



# Federally Qualified Health Centers: An Overview

## Introduction

Health center is an all-encompassing term for federally qualified health centers (FQHCs) and FQHC look-alikes; they are a key component of the health care safety net that provided care to more than 20 million Americans in 2011. The Patient Protection and Affordable Care Act of 2010 (ACA) has positioned health centers to play a crucial role in the future health care environment. Expansions in Medicaid and privately insured populations are expected to put a significant demand on primary care, particularly in underserved, low-income communities, where large increases to the number of newly insured are anticipated. Despite the expected growth in coverage, an estimated 23 million people (or more if states opt out of the allowed Medicaid expansion) will remain uninsured. Newly insured and uninsured populations will depend on FQHCs and FQHC look-alikes for primary care. Despite bipartisan political and financial support, FQHCs face challenges. To achieve long-term sustainability, FQHCs need to become financially self-sufficient, find ways to address the growing health professional shortages, advance collaboration efforts with provider networks, and improve cost and quality outcomes.

This paper begins by looking at the overall picture of safety net organizations in Michigan. Next, it describes the FQHC model and how FQHCs operate nationally; it then provides information on the FQHC environment in Michigan, followed by a look at the future of FQHCs within the context of health care reform, and concludes by summarizing the challenges facing FQHCs. A companion piece to this paper summarizes the effectiveness of FQHCs.

## Michigan's Safety Net: An Overview

The Institute of Medicine of the National Academies (IOM) defines safety net providers as those that “by mandate or mission organize and deliver a significant level of health care and other health-related services to the uninsured, Medicaid, and other vulnerable patients.”

Safety net organizations in Michigan provide a variety of health care services—including primary care, urgent care, preventive care, mental health, dental, and vision—and enabling services such as language interpretation, transportation and outreach.<sup>1</sup> Michigan's safety net providers include:

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- **Community hospitals**, which provide various community health improvement services such as free and discounted health education, outreach, screening, counseling, and financial support to free clinics.<sup>2</sup> These hospitals provide a disproportionate share of services to underserved groups. Currently, there are 134 community hospitals in Michigan, 127 of which are nonprofit.<sup>3</sup> Commonly supported community benefit programs include school-based health education and health centers.<sup>4</sup>
- **Rural health clinics (RHCs)**, which provide outpatient primary care in underserved rural areas. They may function as freestanding independent practices, or be affiliated with hospitals or other providers. There are 172 certified RHCs in Michigan.<sup>5</sup>
- **School-based health centers**, which provide services for acute and chronic health conditions, substance abuse, case management, dental, reproductive health, nutrition education, and health promotion, among others.<sup>6,7</sup> There are currently more than 90 school-based/linked health centers and programs in Michigan.
- **Local public health departments**, which provide safety net services such as immunizations, family planning, and nutrition programs.<sup>8</sup> The Michigan Public Health Code requires the state to support a system of local public health services, which are managed by local governments.<sup>9</sup> Currently, Michigan has 45 city, county, or district health departments.
- **Free clinics/local volunteer programs**, which provide patients with various services, including primary care and prescription assistance, mental health care, dental, patient education programs, optometry, and social and specialty services. There are a number of different operating models among Michigan's 80 known free clinics.<sup>10</sup>
- **Health centers (FQHCs and FQHC look-alikes)**, which provide comprehensive primary health, oral health, mental health/substance abuse services, and enabling services. Health center is an all-encompassing term for a diverse range of public and nonprofit organizations and programs that provide primary care services. Those that receive federal grant funding are known as Section 330 grantees, which include FQHCs. FQHC look-alikes meet the same requirements as FQHCs but do not receive federal grant funding.<sup>11,12</sup> Michigan currently has 35 health centers (30 FQHCs, three FQHC look-alikes, and two clinics that are both an FQHC and an FQHC look-alike) that provide care at 216 delivery sites to more than 600,000 patients, regardless of their insurance status.<sup>13</sup>

## FQHCs – The National Environment

Medicare and Medicaid statutes define an FQHC as a health center that receives federal funding under Section 330 of the Public Health Service Act to provide comprehensive primary care services to uninsured and underinsured populations.<sup>14,15</sup>

Health centers originated as “neighborhood health centers” under the Economic Opportunity Act of 1964, established as part of the federal government’s “War on Poverty.” Amended by the Health

Centers Consolidation Act of 1996, Section 330 of the Public Health Service Act established the Health Center Program, which provides federal funding for health centers. Section 330 created a health center reimbursement status (i.e., enhanced Medicare and Medicaid payments, granted to designated health centers). The legislation also provided federal grants to community and migrant health centers to serve the uninsured, but provided no special payments from Medicare and Medicaid.<sup>16</sup> The FQHC program that exists today was enacted under the Omnibus Budget Reconciliation Act (OBRA) of 1989 and expanded under OBRA of 1990. The legislation enables enhanced Medicare and Medicaid payments to health centers via cost-based reimbursement for services specified under Section 330.<sup>17</sup>

The Federal Health Center Program supports four types of health centers. These centers, which receive federal funding, may be either public or private nonprofit health care organizations. The four types of health centers are:

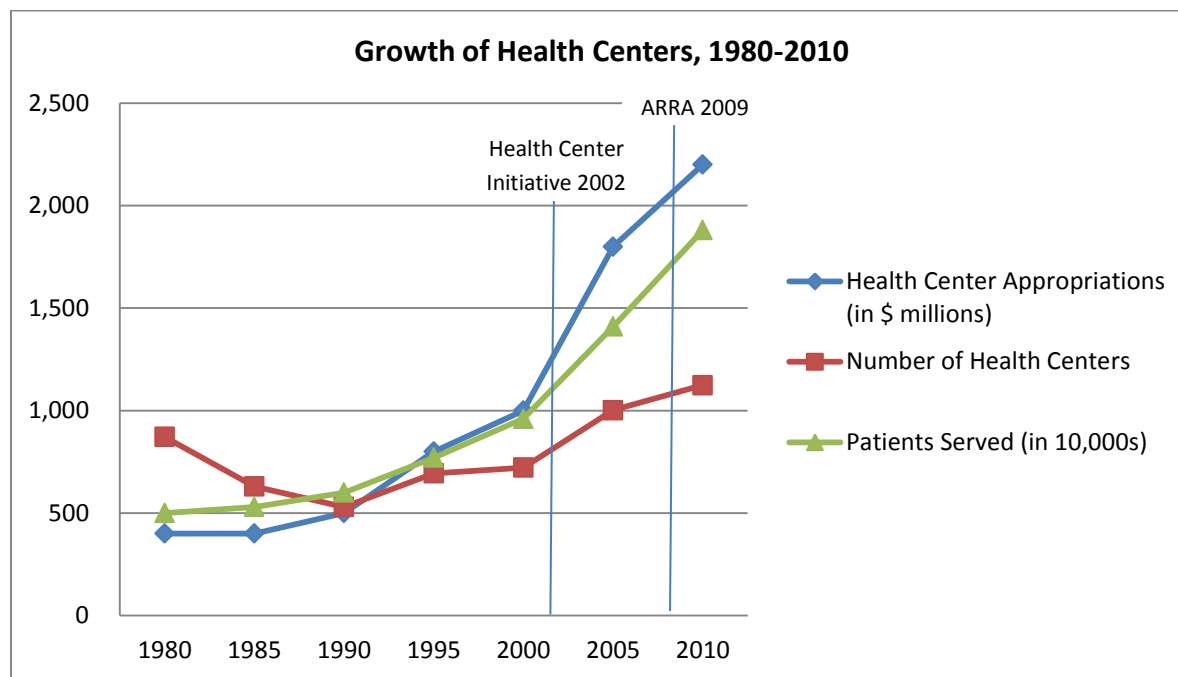
- **Federally qualified health centers—Section 330 (e)**, which serve a variety of medically underserved populations and areas.
- **Migrant health centers –Section 330 (g)**, which provide care to migrant and seasonal agricultural workers and their families in a culturally sensitive way.
- **Health care for the homeless programs—Section 330 (h)**, which reach out to homeless individuals and families to provide primary care, substance abuse, and mental health services.
- **Public housing primary care programs—Section 330 (i)**, which are located in public housing communities and serve their residents.<sup>18</sup>

## Growth of FQHCs

In the 1960s, only eight health centers existed in the United States, but the number has steadily grown. By 2001, there were 748 health centers at 4,128 service sites around the nation, serving approximately 10 million individuals. Federal support for FQHCs grew substantially while President George W. Bush was in office. In 2002, Bush launched the Health Center Initiative, which provided hundreds of new grants to expand health centers and double the number of patients served.<sup>19,20</sup> Support for health centers has continued under the Obama administration.

