco cessation.[5]

PPACA expanded the FQHC Medicare benefit by cross-referencing the Medicare preventive services established by the law. As shown in Figure 6-2, some services provided in FQHCs are separately billable under Part B because they are not covered in the Medicare all-inclusive payment rate. In addition, because an FQHC has to offer the same services to all patients, regardless of their insurance status, FQHCs may provide Medicare beneficiaries care such as preventive dental services that are not covered by Medicare under either the all-inclusive payment rate or the Part B fee schedule (Centers for Medicare & Medicaid Services 2010b).

Medicare reimburses FQHCs using a cost-based all-inclusive reimbursement rate

Medicare pays for beneficiaries' visits to FQHCs using an all-inclusive rate per covered visit. Medicare's all-inclusive payment rate for FQHCs was generally modeled after the system in place for payment to RHCs, including productivity thresholds and per visit limits (Government Accountability Office 2010).

Medicare's FQHC reimbursement rate is based on the center's costs, subject to productivity requirements and a per visit payment limit

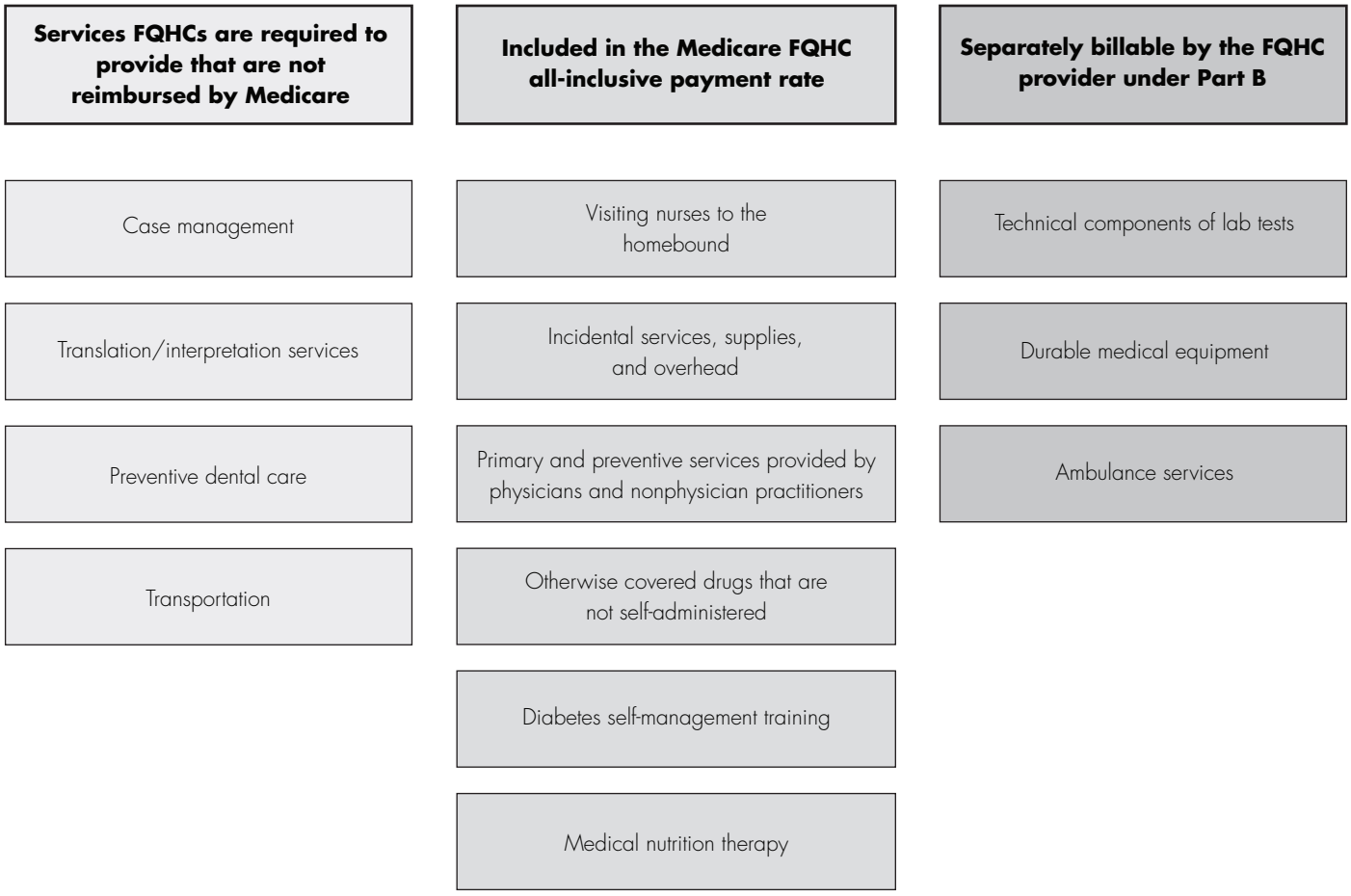
Medicare payment to an FQHC is based on allowable visits and allowable costs. Allowable visits include an in-person encounter with a physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker, or visiting nurse for preventive or primary care. A visit for diabetes self-management training or medical nutrition therapy services can be counted as a visit, provided that it is not a group session (Centers for Medicare & Medicaid Services 2009).[6] FQHCs may bill for only one medical visit per patient per day. FQHCs may also bill for one mental health visit per patient per day and one diabetes self-management individual training visit per patient per day.

