

CRS Report for Congress

Federal Health Centers Program

Updated June 13, 2008

Barbara English
Information Research Specialist
Knowledge Services Group



Prepared for Members and
Committees of Congress

Federal Health Centers Program

Summary

Health centers were first funded by the federal government as part of the War on Poverty in the mid-1960s. When the Economic Opportunity Act (P.L. 88-452) was phased out in the 1970s, about 100 neighborhood health centers were transferred to the Public Health Service and funded as community health centers beginning in 1975.

Health centers under Section 330 of the Public Health Service Act (P.L. 87-838) include community health centers, migrant health centers, health centers for the homeless, and health centers for residents of public housing. In CY2006, there were 6,208 delivery sites serving more than 15 million clients with a total of 1,002 grantees.¹ The clients are predominantly uninsured, underinsured, or are without access to health care providers.

The Health Centers Consolidation Act of 1996 (P.L. 104-299) consolidated funding for community health centers (CHCs) with similar programs in Section 330. Under this authority, health centers' grants provide largely primary health care services to medically underserved populations. The act expired September 30, 2006. Two major Reauthorization bills were introduced in the 110th Congress: S. 901, the Health Care Safety Net Act (introduced March 15, 2007) was passed by the Senate Health Education and Labor Committee on November 14, 2007, and a written report was filed on March 12, 2008; and H.R. 1343, the Health Centers Renewal Act of 2007 (introduced March 6, 2007), was approved by the House Subcommittee on Health on April 23, 2008.

The Health Centers Program was the focus of a multi-year initiative by President Bush to strengthen the health care safety net. Its goal was to establish new health centers in the poorest counties in the nation. In FY2008, the final year of the President's initiative, an additional 340 sites (220 new sites and 120 expansions) were funded and total enrollment is expected to reach more than 16 million patients.²

The President requested \$1.988 billion for FY2008 for CHCs. The Consolidated Appropriations Act for 2008 (P.L. 110-161) provided a final amount of \$2.065 billion.³ For FY2009, the President requested \$2.092 billion, a \$27 million increase. This report⁴ will be updated periodically to reflect legislative activity.

¹ *U.S. Health Center Fact Sheet*, National Association of Community Health Centers, 2007.

² U.S. Department of Health and Human Services, *Budget in Brief*, FY2008, p. 20.

³ The Continuing Resolution, H.J.Res. 20, passed on January 31, 2007, by the House provided \$1.765 billion for FY2007 funding. The Resolution passed the Senate February 14, 2007, and became P.L. 110-5. It provided a final amount of \$1.988 billion for FY2007. U.S. Department of Health and Human Services, *Budget in Brief*, FY2009, p. 18.

⁴ This report was originally written by former CRS Information Research Specialist Sharon Kearney Coleman.

Contents

Introduction	1
Consolidated Health Centers Programs	3
Grant Amounts	3
The Health Centers Patient Profile	3
PHS Act Section 330 Health Centers	4
Community Health Centers	4
Required Services	4
Migrant Health Centers	5
Health Centers for the Homeless	6
Health Centers for Residents of Public Housing	7
Native Hawaiian Health Care	7
Federally Qualified Health Centers	7
FQHC Look-Alikes	8
Tribal FQHCs	8
Rural Health Clinics	8
Medicare and Medicaid Payments	10
Medicare Payments	10
Medicaid Payments	11
Funding for Consolidated Health Centers Program	12
Other Federal Support	14
Non-Federal Assistance	14
Websites on Community Health Centers	15

List of Tables

Table 1. Limited Comparison of Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs)	9
Table 2. Medicare Payment Update for FQHCs and RHCs Effective January 1, 2008, through December 31, 2008	11
Table 3. Consolidated Health Center Funding, Grantees, and Sites, FY2001-FY2008	13

Federal Health Centers Program

Introduction

Health centers were first funded by the federal government as part of the War on Poverty in the mid-1960s. When the Economic Opportunity Act (P.L. 88-452) was phased out in the 1970s, about 100 neighborhood health centers were transferred to the Public Health Service (PHS) and funded as community health centers (CHCs) beginning in 1975. The Health Centers Program is administered by the Bureau of Primary Health Care (BPHC) under the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS).

The Health Centers Consolidation Act of 1996 (P.L. 104-299) consolidated funding for CHCs with other similar programs in Section 330 of the Public Health Service Act (P.L. 87-838). Under this authority, health centers receive grant support to provide largely primary health care services to medically underserved populations residing in “an urban or rural area designated by the Secretary of HHS as an area with a shortage of personal health services or a population group designated as having a shortage of such services.”⁵ The authorization expired at the end of FY2006. There are two major Reauthorization bills in the 110th Congress:

- S. 901, the Health Care Safety Net Act (introduced March 15, 2007), which was passed by the Senate Health Education and Labor Committee on November 14, 2007, would reauthorize appropriations for FY2008-FY2012. It would also require a study of the economic costs and benefits of school-based health centers and their impact on the health of students. On March 12, 2008, a written report was filed by Senator Kennedy for the Committee.
- H.R. 1343, Health Centers Renewal Act of 2007 (introduced March 6, 2007), would reauthorize the program through FY2012 and would also allow limited liability protection for physicians who volunteer at health centers. It would also extend liability protections to health center employees who travel to provide services in emergencies. The House Energy and Commerce’s Subcommittee on Health approved the bill for full committee consideration on April 23, 2008.