Federal funding for health centers has increased from \$750 million in 1996 to \$2.2 billion in 2010. In 2009, the American Recovery and Reinvestment Act (ARRA) added another \$2 billion in funding and the Patient Protection and Affordable Care Act (ACA) appropriated \$11 billion more in federal funding for health centers between 2011 and 2015. Due to increased federal support over the last 10 years, health centers now provide care to 20 million patients.<sup>21,22</sup> In 2011, there were 1,128 health centers providing care at more than 8,000 rural and urban delivery sites in the United States and territories.<sup>23</sup>

Figure 1: Growth of Health Centers, 1980-2010



Source: Kaiser Commission on Medicaid and the Uninsured (data from the National Association of Community Health Centers and the Uniform Data System (UDS) of the Health Resources and Services Administration (HRSA))

## Operational Features

Health centers must meet several requirements to be recognized as an FQHC, including location, mission and strategy, governance, financing, and services.

### Location

All health centers must be located in or serve a high-need community, specifically a federally designated, medically underserved area or population (MUA/MUP). Medical underservice is defined by a shortage of health professionals or services in a geographic area or among a population, as well as high rates of poverty and infant mortality.<sup>24</sup>

Health centers may add service sites after the initial FQHC designation has been approved by the U.S. Health Resources and Services Administration (HRSA) as long as the additional site continues to serve an MUA/MUP in whole or in part, though the site may be located outside of an MUA. The additional site(s) must not require additional federal funding, shift resources away from the FQHC's current target population or significantly affect the current operation of another health center located in the same or adjacent service area, among other criteria.<sup>25</sup>

### ***Mission and Strategy***

All FQHCs must have a mission to improve the health status of underserved populations in their targeted community. To achieve this, they must:

- Complete a needs assessment to determine gaps in health care services in the community they serve.
- Use the needs assessment results to design culturally and linguistically appropriate health service programs.<sup>26</sup>
- Collaborate with other health care providers and social service agencies, becoming part of the community's health care and social service infrastructure.
- Have quality improvement systems that measure and document the effectiveness, performance, and quality of management and clinical services.<sup>27</sup>

### ***Governance***

Health centers must be governed by a community-based board of directors. A majority of the board must be consumers or users of the health center's services and represent the health center's service area in terms of demographic factors such as race, ethnicity and gender. Non-consumer board members are selected from professional fields such as legal, financial, health care and social services. No more than half of the non-consumer board members can earn more than 10 percent of their income from the health care field.

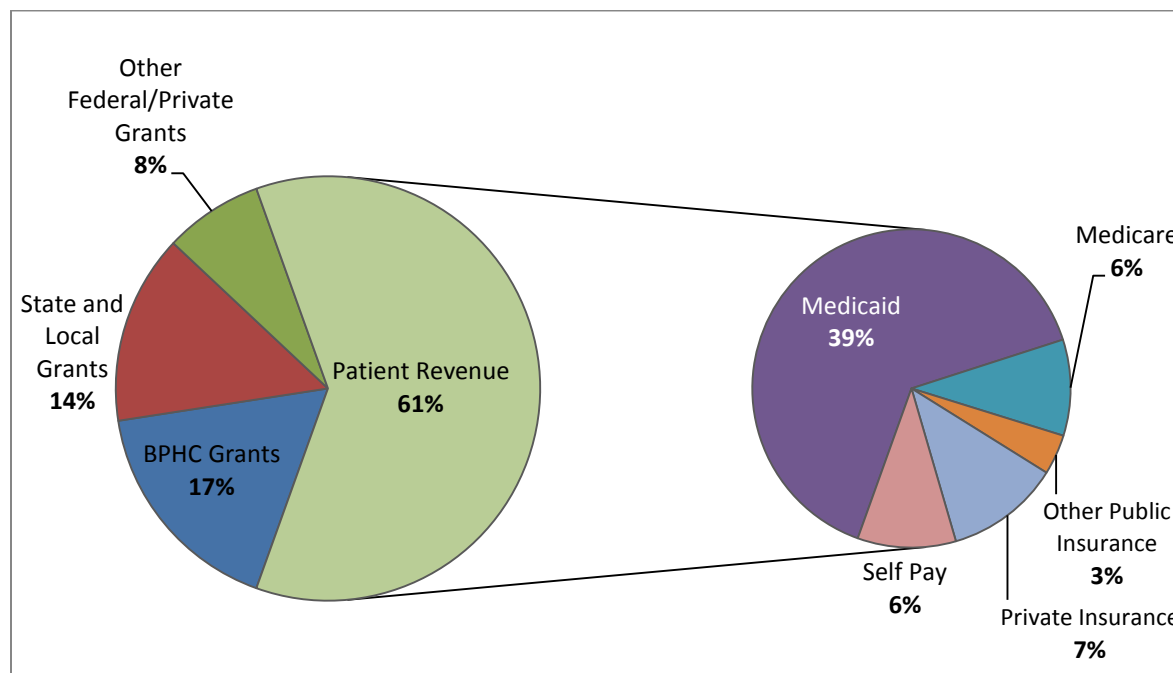
The board must carry legal and fiduciary responsibility for the health center's operations and grants, periodically perform strategic planning, and evaluate progress of the organizational goals.<sup>28</sup>

### ***Financing and Reimbursement***

Health centers are required by law to provide services to all people, regardless of ability to pay. The uninsured are charged for services on a board-approved sliding-fee scale, which is based on a patient's family income and size.

Health centers are financed through a mix of Medicaid and Medicare reimbursements (with different payment methodologies), direct patient revenue, other third-party payers (private insurers), state funding, local funding, philanthropic organizations, and grant funding from the Bureau of Primary Health Care (BPHC) of HRSA of the U.S. Department of Health and Human Services (HHS).

Figure 2: National FQHC Revenue Distribution, 2011



Source: UDS 2011

*Bureau of Primary Health Care—Federal 330 Grant*

Seventeen percent of the typical health center’s budget is funded by BPHC.<sup>29</sup> In addition to grants that target migrant and seasonal workers, homeless populations, and residents of public housing, Section 330 of the Public Health Service Act permits BPHC to award grants to health centers to fund the operations of each site, specifically the following:

- **Planning grants:** Health centers can receive up to \$80,000 to plan and develop their delivery sites, which includes: 1) conducting a comprehensive needs assessment; 2) designing a care delivery model; 3) acquisition costs; 4) leasing costs of buildings and equipment; and 5) funds to develop managed care and practice management networks.<sup>30</sup>
- **Operating grants:** These funds are available for the general operation of health centers, networks and plans.<sup>31</sup>
- **Access grants:** Available for health centers with a significant population of those with limited English speaking proficiency, these funds are targeted to provide translation and interpretation services for health center patients.<sup>32</sup>
- **Infant mortality grants:** Given to clinics located in areas with high infant mortality rates, these grants serve to support the reduction of the incidence of infant mortality, morbidity among children less than 3 years old, and health management of pregnant women.<sup>33</sup>

### *Medicaid Reimbursement*

Although health centers rely on a number of revenue sources, their single largest source of funding is revenue from Medicaid, accounting for more than one-third of all health center revenue. Medicaid reimburses health centers using a payment methodology unique to health centers. The Benefits Improvement and Protection Act of 2000 dramatically changed the way in which state Medicaid programs reimbursed health centers. Instead of reimbursing health centers retroactively based on their costs, the Benefits Improvement and Protection Act required state Medicaid programs to use a Prospective Payment System (PPS) methodology that pays health centers on a per-visit encounter rate based on 100 percent of their historical reasonable costs. The definition of a visit is state specific. In Michigan, an allowable health center visit is a face-to-face medical, dental, or behavioral health visit between a patient and a practitioner. Health centers may bill for different types of visits on the same day, such as a medical visit and a dental visit. Health centers use Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) to bill Medicaid.<sup>34</sup> The base encounter rate is re-calculated every year using the Medicare Economic Index, based on inflation.<sup>35</sup> Using enhanced payments, Medicaid reimburses FQHCs more per encounter than any other payer. Because of this, health centers currently see an advantage in serving a large proportion of Medicaid patients.<sup>36</sup>

A state may reimburse a health center based on an alternative methodology other than the Medicaid PPS; however, the state and each applicable individual health center must agree to these payments and the resulting payment must be at least equal to the payment the health center would receive under the Medicaid PPS.