Allowable costs are those that are "reasonable in amount and necessary and proper to the efficient delivery of services," as described in the Medicare claims processing manual (Centers for Medicare & Medicaid Services 2010b). These costs include practitioner compensation, overhead, supplies, and other costs incident to delivery of the Medicare FQHC benefit. Costs for services provided that are not covered by Medicare (e.g., preventive dental care) must be excluded as well as costs associated with items outside the FQHC benefit, such as the technical component of labs (Centers for Medicare & Medicaid Services 2010b).

In general, the calculation of the FQHC per visit payment rate uses allowable costs divided by allowable visits. However, Medicare applies an adjustment for the productivity of FQHC medical staff, using a floor of 4,200 visits for each full-time physician and 2,100 visits for each full-time physician assistant, advanced practice nurse, or clinical nurse midwife in a year. FQHCs with total allowable visits below these thresholds must nevertheless use them to calculate the number of allowable visits. This requirement raises the number of visits in the calculation and thus reduces the per visit rate.

FIGURE 6–2

Benefits provided at FQHCs



Note: FQHC (federally qualified health center).

Source: Compiled by MedPAC from the Medicare benefit policy manual.

An FQHC's reimbursement is the lower of its calculated per visit rate or the per visit payment limit. In 2011, the per visit payment limit is $109.24 for rural FQHCs and $126.22 for urban FQHCs. Urban FQHCs are those that are located in a metropolitan statistical area (Centers for Medicare & Medicaid Services 2010a).

Using 2007 cost reports, GAO estimated that 72 percent of FQHCs had costs for delivering the FQHC Medicare benefit that exceeded the Medicare per visit limit and that their costs exceeded Medicare reimbursement by approximately $72 million in total, or 17 percent of payments that year.[7]

In reviewing these findings, it is worth noting that CMS dissented with the findings as the data used in the report were not derived from "comprehensive, full scope audited Medicare FQHC cost reports." As CMS noted in its comments, the presence of the per visit payment limit reduces the need for a detailed audit of the FQHC cost reports (Government Accountability Office 2010). The use of unaudited cost reports for reimbursement may also have implications for the transition to the PPS.

Medicare provides an interim payment to FQHCs that is later reconciled with FQHC's actual spending

Medicare currently pays FQHCs using cost-based reimbursement. Under this arrangement, a Medicare contractor makes interim payments to an FQHC at the beginning of the reporting period based on either

TABLE 6–1 **Comparing Medicare's FQHC and RHC payment limits with payment for a physician office visit and hospital outpatient department visit, 2011**

	Medicare payment amount
Payment limit	
FQHC, rural	$109.24
FQHC, urban	126.22
RHC	78.07
Physician office	
Physician fee schedule, office visit by an established patient	68.97
Hospital outpatient department	
Facility	75.13
Physician work	49.27
Total	124.40

Note: FQHC (federally qualified health center), RHC (rural health clinic). The physician fee schedule and outpatient department (OPD) figures are the national payment amount. Healthcare Common Procedure Coding System code 99213 is used for the physician fee schedule and OPD payment amounts. Medicare's payment rate for a physician office visit includes the practice expense (i.e., facility-level) payment. Please see text on this page for additional caveats to this comparison.