In 2002, President Bush began his “Health Centers Initiative,” a multi-year program to strengthen the health care safety net. The plan was to increase access to health care in 1,200 of the nation’s neediest communities through a “New Access

⁵ 42 U.S.C. § 254b(b)(3).

Point (NAP)” grant.⁶ NAP was intended to provide comprehensive primary and preventive health care services to address the unique and significant barriers to affordable and accessible health care services for a specific population or community. The two types of grants were: *new starts*, for entities who currently did not receive the federal grants under Section 330, and *satellites*, for entities which already received Section 330 grant money, but were establishing new access point(s) to serve a new patient population outside the applicant’s already-approved scope of project.⁷

Beginning in FY2006, the Consolidated Health Center Program targeted the nation’s poorest counties through a *second* health centers’ initiative, the “High Poverty Counties Initiative.” The goal was to increase access over the next five years to primary health care in 200 of the nation’s poorest counties that are in need of a comprehensive health center.

In FY2008, the final year of the President’s initiative, HRSA funded an additional 340 sites (220 new sites and 120 expansions), and expected to reach a total enrollment of more than 16 million patients.⁸ In FY2009, the Administration plans to fund up to 40 new access point grants and 25 planning grants for applicants who can demonstrate they will serve areas with high levels of poverty and no access to an existing health center site.⁹

Though the Administration increased the number of CHCs, providers are needed to match their growing caseloads. A study in the *Journal of the American Medical Association (JAMA)* concluded that “the largest numbers of unfilled positions were for family physicians” at a time when there is declining interest in family medicine among US graduating medical students, leaving “CHCs “challenged by these issues.” There is also a high demand for dentists. Lack of provider interest in serving these geographic and specialty areas and centers’ difficulty competing with salaries in the private sector are some of the factors affecting the number of unfilled positions. The “need for spousal employment opportunities, cultural activities, adequate housing, and poor quality schools” were considered major barriers for rural centers.¹⁰

The Consolidated Health Centers Program, under Section 330, includes community health centers, migrant health centers, health centers for the homeless, and health centers for residents of public housing.¹¹ Similar programs such as the

⁶ Department of Health and Human Services, *Budget in Brief*, FY2007, pp. 5-6 and 21.

⁷ Department of Health and Human Services, *Budget in Brief*, FY2007, pp. 5-6.

⁸ Department of Health and Human Services, *Budget in Brief*, FY2008, p. 20.

⁹ *Ibid.*

¹⁰ Rosenblatt, Roger A., et al., “Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion,” *Journal of the American Medical Association*, March 1, 2006, vol. 295, no. 9.

¹¹ Though HRSA has made reference to the School-Based Health Center (SBHC) Program in past documents, Section 330 of the PHS Act does not include authorization for an SBHC Program. Therefore, HRSA will no longer identify SBHCs as a separate Health Center Program or category/type of health center. Although HRSA will continue to recognize (continued...)

Native Hawaiian Health Care, FQHC-Look-Alikes, and Tribal FQHCs also fall under the umbrella of the Consolidated Health Centers Program.

All health centers receiving funds under the program are eligible for coverage for medical malpractice under the Federal Tort Claims Act (FTCA). Under FTCA coverage, the federal government assumes responsibility for malpractice claims against centers and their practitioners.

The Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239) established Federally Qualified Health Centers (FQHCs) under Medicare and Medicaid. FQHCs include Section 330 grantees and certain other outpatient clinics. FQHCs receive reimbursement payments from the Centers for Medicare and Medicaid Services (CMS) for services provided at these facilities for Medicare eligibles. The state Medicaid agencies pay FQHCs on a prospective basis and then the state gets a federal matching amount. The prospective payment system establishes a per visit payment rate for each FQHC in advance.

Consolidated Health Centers Programs¹²

Grant Amounts

BPHC awards grants to public and nonprofit entities to operate health centers. Amounts are determined based on the cost of proposed grant activity.

The Health Centers Patient Profile

The patient population is primarily low income, uninsured, or underinsured individuals. A majority of this population — which includes people with chronic diseases, pregnant teens, substance abusers, and a number of individuals living with HIV/AIDS infection — is unemployed. Many are unable to afford even the most basic medical or dental care.¹³ An estimated 92% of health center patients are at or

¹¹ (...continued)

school-aged children as an underserved population, applications for funds to support an SBHC must be made under the Section 330(e) “regular” Community Health Center Program authority. Source: *Budget Period Renewal Non-Competing Continuation Funding Under the Consolidated Health Centers Program Announcement Number: 5-H80-06-001, Catalog of Federal Domestic Assistance (CFA) No. 93.224, Program Guidance, Fiscal Year 2006*. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, July 7, 2005, p. 3, at [<ftp://ftp.hrsa.gov/bphc/docs/2005pins/2005-20.pdf>].