Medicaid recipients do not pay health centers any additional fees because Medicaid pays health centers in full for all services covered under the benefit plan.

### *Medicare Reimbursement*

Medicare uses a different reimbursement methodology than Medicaid and makes up 6 percent of all health center revenue—significantly less than Medicaid. However, FQHCs have seen about a 111 percent increase in Medicare beneficiaries from 2001 to 2011 (from 745,000 to nearly 1.6 million, respectively).<sup>37,38</sup> Medicare reimburses FQHCs through interim payments of an All-Inclusive Reimbursement Rate (AIRR) per covered visit. All encounters that take place on the same day in one location constitute a single visit under Medicare, unless the patient requires additional diagnosis or treatment as a result of an initial encounter. FQHCs use revenue codes to bill Medicare. The AIRR is adjusted annually based on the Medicare Economic Index and cost reports. In general, it is calculated by dividing the FQHC's total allowable cost by the total number of visits for all FQHC patients. Reimbursement payments are capped at a specific rate that is also set annually and differs in rural and urban communities.<sup>39</sup> The Medicare payment cap, per visit, for urban FQHCs is \$128.00 and \$110.78 for rural FQHCs.<sup>40,41</sup> Medicare reimburses FQHCs at 80 percent of the AIRR. Therefore, unlike Medicaid recipients, Medicare patients have a coinsurance rate and pay 20 percent of the allowable charges to which FQHCs must apply a sliding fee discount, depending on the patient's ability to pay.<sup>42</sup>

### *Other Revenue Sources*

- Patient revenue: Sliding fee scales are determined based on the patient's income and family size, and dependent on current federal poverty guidelines<sup>43</sup>
- Local and state grants
- Philanthropic donations
- Private payers: In contrast to Medicaid and Medicare payments to health centers, private payers tend to reimburse at much lower rates, covering only about 57 percent of costs<sup>44</sup>

### *Services*

FQHCs provide comprehensive primary health, oral health, and mental health/substance abuse services, as well as supportive or enabling services such as transportation and translation to individuals of all ages.<sup>45</sup> FQHCs serve diverse populations, so each scope of services is tailored to meet the unique needs of an FQHC's patients and surrounding communities. This variety creates a range of service delivery models with varying site locations, hours of service, mix of services, and type of staff providing services.

Although there is variety among health centers, all FQHCs must be open a minimum of 32 hours per week and provide basic health services, either directly or through contracts or cooperative arrangements.<sup>46</sup> These basic health services include:

- Primary care
- Diagnostic laboratory and radiologic services
- Preventive services including preventive dental, immunizations, well child visits, prenatal, and perinatal services
- Disease screening
- Blood level screenings for elevated lead levels, communicable diseases, and cholesterol
- Eye, ear, and dental screening for children
- Family planning services
- Mental health and substance abuse services
- Emergency medical and dental services
- Pharmaceutical services

FQHCs are also required to provide supportive services, which help ensure and facilitate access to these basic health services. Specifically, these supportive services include:

- Case management
- Financial support services
- Enabling services, such as outreach, education about services, transportation and translation



The main foci of FQHCs are primary and preventive care. However, to provide their target populations with a comprehensive system of care, FQHCs must have ongoing referral arrangements with one or more hospitals and established arrangements for hospitalization, discharge planning, and patient tracking. To achieve these requirements and improve access to hospitals and health care services, some FQHCs are parts of integrated delivery systems.<sup>47</sup>

### Special Treatment of FQHCs

In addition to Section 330 federal grant funding and enhanced reimbursement revenue from Medicare and Medicaid, FQHCs receive the following direct benefits:

- Medical malpractice coverage under the Federal Tort Claims Act (FTCA).
- Federal loan guarantees for capital improvements.
- Access to National Health Services Corps placements to provide medical, dental, and mental health provider staff.
- Access to on-site HHS out-stationed eligibility workers.
- Access to the Vaccines for Children (VFC) program, which provides vaccines for uninsured children.
- Drug pricing discounts for pharmaceutical products under the 340B Drug Discount Program. This program, enacted in 1992 under Section 340B of the Public Health Service Act, requires drug manufacturers to provide outpatient drugs to covered entities at a significantly discounted price based on agreements with HHS. Also known as “PHS Pricing” or “602 Pricing,” these discounts include prescription and prescribed over-the-counter drugs but exclude vaccines and drugs given in an inpatient setting.<sup>48</sup> Under the 340 drug discount program, drug prices range between 25 percent to 50 percent less than the average wholesale drug price.<sup>49,50</sup>

Approximately 12,000 safety net providers participate in the 340B drug pricing program. These providers, which health centers, may decide to take advantage of this program by establishing in-house pharmacies to provide prescriptions for their patient populations or by contracting with local pharmacies.

- In-house pharmacies, also known as closed pharmacies, are owned and operated by the health center. The health center may purchase and dispense drugs through their own state-licensed pharmacies, which must be supervised by a pharmacist.
- Contracted pharmacy arrangements occur when a health center has an agreement with local retail pharmacies to dispense drugs purchased by the health center (and shipped to the pharmacy) to a 340B patient, in exchange for a dispensing or administrative fee. Any patient whose primary health care provider is located at or contracted with a covered entity is considered a 340B patient. Only prescribers affiliated with a covered entity are able to write 340B-covered prescriptions. Additionally, health centers and other covered entities cannot

request 340B prices for the same drug for which Medicaid will request a rebate. This protects the drug manufacturer from giving discounts to both Medicaid and the health center for the same drug.<sup>51</sup>