Source: Calendar year 2011 physician fee schedule, Hospital Outpatient Prospective Payment System Addendum A.

the FQHC's historic costs of providing services or the FQHC's budget for that year.[8] At the end of a period up to, but not exceeding, 12 months, the FQHC submits a cost report, which includes the detail needed for the Medicare contractor to determine the FQHC's final Medicare reimbursement. If interim payments to the FQHC exceed the final settlement amount, the FQHC must repay the excess amount. Similarly, if the interim payments are less than the final settlement amount, Medicare pays the FQHC the difference in a lump sum up to the per visit payment limit (Centers for Medicare & Medicaid Services 2010b).

Medicare's payments to FQHCs and Medicare's payments for office visits in other ambulatory care settings

Table 6-1 shows the Medicare FQHC payment limit with Medicare's payment for a level three physician office visit and a level three hospital outpatient clinic visit. There are a number of important caveats to this comparison. First, Medicare's payment to FQHCs includes all services covered by the FQHC benefit. Thus, the FQHC payment includes the professional component of laboratory services or procedures, physician-administered medication, and some additional Medicare-covered services that FQHCs provide as a condition of their grant or look-alike designation, which could be billed separately in the case of a private physician practice or a hospital outpatient department. In other words, an apples-to-apples comparison would use Medicare's payment for a physician visit and outpatient visit (and other services that may be billed separately) that corresponds to a typical FQHC visit. However, our ability to define a typical visit to an FQHC for a Medicare beneficiary is not possible because FQHCs did not report Healthcare Common Procedure Coding System (HCPCS) codes until very recently. Beginning in January 2011, FQHCs are required to report HCPCS codes.

Second, the payment rate to FQHCs does not vary based on whether the visit is with a new or established patient or on the intensity of the visit.

Third, the payment limit for FQHCs is an upper payment limit—meaning that some FQHCs receive a per visit amount that is less than the amount shown in Table 6-1.

With these caveats, Table 6-1 shows Medicare's payment rate for a level three office visit with an established patient for the physician fee schedule rates and a level three outpatient department visit. We chose a level three visit because, as noted above, Medicare's FQHC payment limit covers all types of visits to the FQHC—including shorter or less complex visits with established patients as well as longer or more complex visits with new patients.

According to the Medicare physician fee schedule, for a level three office visit by an established patient, practitioners typically spend 15 minutes face to face with patients or their families, compared with 5 minutes of face-to-face time for a level one office visit and 40 minutes for a level five office visit.

FQHCs can reduce cost sharing for low-income Medicare beneficiaries

Medicare's Part B deductible does not apply to FQHC visits. Patients at FQHCs pay a coinsurance of 20 percent of the center's reasonable customary charge for the service (Centers for Medicare & Medicaid Services 2011b). The coinsurance percentage is applied to the FQHC's customary charges, even if this customary charge would exceed the Medicare FQHC payment limit. However, per the Section 330 PHSA grant requirements, the patient's

coinsurance is also subject to a sliding scale reduction based on income. The coinsurance for patients with income below 200 percent of the federal poverty threshold is reduced and patients with incomes below 100 percent of the federal poverty threshold pay a nominal fee. If patients do not pay their coinsurance, Medicare reimburses 100 percent of the bad debts for the FQHC. Of the general population over age 65 years, 34 percent are below the 200 percent federal poverty threshold and so could receive some reduction in their coinsurance (Census Bureau 2010). This reduction in coinsurance may become less of a relative benefit of FQHCs as Medicare cost sharing for certain preventive services has been eliminated in all settings.[9]

Patients at FQHCs are predominantly low income and minority

In 2009, 1.4 million Medicare beneficiaries received care at an FQHC—an increase of 20 percent from 2006 (Health Resources and Services Administration 2010). Despite this increase, over the same period, the share of the FQHC population who were Medicare beneficiaries fell slightly, as the overall FQHC patient population increased by 25 percent, to 18.8 million people (Figure 6-3) (Health Resources and Services Administration 2010).

