American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Federally Qualified Health Centers

an Information Paper

Developed by Members of the

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The Federally Qualified Health Center (FQHC) designation was originally created by the Centers for Medicare and Medicaid Services (CMS) under Section 330 of the Public Health Service Act to provide critical primary care access and services to the poor and underserved. The latter category includes potentially both Medicaid and Medicare but was not widely seen as a solution for increasing access for the uninsured. The Patient Protection and Affordable Care Act (PPACA) includes within its provisions the intention and funding to dramatically expand the number and scope of these facilities over the next five years. With declining Medicaid provider participation, the number of locations qualifying as underserved has significantly expanded. FQHCs have also been expanding beyond traditional primary care services into other healthcare areas such as dental and psychiatric services. A 2009 study done at the Morehouse School of Medicine in conjunction with the National Association of Community Health Centers[1] demonstrated significant emergency department (ED) Medicaid volume reductions in counties having an FQHC. The FQHC must provide at least the following services:

- Primary care
- Diagnostic x-ray and lab
- Health screenings and immunizations
- Emergency medical services (patient intake and referral; after-hours on-call)
- OB/GYN services, including well child services
- Preventive dental hygiene care
- Pharmacy services
- Mental health, substance abuse and specialty services via referral

And also:

- Case management and counseling
- Follow-up and discharge planning
- Support for Medicaid enrollment
- Health education
- Transportation, translation and outreach

It must also maintain a staffing level sufficient to see 4,200-6,000 visits per year per provider full-time equivalent.

Though targeted most specifically at uninsured and Medicaid primary care patients, the FQHC must serve all patients regardless of their ability to pay and must utilize a sliding scale fee schedule. It is important to note that FQHC's do not receive any direct reimbursement for uninsured encounters and must create a sustainable operating budget often with a panel comprised of between 35% and as much as 70% uninsured patients.

The competitive advantages of an FQHC are significant. Among others, they include:

- Up to $650,000 in annual Section 330 grant funding
- Enhanced Medicare and Medicaid reimbursement (approaching cost-based reimbursement in many cases, especially for Medicaid)
- Provider medical malpractice coverage through the Federal Tort Claims Act
- Eligibility to purchase drugs for patients at reduced cost through the federal 340B Drug Pricing Program
- Access to National Health Service Corps personnel and J-1 visa holders for recruiting purposes
- Eligibility for various other federal grants and programs

- Access to the federal Vaccines for Children (VFC) program

The FQHC must be organized and governed by a non-profit community controlled board where at least 51% of the board is comprised of "active, registered clients of the health center." The FQHC board must have at least 9 but no more than 25 board members and it can be owned by a 501(c)3 non-profit hospital as long as the governance rules are met.

The FQHC can be located in a separate building across town or across the parking lot from the hospital ED, or even across the hall from the ED within the hospital. Any physician can seek to contract with the FQHC to provide physician staffing.

The procedure for establishing an FQHC varies by state but is generally started by submitting a letter of interest to the federal Bureau of Primary Health Care. State departments of health also typically have resources to assist in making application.

The FQHC may be a vehicle to decompress ED primary care services volume. The cost advantages along with the enhanced Medicaid and Medicare funding enable patients to be seen in the FQHC much more cost effectively than in the ED while still paying a competitive provider reimbursement rate. As ED Medicaid volumes increase with expanded coverage under the PPACA, an FQHC may be worth exploring.

1. Rust G, Baltrus P, Ye J, et al. Presence of a community health center and uninsured emergency department visit rates in rural counties. *J Rural Health.* 2009;25(1):8-16. http://onlinelibrary.wiley.com/doi/10.1111/j.1748-0361.2009.00193.x/pdf

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