### What is an FQHC Look-alike?

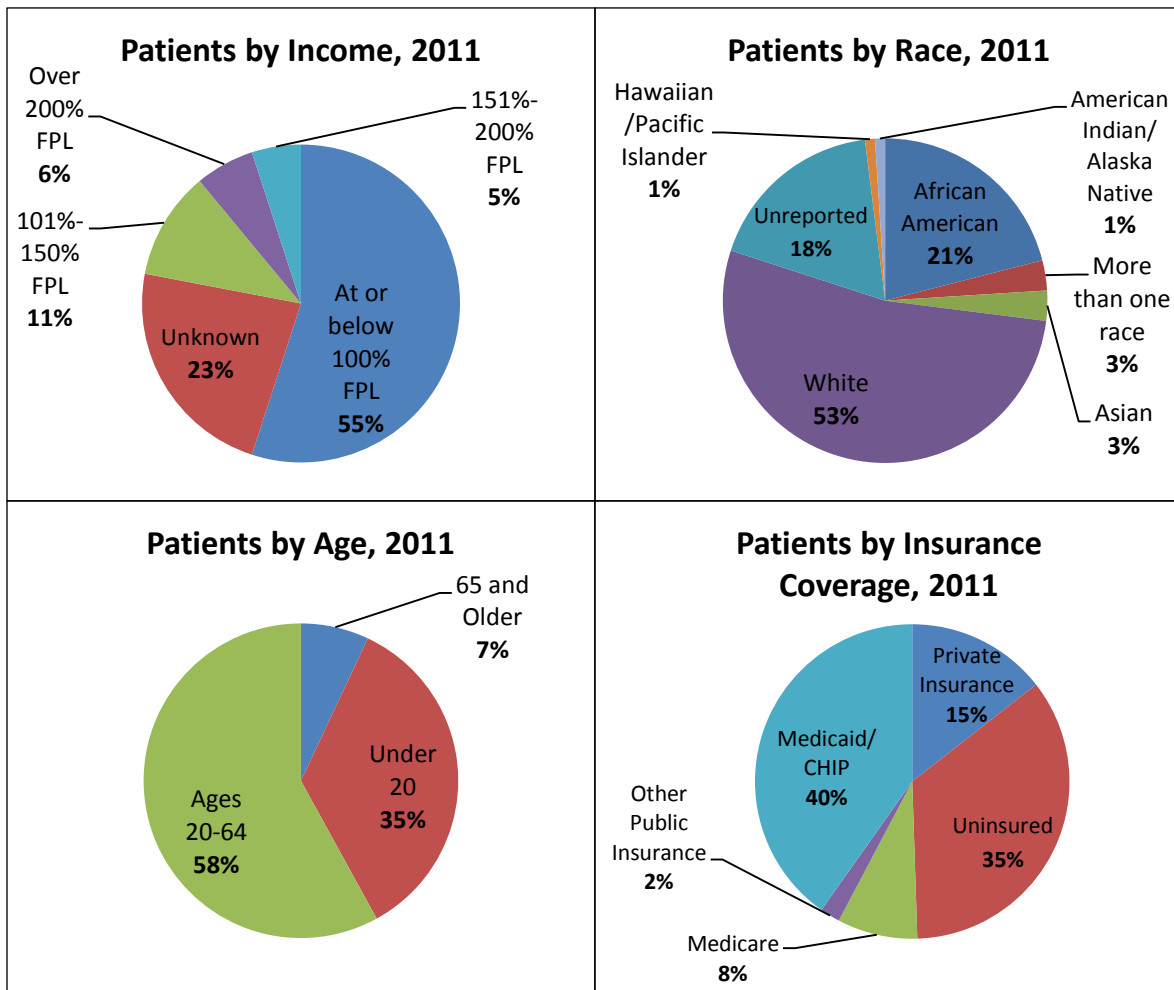
When creating the Health Center Program, Congress also authorized the special Medicare and Medicaid payments for clinics that operate in compliance with the requirements of the Health Center Program but do not receive grant funding under Section 330 of the Public Health Service Act. These clinics are commonly known as FQHC look-alikes. Although these look-alike clinics do not receive Section 330 grant funding, they meet the requirements for receiving such a grant by, for example, being located in an MUA/MUP area and receive a formal designation by the secretary of HHS, based on recommendations from the HRSA. Unlike the Section 330 funding application process, the look-alike status application process is non-competitive.

In addition to receiving enhanced payments from Medicare and Medicaid, look-alike clinics receive many of the same direct benefits as health centers, including: 340B Drug Pricing Discounts for pharmaceutical products, access to onsite HHS out-stationed eligibility workers, access to the VFC program, and access to National Health Service Corps placements to provide additional health care provider staff.<sup>52</sup>

### Patient Population

By nature of where health centers must be located to qualify as a health center (in medically underserved areas or serve medically underserved populations), health center patients are disproportionately low income, uninsured or publicly insured, and of a racial/ethnic minority, compared to the general population.<sup>53</sup>

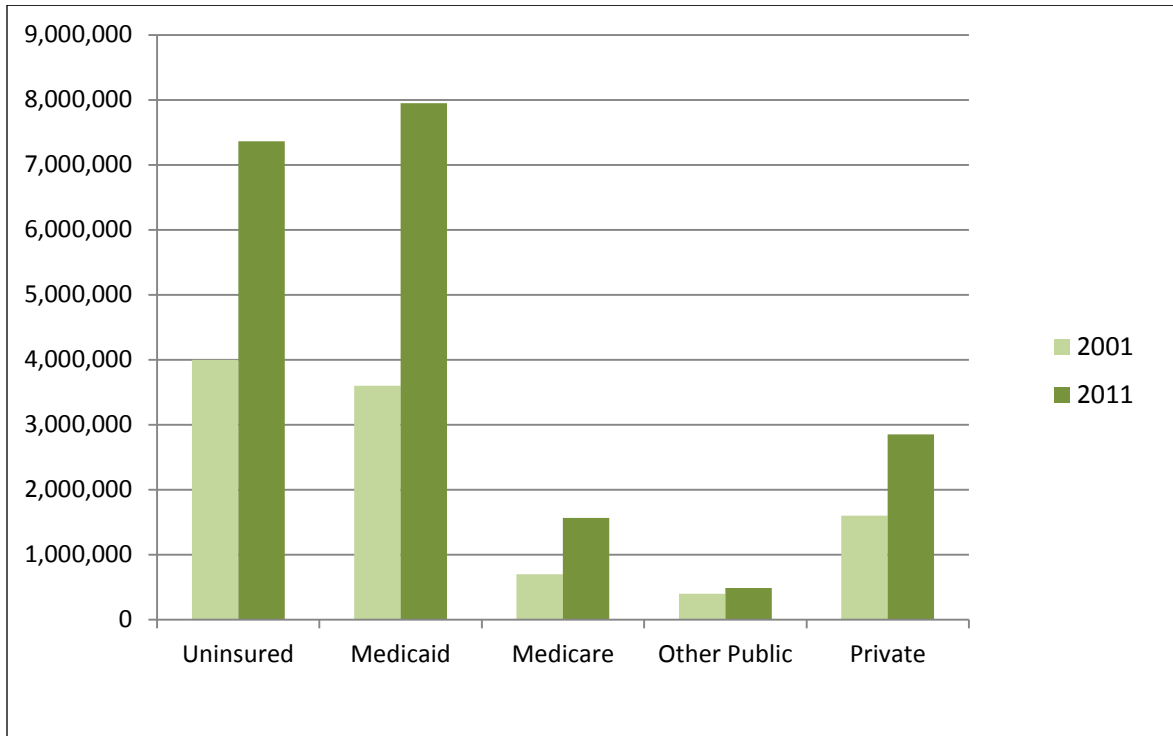
Figure 3: Patients by Income, Race, Age and Insurance Status, 2011



Source: UDS 2011

Note: Percentages may not add up to 100 due to rounding.

Figure 4: Change in Patients Served by Coverage Type, 2001 and 2011



Source: UDS

In 2010, health centers served approximately 15 percent of the total U.S. uninsured population, 15.5 percent of Medicaid enrollees, and 6.4 percent of the total U.S. population (Figure 5).<sup>54,55</sup>

Figure 5: Patients Served by FQHCs Relative to Total U.S. Population, 2010

	Number served by FQHCs	Total	Percent served by FQHCs
<b>Uninsured</b>	7,308,644	49,903,900	14.65%
<b>Medicaid*</b>	7,505,047	48,400,200	15.51%
<b>Medicare*</b>	1,461,485	38,128,000	3.83%
<b>Other Public</b>	495,108	3,942,500	12.56%
<b>Private</b>	2,699,183	164,816,500	1.64%
<b>Total</b>	19,469,467	305,191,100	6.38%

Source: UDS 2010 and Kaiser Health Insurance Coverage of Total Population, 2010

\*Dual eligibles included in Medicaid figures

## FQHCs: The Michigan Environment

Michigan has 35 health centers, 30 of which are FQHCs, 3 are FQHC look-alikes, and 2 are both an FQHC and an FQHC look-alike (Figures 6 and 7), providing care to more than 600,000 patients at 216 delivery sites.<sup>56</sup> In 2010, Michigan had fewer than two FQHC delivery sites per 10,000 uninsured individuals, ranking Michigan 37th in the nation on FQHC service delivery sites per 10,000 uninsured; in 2008,

Michigan was ranked 31st. The state with the highest ratio of delivery sites in 2010 was Alaska, with 13.2 per 10,000 uninsured. Nevada had the lowest ratio at 0.6 delivery sites per 10,000 uninsured individuals.<sup>57</sup> This ranking does not account for funding from the Affordable Care Act's \$11 billion Health Center Trust Fund, which did not go into effect until fiscal year (FY) 2011.