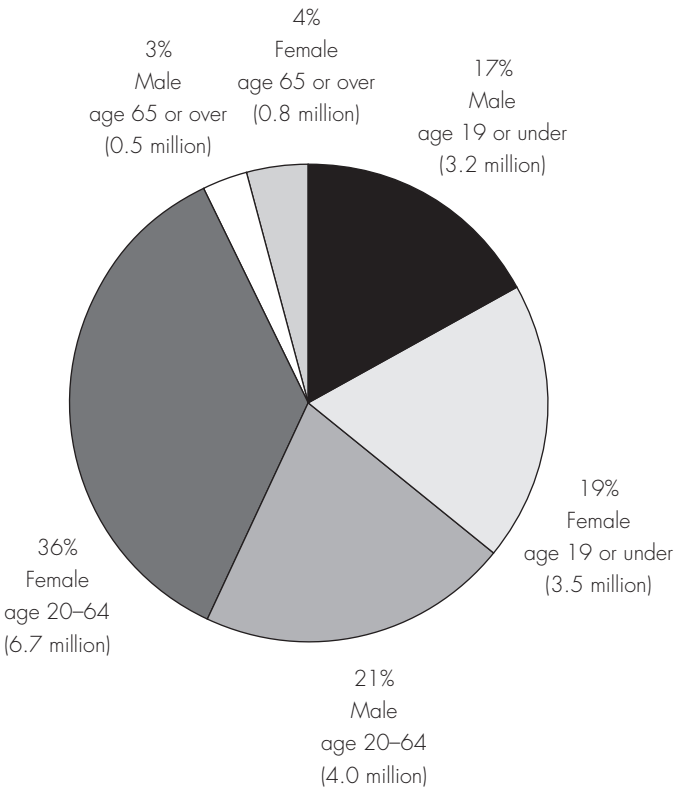
More than 70 percent of grantee FQHCs' patients have income below 100 percent of the federal poverty threshold (Health Resources and Services Administration 2010). Patients at FQHCs are disproportionately minority and non-English speakers—in 2009, 63 percent were members of a racial or ethnic minority (predominantly Hispanic), and 25 percent were best served in a language other than English (Health Resources and Services Administration 2010).

Chronic disease burden of patients at FQHCs appears to be higher than for comparable patients at physician offices

Studies over the years have assessed the chronic disease burden of patients visiting FQHCs, outpatient departments, and physician offices. One study using the 2006 NAMCS found that a higher percentage of community health centers' patients (13 percent) were more likely to have diabetes than physician offices' patients (9 percent). Significantly higher rates of patients at health centers were obese or suffering from depression compared with patients in physician offices (Shi et al. 2010). A study that updated these findings based on the 2008 NAMCS found that patients in FQHCs were more likely to have a chronic condition than patients in a physician office or outpatient department (Hing and Uddin 2010).

FIGURE 6–3

FQHC patients are predominantly young, 2009



Note: FQHC (federally qualified health center). The centers in this chart reflect all grantees, but exclude look-alikes, and may include some centers that are not certified as FQHCs.

Source: Health Resources and Services Administration, Department of Health and Human Services. 2010. *2009 national summary report.* Rockville, MD: HRSA.

Patients with chronic conditions make more visits to FQHCs, and frequent visitors to FQHCs are more likely to be older

In 2009, FQHC patients with chronic conditions were more likely than other FQHC patients to make multiple visits to FQHCs in a year—three visits a year on average for those with diabetes, two and a half visits a year for those with heart disease, and just over two visits a year for those with hypertension (Health Resources and Services Administration 2010). In contrast, the number of visits

for those with acute conditions ranged from 1.45 visits for patients with dehydration to 1.22 visits for patients with contact dermatitis.

One study of an FQHC in central Massachusetts that reviewed center records for 1999 found that among all patients, frequent visitors to the FQHC were more likely to be older. Patients aged 45 to 64 years made up a third of all established patients but half of frequent visitors. The share of the total patient population at the FQHC over age 65 was 7 percent, but it made up 13 percent of frequent visitors (Savageau et al. 2006).

FQHCs report chronic care outcomes for their patients

FQHCs track and report intermediate outcome measures to HRSA on an aggregate basis for their patients who have been diagnosed with certain common chronic diseases. Among patients between the ages of 18 and 85 who visited an FQHC in 2009 and who were diagnosed with hypertension, 63 percent had a reading on their last blood pressure measurement of 140/90 or below (Health Resources and Services Administration 2010).[10] Among FQHC patients with diabetes, 71 percent had a hemoglobin A1c (HbA1c) level below 9 percent—one measure of blood sugar control for diabetics. Overall, the literature of quality at FQHCs in comparison to other primary care sites is mixed, and the underlying health status of patients confounds these findings. One analysis of chronic care management at health centers found that the rates of blood pressure control were better than the documented rates for hospital-affiliated clinics or the Veterans Affairs health system; it also found that the quality of diabetes care was lower at health centers than for publicly reported rates for some managed care organizations, although this comparison does not adjust for patient status between those at FQHCs and in managed care organizations (Hicks et al. 2006). Another study that focused directly on glycemic control in FQHCs found that the rate of glycemic testing equaled or exceeded national figures for the total U.S. population as well as managed care plans participating in the Healthcare Effectiveness Data and Information Set reporting. This study also found that the percentage of patients with HbA1c levels below 9.5 percent was higher for the surveyed health centers than managed care plans (Maizlish et al. 2004).

Presence of an FQHC may reduce preventable hospitalizations

One study conducted among publicly insured and uninsured residents noted that FQHCs reduced the rate of preventable hospitalizations (Epstein 2001). Using a database of hospital discharges in Virginia, Epstein found that the presence of an FQHC reduced the preventable hospitalization rate for those residing in an MUA. Over the three years covered in his study, the presence of an FQHC in an MUA was associated with 5.8 fewer preventable hospitalizations per 1,000 people, as compared with the rate of preventable hospitalizations in MUAs without an FQHC. The study did not disaggregate the findings among those with public insurance and those without insurance.

Other studies have found that the presence of an FQHC reduced the rate of ambulatory-care-sensitive conditions among the uninsured and that, even among the insured population, the presence of an FQHC decreased use of the emergency department for ambulatory-care-sensitive conditions (Falik et al. 2006, Rust et al. 2009).

Recent legislation directs significant increases in FQHC capacity and fundamental changes in Medicare's payment

PPACA establishes a new PPS for Medicare payment to FQHCs beginning on October 1, 2014. As noted earlier, current payments to FQHCs are constrained by both the productivity assumption and the per visit limit. Under the new payment system, payments in the first year of the PPS shall be set equal to the estimated payments that would have occurred under the current reasonable cost payments without respect to the productivity assumptions or the per visit payment limit. The payment rate shall be increased each year by either an FQHC-specific index or the Medicare Economic Index if an FQHC index is not available. There is not a specific statutory provision for an ongoing budget-neutrality factor after the first year of the PPS.

In preparation for the PPS, starting in 2011, FQHCs must report to CMS on the specific services they provide to Medicare beneficiaries using HCPCS codes (Centers for Medicare & Medicaid Services 2011d). The statutory language establishing the PPS also contemplates that payment rates could take into account the type, intensity, and duration of services and could incorporate geographic adjustments.

One concern in Medicare payment policy is that in transitioning from a cost-based reimbursement system to

FQHC look-alike program

The federally qualified health center (FQHC) look-alike program was established in 1990 as a result of the demand for FQHC services by low-income uninsured or Medicaid enrollees and limited Section 330 grant funding (Taylor 2010). The creation of this program enabled centers that complied with all the grant requirements to be reimbursed as FQHCs by Medicare and Medicaid, even if they were unable to receive grant funds. Many FQHC look-alikes compete for and obtain federal grant funding—between 2002 and 2007, 286 FQHC look-alikes applied for an FQHC grant, and 36 percent of them were successful (Health Resources and Services Administration 2008). FQHC look-alikes can also participate in the 340B program, although they are not covered under the Federal Tort Claims Act. ■

a PPS, there may be less of an incentive for providers to constrain their costs so that costs in a base year result in a higher payment amount under the PPS.[11]