Figure 6: FQHCs, by Location

FQHC	Location (Based on administrative site)
Advantage Health	Detroit
Alcona Health Centers	Lincoln
Baldwin Family Health Care	Baldwin
Bay Mills Health Center	Brimley
Cassopolis Family Clinic	Cassopolis
Center for Family Health	Jackson
Cherry Street Health Services	Grand Rapids
Community Health and Social Services Center	Detroit
Covenant Community Care	Detroit
Detroit Community Health Connection	Detroit
Downriver Community Services	Algonac
East Jordan Family Health Center	East Jordan
Family Health Center, Inc	Kalamazoo
Family Health Center of Battle Creek	Battle Creek
Family Medical Center of Michigan	Carleton
Genesee Community Health Centers	Flint
Hackley Community Care Center	Muskegon Heights
Hamilton Community Health Network	Flint
*Health Delivery, Inc	Saginaw
*Ingham County Community Health Centers	Lansing
InterCare Community Health Network	Bangor
MidMichigan Health Services	Houghton Lake
Muskegon Health Care	Muskegon Heights
Northwest Michigan Health Services	Traverse City
Oakland Primary Health Services	Pontiac
Saint Mary's Health Care Community Health Centers	Grand Rapids
Sterling Area Health Center	Sterling
Thunder Bay Community Health Services	Hillman
Upper Peninsula Association of Rural Health Services	Marquette
Wayne County Health and Human Services	Hamtramck
The Wellness Plan Medical Centers	Detroit
Western Wayne Family Health Centers	Inkster

Source: Michigan Primary Care Association

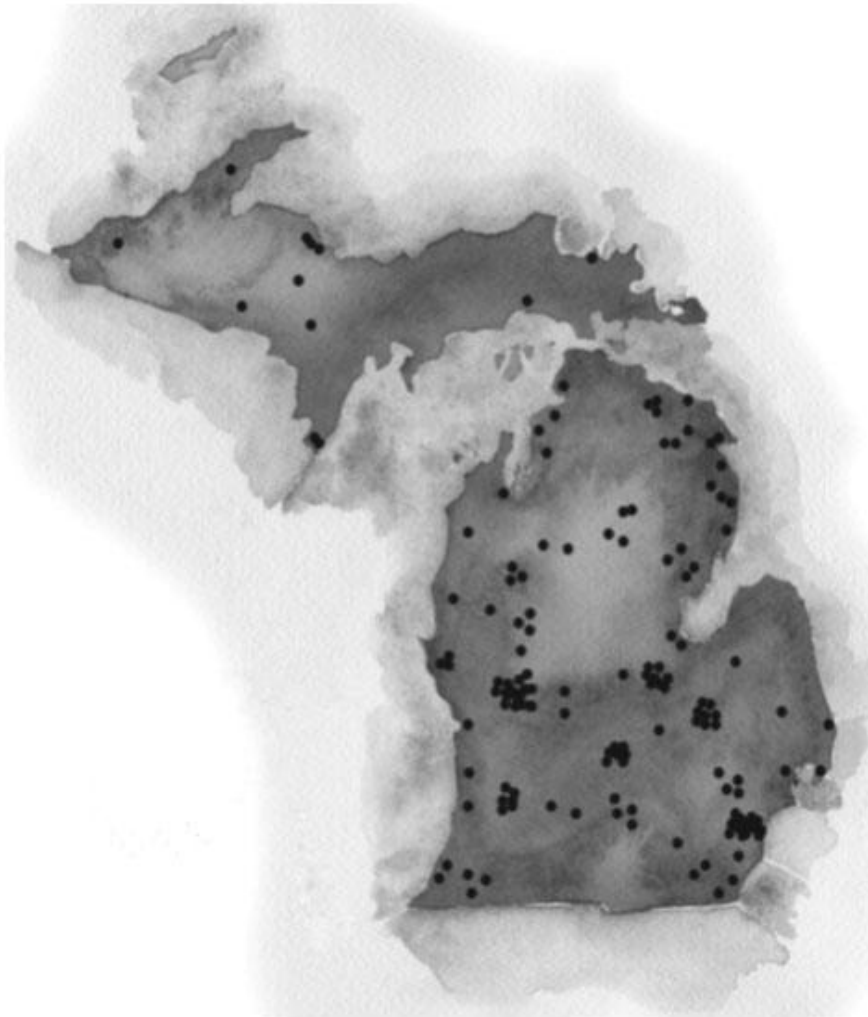
\*Dual status health centers— health centers that receive grant funding under section 330 for sites in the grant’s approved scope of project and simultaneously operate other sites under an FQHC look-alike designation.

Figure 7: FQHC Look-alikes, by Location

FQHC Look-Alikes	Location
Health Centers Detroit Medical Group	Detroit
Upper Great Lakes Family Health Center	Gwinn
Oakland Integrated Health Network	Pontiac

Source: Michigan Primary Care Association

Figure 8: Michigan health center sites, 2013



Source: Michigan Primary Care Association, 2013

In 2010, FQHCs provided health care for approximately 5.5 percent of all Michigan residents, 14.5 percent of the state’s uninsured, and 14.5 percent of Michigan Medicaid beneficiaries.<sup>58</sup>

Figure 9: Patients Served by FQHCs Relative to Total Michigan Population, 2010

	Number served by FQHCs	Total	Percent served by FQHCs
Uninsured	184,890	1,272,600	14.53%
Medicaid <sup>1</sup>	225,356	1,550,400	14.54%
Medicare <sup>1</sup>	49,134	1,368,400	3.60%
Private	75,786	5,555,400	1.36%
Total	537,847 <sup>2</sup>	9,746,800	5.52%

Source: UDS 2010 and Kaiser Health Insurance Coverage of Total Population, 2010

<sup>1</sup>Dual eligibles included in Medicaid figures

<sup>2</sup>Total includes other publicly insured (2,681)

Due to the economic environment, Michigan experienced about a 60 percent increase in the state’s Medicaid population from 1999 to 2010, rising from approximately 1.1 million recipients to 1.8 million, respectively.<sup>59</sup> Not surprisingly, the number of uninsured and Medicaid patients served by Michigan FQHCs increased approximately 127 percent, from 180,596 in 2001 to 410,145 in 2010.<sup>60</sup>

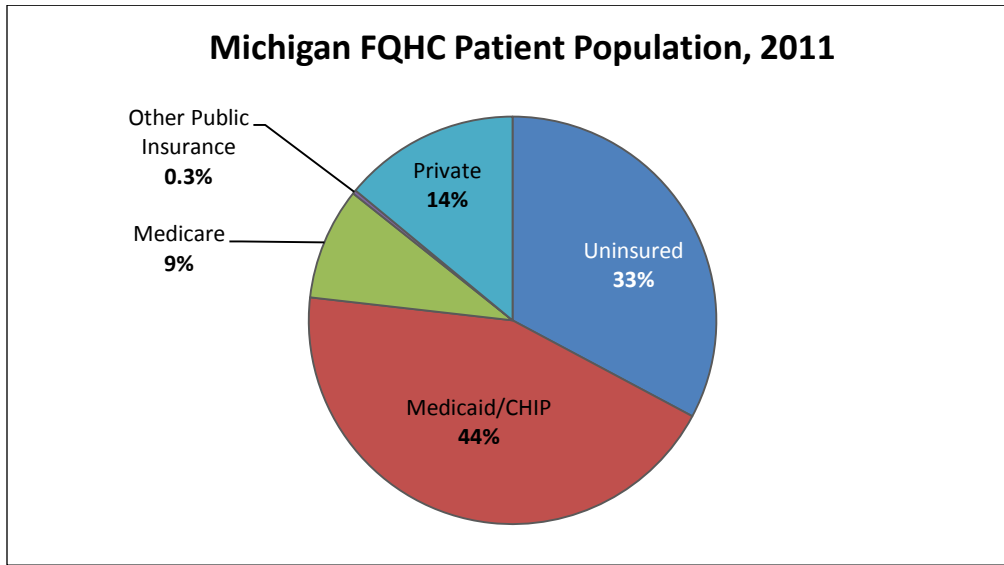
## Detroit

Detroit is the country’s poorest large city, with 34.5 percent of residents living in poverty.<sup>61</sup> Nearly all of Detroit has been designated as a MUA/MUP. There are currently 22 health center sites in the Detroit area<sup>62</sup>, up from 16 in 2007.<sup>63</sup> Some health centers in Detroit serve up to 18 percent of all residents who share its zip code.<sup>64</sup> Three Detroit-area FQHCs report that more than 70 percent of their patient population is uninsured.<sup>65</sup>

## Michigan’s Patient Population

In 2011, most (about 92 percent) of Michigan’s 546,245 FQHC patients had incomes up to 200 percent of the federal poverty level, with the largest group (about 44 percent) covered by Medicaid, one-third (about 32.8 percent) uninsured, and the remainder covered by private insurance, Medicare or other public insurance. Michigan FQHCs generally have a high percentage of Medicaid-insured patients. However, Medicaid enrollment varies throughout the state and therefore affects the patient make up of FQHCs throughout the state.<sup>66</sup>

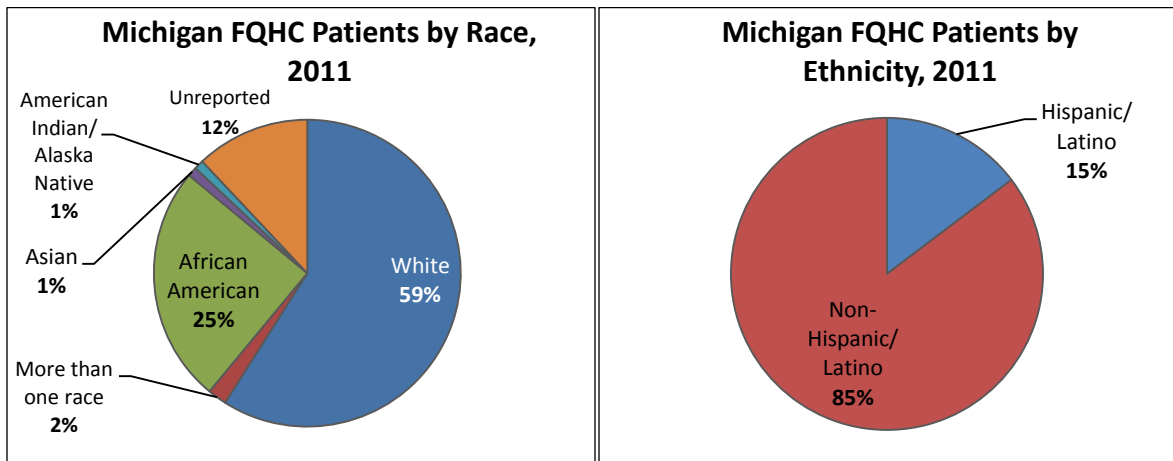
Figure 10: Michigan FQHC Patient Population, by Coverage Type, 2011



Source: UDS 2011

Michigan’s FQHC patient population is diverse. Most (59 percent) are white, with one-fourth African American. Fifteen percent of Michigan’s FQHC patients are Hispanic/Latino, and 10.4 percent of patients identified as being best served in a language other than English (considerably less than the 24 percent reported nationally).<sup>67</sup>

Figure 11: Michigan FQHC Patient Population, by Race and Ethnicity, 2011



Source: UDS 2011

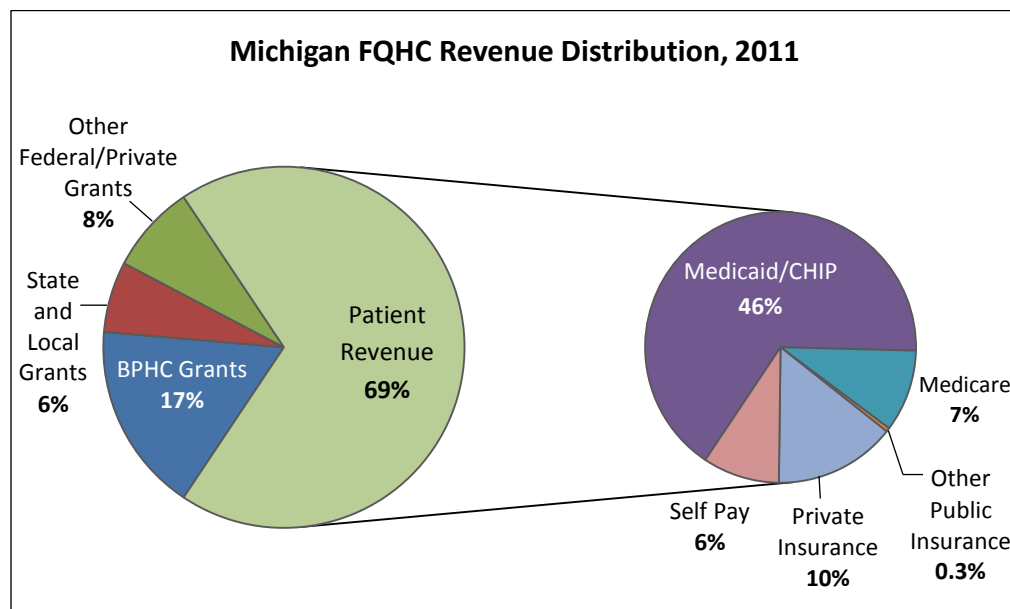
### Michigan FQHC Financing and Reimbursement

Michigan FQHCs are funded similarly to the financing and reimbursement methodology described in the national environment. However, there are notable differences in the distribution of funding sources due to variations in patient demographics and payment methodology. Patient revenue—paid by publicly



financed and private third-party payors and patient out-of-pocket expenditures—accounts for about 69 percent of Michigan FQHC funding, compared to 61 percent nationally.

Figure 12: Michigan FQHC Revenue Distribution, 2011



Source: UDS 2011

### Medicaid Reimbursement

Medicaid accounts for 44 percent of total health center patients' insurance in Michigan (5 percent higher than the national health center patient average).<sup>68</sup>

Michigan FQHCs receive Medicaid reimbursement using an alternative payment methodology (APM) agreed upon by the Michigan Department of Community Health and the FQHCs via a memorandum of agreement (MOA). Michigan's APM is a prospective payment amount (PPA) based on 1999/2000 reasonable costs; the PPA is adjusted annually based on the Medicare Economic Index and may also be adjusted to reflect changes in the scope of services rendered by an FQHC. FQHCs receive quarterly payments, which may include Medicaid wrap-around payments that make up the difference between the Medicaid Managed Care fee-for-service reimbursement and the APM rate.<sup>69</sup> The Medicaid Managed Care reimbursement rate for FQHCs is a negotiated amount that must be equal to or above that of other rates of contracted providers.

In 2011, all Michigan FQHC Medicaid payment fell between \$114.31 and \$157.57 per patient visit (the 2011 Medicaid APM reimbursement cap). The patient visit encompasses all health center primary care services.<sup>70</sup> In 2010, the average cost per total patient visit in Michigan was \$156.85.<sup>71</sup>

### Grants and Contracts

In 2011, Michigan's 29 FQHCs received a total of \$111.8 million in revenue from grants and contracts (including \$7 million from ACA Capital Development Grants and \$16.3 million from the American

Recovery and Reinvestment Act). This allowed FQHCs to increase patient capacity by 8,400 patients from 2010, upgrade and expand health centers, increase offered services, increase patient capacity and improve health information technology. Michigan received \$83.4 million in federal funding, an 83.4 percent increase from 2008, and the 10th highest state allotment (Figure 10).<sup>72</sup>