FQHCs could have the same incentive to not constrain their costs in anticipation of the PPS. It is also important to note that CMS does not audit FQHC cost reports, and they note in their comments to the GAO report on Medicare's payment to FQHCs that the presence of the per visit payment limit constrains Medicare's overall payment to FQHCs without requiring a detailed audit (Government Accountability Office 2010). If these cost reports form the basis of the PPS along with the procedure and service codes reported, it will be important for CMS to audit the growth in costs for FQHCs in the years before the PPS is established and ensure that Medicare's payment rates reflect the efficient provision of services at FQHCs.

Considerations in developing Medicare PPS for FQHCs

There are three general reasons to look at the relationship between FQHCs and Medicare. First, FQHCs are one model of team-based primary care delivery. FQHCs emphasize the use of physician assistants, nurse practitioners, clinical nurse midwives, and other practitioners for routine care, allowing physicians affiliated with FQHCs to focus their attention on more complex cases. They are required by their grants or look-alike designations to coordinate care by having off-hours coverage, having admitting privileges with facility-based providers, and locating their service sites to facilitate access to care.

Second, FQHCs can provide access for Medicare beneficiaries seeking routine and preventive care in areas where physician office capacity is limited. As a result of their grant requirements, FQHCs are located in underserved areas (such as rural areas where health care services are widely dispersed) or treat populations that have barriers to care (such as those whose members have difficulty obtaining transportation to a doctor's office).

Third, the conversion to a Medicare PPS could encourage FQHCs to serve more Medicare beneficiaries, as it is likely that Medicare payments to FQHCs will increase under the PPS. In designing the PPS, CMS will have to address questions about the most appropriate services for Medicare beneficiaries at FQHCs and the relative value of these services.

Several questions remain regarding FQHCs' delivery of care to Medicare beneficiaries. For example, do FQHCs have the expertise to handle multiple chronic conditions among the elderly? While FQHCs treat a significant number of patients with chronic and disabling conditions, the share of their patients who are over age 65 is relatively small. Next, is the care provided at FQHCs of comparable quality to other ambulatory care sites available to Medicare beneficiaries, and does Medicare's payment to FQHCs reflect the efficient delivery of care? These issues will be part of the discussion as CMS develops Medicare's PPS for FQHCs. ■

Endnotes

1 Health centers classified as comprehensive federally funded health centers as of January 1, 1990, are also categorically eligible to be FQHCs.

2 Outside an FQHC or RHC, nurse practitioners and physician assistants are paid at 85 percent of the physician fee schedule.

3 CMS requires that physicians make at least one visit every two weeks to meet the physician supervision requirement.

4 Since this report was issued, the Congress raised the Medicaid FQHC PPS by $5.

5 Preventive care under the Medicare RHC benefit is limited to services that are covered under Medicare Part B.

6 In general, group education sessions are not included in the FQHC Medicare benefit.

7 GAO estimates that the productivity threshold had a smaller effect on Medicare spending—7 percent of FQHCs had their total reimbursement rate lowered because of the productivity threshold, reducing Medicare payment to FQHCs by $1.1 million.

8 For example, if an FQHC is new, the Medicare administrative contractors may pay an interim rate based on a budget. If the FQHC is expanding the services it provides or expects a significant increase in costs (such as rent) it may request payment based on a budget.

9 PPACA eliminates cost sharing for preventive services ranked as A or B by the Preventive Services Task Force.

10 Lower blood pressure measurement and higher shares of patients with lower hemoglobin A1c levels suggest higher quality.

11 For example, GAO found that "HCFA [Health Care Financing Administration] used 1995 reported SNF [skilled nursing facility] costs as the basis for the federal per diem rates under PPS. We believe these base-year costs are likely to be too high as a result of inefficient service provision, unnecessary care, and improper billing for services, which went undetected due to minimal program oversight." (Government Accountability Office 1999).

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