Figure 13: FQHC Federal Funding by State, 2008 and 2011

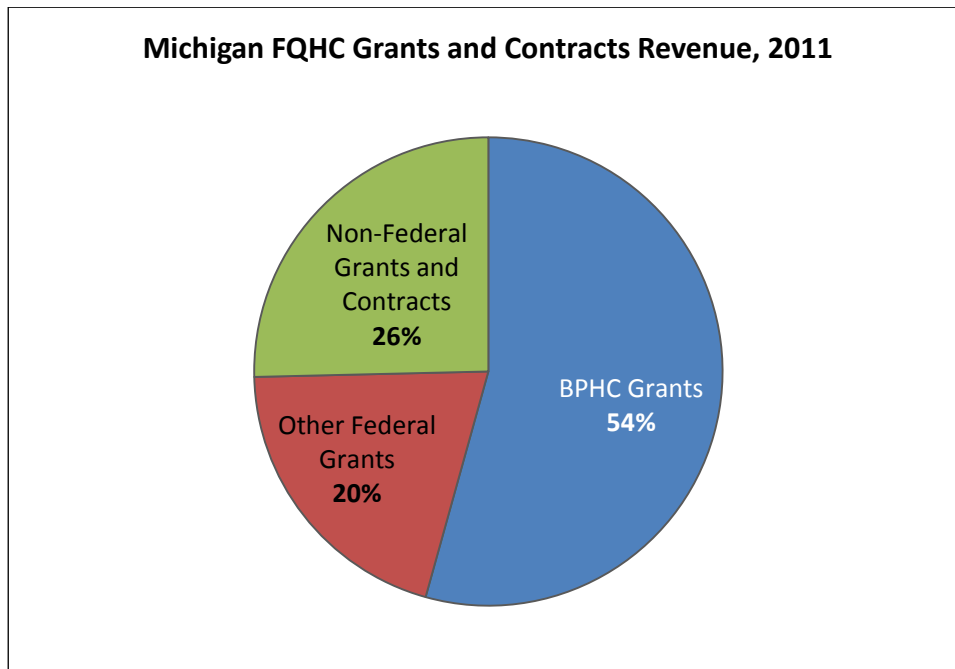
Rank (2011)	State	2008 Funding	2011 Funding	% Change
1	California	225,967,523	405,336,111	79.4%
2	Texas	120,982,578	206,282,902	70.5%
3	New York	122,843,414	185,717,223	51.2%
4	Illinois	102,710,602	158,142,274	54.0%
5	Florida	98,960,896	150,352,360	51.9%
6	Massachusetts	78,640,440	133,475,822	69.7%
7	Pennsylvania	53,704,462	101,575,761	89.1%
8	Washington	57,711,496	95,661,338	65.8%
9	Ohio	46,933,140	93,768,173	99.8%
10	Michigan	45,475,906	83,417,930	83.4%
11	North Carolina	56,427,396	78,681,463	39.4%
12	Colorado	56,236,656	72,657,608	29.2%
13	Oregon	43,677,111	69,938,369	60.1%
14	Alabama	43,652,853	69,703,079	59.7%
15	Arizona	39,637,689	69,292,437	74.8%
16	Missouri	46,577,271	68,286,718	46.6%
17	Georgia	44,813,909	68,105,069	52.0%
18	South Carolina	49,512,535	61,990,518	25.2%
19	Connecticut	23,995,227	61,274,157	155.4%
20	New Mexico	41,356,995	60,529,387	46.4%
21	Mississippi	43,185,804	59,296,232	37.3%
22	New Jersey	36,291,537	56,384,938	55.4%
23	Virginia	39,691,057	54,800,824	38.1%
24	Alaska	37,637,841	51,252,543	36.2%
25	Tennessee	35,542,008	51,138,192	43.9%
26	Louisiana	32,104,142	50,511,986	57.3%
27	Indiana	22,666,044	49,039,223	116.4%
28	West Virginia	26,337,629	43,335,166	64.5%
29	Kentucky	26,807,268	40,867,270	52.4%
30	Oklahoma	17,432,165	40,555,536	132.6%
31	Maryland	31,821,710	35,790,451	12.5%
32	Arkansas	25,780,693	32,243,310	25.1%

<b>33</b>	Maine	13,403,753	32,064,951	139.2%
<b>34</b>	Iowa	19,423,084	31,507,291	62.2%
<b>35</b>	Wisconsin	20,051,969	28,686,423	43.1%
<b>36</b>	Minnesota	20,271,884	28,250,900	39.4%
<b>37</b>	Idaho	16,368,457	25,918,067	58.3%
<b>38</b>	District of Columbia	14,284,697	24,807,320	73.7%
<b>39</b>	Hawaii	16,114,497	22,942,262	42.4%
<b>40</b>	Montana	16,776,442	22,012,570	31.2%
<b>41</b>	Vermont	6,037,832	20,987,518	247.6%
<b>42</b>	New Hampshire	7,740,301	20,852,557	169.4%
<b>43</b>	Utah	13,601,689	19,508,458	43.4%
<b>44</b>	Rhode Island	12,152,477	19,318,305	59.0%
<b>45</b>	Kansas	10,737,969	17,471,248	62.7%
<b>46</b>	Nebraska	7,680,455	11,612,092	51.2%
<b>47</b>	South Dakota	8,001,936	10,476,593	30.9%
<b>48</b>	Delaware	6,164,684	8,426,309	36.7%
<b>49</b>	North Dakota	3,582,218	7,445,515	107.8%
<b>50</b>	Wyoming	4,349,040	6,913,292	59.0%
<b>51</b>	Nevada	N/A	N/A	N/A

Source: UDS 2008 and 2011

Note: Includes BPHC and all other federal funding; 2011 includes ACA funding

Figure 14: Michigan FQHC Revenue from Grants and Contracts, 2011



Source: UDS 2011

### Michigan FQHC Cost Outcomes

A 2006 cost analysis of Medicaid fee-for-service (FFS) claims, including those from FFS Managed Care Organizations (MCOs), and supplemental payments in Michigan, was conducted by the Institute for Health Care Studies at Michigan State University and commissioned by the Michigan Primary Care Association. Researchers found that FQHCs produced lower per member per month (PMPM) costs and lower average patient utilization of services than non-FQHC settings in Michigan. The analysis included 4,713 beneficiaries in the FQHC user group and 33,388 non-FQHC user beneficiaries. Individuals who were dually eligible for Medicare and Medicaid or those enrolled in a Medicaid HMO were not included in the study.<sup>73</sup> Specifically, the study found:

- Non-disabled Medicaid beneficiaries, age 18-64, had lower average utilization per beneficiary of office visits, emergency department visits, outpatient hospital, inpatient hospital, and pharmacy than non-FQHC FFS beneficiaries.
- FQHC user PMPM costs were lower than non-FQHC users, for non-disabled Medicaid beneficiaries, age 18-64, in all service categories but office visits.<sup>74</sup> PMPM costs for office visits were 2.6 times higher for FQHC uses than non-FQHC uses because of the enhanced payments that FQHCs are allotted (\$26 vs. \$10, respectively).<sup>75</sup>

According to the study, Michigan’s health centers saved Michigan’s Medicaid program \$44.87 PMPM overall, relative to Medicaid FFS beneficiaries in non-FQHC settings.

## FQHCs and Health Care Reform

FQHCs are expected to play a greater role in the future of health care in Michigan and across the country. Research by Rosenbaum, Shin, and others has shown that in states with broad health care coverage, the safety net continues to play a critical role in enrolling and serving the newly insured after their coverage expansion was enacted.<sup>76</sup>

The ACA provided funding to and renewed focus on the role that FQHCs will play as the anticipated 32 million people gain health insurance. Specifically:

- Section (§)10503 allocated an \$11 billion health center fund to be used between FY2011-FY2015 for the operation, expansion and construction of health centers across the United States.<sup>77</sup> Of the \$11 billion, \$1.5 billion is allocated to expand the National Health Service Corps by an estimated 15,000 providers by 2015.<sup>78</sup>
- §5508 allows FQHCs to serve as health center-based residency programs for medical and dental students.
- §5601 permanently authorizes the Health Center Program (i.e., FQHC status). It provides the authorization for appropriations for health center grants in subsequent years (post- FY2015) by escalating funding levels under Section 330 based on changes in medical costs per patient plus 1 percentage point and changes in the number of patients served plus 1 percentage point.<sup>79</sup>
- §2001 provides a Medicaid expansion provision to include individuals with incomes up to 138 percent of the federal poverty level (138 percent with a five percent income disregard). This provision is state optional. If Michigan implements the expansion, health centers in the state are projected to serve 1.1 million new patients by 2019.<sup>80</sup>
- §5502 removes Medicare payment caps for FQHCs starting in 2014 and revises the Medicare payment system for health centers to improve payment levels by 2014 to a prospective payment rate system that must equal 100 percent of health centers' costs. It also expanded the number of Medicare-covered preventative services to be eligible for FQHC reimbursement, effective January 2011.<sup>81</sup>
- §3021 established the Center for Medicare and Medicaid Innovation, which implemented a three-year FQHC demonstration project in November 2011, designed to improve quality of care, promote better health and lower costs; 18 Michigan health center sites are among the 500 national sites involved in the FQHC Advanced Primary Care Practice demonstration.<sup>82,83</sup> The new center developed another three-year demonstration called the Multi-Payer Advanced Primary Care Practice Demonstration; it is designed to improve the delivery of primary care and reduce costs through the use of patient-centered medical homes (PCMHs) and chronic disease management.<sup>84</sup> Michigan was one of the eight states chosen to participate in the demonstration, which they have named the Michigan Primary Care Transformation Project (MiPCT); eight health center sites are participating in MiPCT.
- §1301 establishes qualified health plans (QHPs) sold through state health insurance exchanges.
- §1311 requires QHPs to contract with health centers and other safety net providers.<sup>85</sup>

- §10104 states that QHPs must pay FQHCs equal to or more than Medicaid reimbursement rates.
- CMS final rules on the Medicare Shared Savings Program (§3002) permit FQHC participation or formation of accountable care organizations (ACOs). ACOs are intended to increase coordination of patient care, improve quality of care and reduce barriers in accessing appropriate care for patients.<sup>86</sup>

## Going Forward – Challenges Facing Health Centers

Health centers face a number of challenges. Long-term sustainability, clinical staff shortages, lack of access to specialty care, insufficient collaboration, and inadequate access to pharmaceuticals all pose challenges to health centers.

### Sustainability

A key challenge facing health centers is their need to become self-sufficient for long-term sustainability. Health centers have already experienced a significant funding retrenchment. In 2011, the federal government cut the appropriation for health centers by 27 percent (from \$2.2 billion to \$1.6 billion). Due to the appropriation cut, a substantial amount of the FY2011 ACA funding had to be diverted to maintain existing health center operations. The diversion of ACA funds meant that the HRSA, which manages the health center program, could only award 67 of the more than 800 “new access point” (NAP) and “expanded services” grant applications.<sup>87</sup> This was the first cut in federal health center funding since 1982.<sup>88</sup>

The ACA’s optional Medicaid expansion also excludes undocumented immigrants from coverage and it is expected that this group will make up approximately one-third of the population (depending upon the number of states that opt out of the Medicaid expansion) that will remain uninsured. Some FQHC leaders worry that FQHCs could lose funding if it is perceived that federal dollars are supporting care for undocumented immigrants, further confounding concerns about financial sustainability.<sup>89</sup>

Many FQHCs have developed strategies for financial growth by increasing the number of insured patients, working with Medicaid managed care, improving billing and collection practices and becoming more operationally efficient. FQHCs have focused on increasing the number of Medicaid patients they serve because Medicaid is generally their best payer. As such, many FQHCs have devoted resources to help uninsured patients apply for public coverage and some have developed outreach programs to attract privately insured patients.<sup>90</sup>

### Clinical Staff Shortages

The National Association of Community Health Centers, Inc., estimated that prior to the ACA, health centers need as many as 19,500 primary care physicians and up to 14,400 nurses to serve their goal of

more than 30 million patients by 2015; health centers are now expected to accommodate 40 million patients.<sup>91,92</sup> Issues such as compensation and physician satisfaction are barriers to clinical recruitment at FQHCs.

### **Medical**

A study by Roger Rosenblatt, et al., published in 2006, found that 13 percent of family medicine, 21 percent of obstetrician/gynecologist, and 23 percent of physiatrist positions were vacant among FQHCs nationally.<sup>93</sup> The study identified six perceived barriers to recruitment of physicians and nurses to rural and urban health centers: compensation, excessive workload, poor-quality schools, lack of housing, lack of cultural activities, and lack of spousal employment. Compensation was the biggest perceived barrier for recruitment of physicians and nurses at urban FQHCs, as well as for nurses at rural FQHCs. Lack of spousal employment was the biggest perceived barrier for rural physicians.<sup>94</sup>

### **Physician Satisfaction**

A recent study by Allison Cole, et al., found that physicians practicing in health centers are less satisfied with their employer than physicians not employed by a health center, irrespective of pay. While the researchers did not definitively know why employer satisfaction was lower, they speculated, based on existing research, that it may be due to issues regarding autonomy and work control. Lower satisfaction of physicians in health centers could potentially impact the recruitment and retention of physicians as the reliance on health centers for primary care increases.<sup>95</sup>

### **Dental**

FQHC patient visits for dental services tripled between 2000 and 2010 (to 9.2 million).<sup>96</sup> FQHCs have an insufficient number of sites and inadequate capacity among existing sites to meet the increased patient demand, especially since they are a key dental service provider for Medicaid patients.<sup>97</sup> Dental provider shortages are also a challenge. There are currently 4,406 dental health professional shortage areas (HPSAs), including 150 dental HPSAs in Michigan, affecting 43.8 million people. As of August 2012, HRSA identified a need for 8,806 dental providers to address the current HPSAs.<sup>98</sup>

## **Specialty Care and Partnerships**

A persistent issue among health centers is the difficulty they face trying to secure specialty care for their patients. Health centers have significantly more difficulty referring their patients, which are largely uninsured and Medicaid insured, than non-health center primary care providers. Lack of access to specialists is attributed to shortages in specialists and exacerbated by refusal to accept Medicaid or uninsured patients.<sup>99</sup>

One way to reduce this barrier for health centers is to partner with hospitals, according to a 2010 report by The Commonwealth Fund. The study found that health centers that are closely affiliated with hospitals are 10 percent less likely to have difficulty securing specialty or subspecialty referrals for their Medicaid patients than health centers without a hospital affiliation (from 79 percent to 69 percent); 11

percent less likely to have difficulty with their uninsured patients (from 91 percent to 80 percent); and 14 percent less likely to have difficulty with their Medicare patient (from 60 percent to 46 percent).<sup>100</sup>

## Collaboration

Collaboration between providers and FQHCs has the ability to improve access and quality of care. A study by the Office of Rural Health Policy of HRSA found that critical access hospitals (CAH) and FQHCs experienced considerable financial gain as a direct result of collaborative agreements.<sup>101</sup> Hospitals often struggle with unremunerated care from uninsured patients who inappropriately use emergency departments for primary care. Partnering with a health center could provide appropriate primary care for many of these patients, thus enabling hospitals to reduce overall costs.

While hospitals and FQHCs prove to gain from a collaborative relationship, a study commissioned by HRSA's Bureau of Primary Health Care and the National Rural Health Association found that only 15 percent of the CAH respondents had a collaborative agreement with a health center. The study identified several barriers to partnership: lack of awareness of health centers in the community, competition with health centers (CAHs also receive enhanced Medicaid payments), and lack of funding for such collaboration, among others.<sup>102</sup> Health centers have seen a particular resistance from hospitals and other providers in rural communities as a result of perceived competition.<sup>103</sup>

Perceived competition between community hospitals and FQHCs creates problems in establishing and maintaining collaborative partnerships and often generates and perpetuates barriers to specialty referrals needed for FQHC patients.

One caveat to hospital collaboration is that the relationship must be mutually beneficial to help the sustainability of FQHCs. A study on Michigan's safety net providers indicated that some partnerships between FQHCs and hospitals have been largely weighted in favor of hospitals.<sup>104</sup>

## Pharmaceutical Services

Although FQHCs can take advantage of funds provided by 340B drug pricing, some lack pharmacy programs. A study of safety net providers found that access to pharmaceuticals presented difficulties and unnecessary duplication of services as patients seen by providers without a pharmacy program were often advised to schedule a repeat appointment with a provider who had access to a pharmacy program. Several providers reported relying on pharmaceutical samples and had limited supply of medications.<sup>105</sup>

## Conclusion

Health centers have been an integral part of the nation's safety net for more than four decades. They have garnered bipartisan support and secured an unprecedented amount of funding from the ACA;



however, they still face many challenges. Financial sustainability, provider recruitment, collaboration with hospitals and specialists, and adapting to an estimated 20 million new patients over the next three years are among the biggest.

The ACA is transforming the health care landscape and, with it, the role of health centers in Michigan and across the country. State decisions on whether to implement Medicaid expansions will affect health center patient capacity and growth; changes in Medicare payments may help make health centers more financially sustainable; and an emphasis on coordination of care is anticipated to improve cost and quality outcomes. The ACA's investment in FQHCs and FQHC look-alikes positions them to be the bedrock of comprehensive and cost-effective quality health care for the insured and uninsured alike.

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