¹² Unless otherwise indicated, all data hereafter cited on health centers are extracted from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, *Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS), Calendar Year 2006 Data, National Rollup Report*. July 2, 2007.

¹³ Department of Health and Human Services, Health Resources and Services (continued...)

below 200% of the federal poverty level. Of this population, 40% have no health insurance, 64% are racial or ethnic minorities, and 35% depend on Medicaid.¹⁴

PHS Act Section 330 Health Centers

Community Health Centers. For HRSA's purpose, the term "health center" refers to *all* the diverse public and nonprofit organizations and programs that receive federal funding under the Consolidated Health Centers program. In CY2006, there were 1,002 grantees, about 50% of which were rural, and 6,208 sites. Each CHC must serve a medically underserved population by providing a range of comprehensive health services, along with supportive/enabling service (such as outreach, translation, transportation, health education, and assistance with eligibility service for programs such as WIC or food stamps) for all residents of the area served by the center (known as the catchment area).¹⁵ They must be governed by community boards, a majority of whose members are current health center patients, to assure responsiveness to local needs. Operating at the community level, health centers provide services regardless of health status, insurance coverage, or ability to pay (centers use a board-approved sliding fee schedule).

Required Services. Every center provides a similar range of primary health services on an ambulatory basis. CHCs are required to provide primary health services, as defined in the regulations,¹⁶ which include services of physicians, physicians' assistants, and nurse clinicians; diagnostic laboratory and radiologic services; preventive health services; emergency medical services; preventive dental services; pharmaceutical services; transportation, and other enabling services.

As appropriate, individual centers may provide supplemental services such as additional dental care or mental health or substance abuse treatment. The Deficit Reduction Act of 2005 (DRA), P.L. 109-171, added diabetes self-management training and medical nutrition therapy for beneficiaries with diabetes or renal disease to the list of services, effective January 1, 2006.

¹³ (...continued)

Administration, *Justification of Estimates for Appropriations Committees*. FY2007, p. 80.

¹⁴ *America's Health Centers Fact Sheet*, #0108, National Association of Community Health Centers, United States, January 2008.

¹⁵ Migrant, homeless, and public housing health centers are exempt from the requirement to serve all residents in a catchment area.

¹⁶ 42 CFR 51c.102(h).

The average center cost per medical patient visit¹⁷ was \$117 in 2006.¹⁸ Centers are generally required to serve all residents of the area in which it is located, regardless of the ability to pay.¹⁹ CHCs served more than 15 million persons in CY2006. In CY2006, health centers also provided

- more than 59 million encounters,
- more than 283,000 mammograms,
- more than 1.6 million Pap tests,
- more than 3.39 million encounters for immunizations,
- 515,965 HIV tests,
- prenatal care for 426,052 women, and
- enabling services to more than 1.5 million patients.²⁰

The Consolidated Health Centers Program includes four special categories (or types of health centers) other than the basic “community” health center category. These are described below.

Migrant Health Centers. Section 330 funded 135 community/migrant dual-funded centers and 16 migrant-only centers as of May 24, 2006.²¹ These centers serve a special medically underserved population of migratory farm workers (persons whose principal employment is in agriculture on a seasonal basis and who establish a temporary abode for the purpose of this work) and seasonal farm workers (persons whose principal employment is in agriculture on a seasonal basis and who are not migratory agricultural workers). Ninety-three percent of these health centers’ beneficiaries are primarily of Hispanic origin.²² Migrant health centers are required

¹⁷ The term “visit” is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which a Rural Health Clinic/Federally Qualified Health Center service is rendered. Encounters with more than one health professional and multiple encounters with the same health professionals which take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist: (a) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; (b) the patient has a medical visit and a clinical psychologist or clinical social worker visit. Source: *Medicare Claims Processing Manual*, Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers, paragraph 20.1 - “Payment Rate for Independent and Provider Based RHCs and FQHCs.”

¹⁸ *U.S. Health Center Fact Sheet*, National Association of Community Health Centers, 2007 at [http://www.nachc.com/client/documents/US_Fact_Sheet_2007.pdf].

¹⁹ Migrant, homeless, and public housing health centers are exempt from the requirement to serve all residents in a catchment area.

²⁰ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, *Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS)*, Calendar Year 2006 Data, National Rollup Report. July 2, 2007.

²¹ Personal communication with an official at HRSA’s Office of Minority and Special Populations on August 5, 2007.

²² Department of Health and Human Services, Health Resources and Services (continued...)

to provide primary health services and, as determined by the Secretary, other services, such as

- supplemental services to support primary health service;
- environmental health services to alleviate unhealthful conditions of the environment, such as problems associated with water supply, sewage treatment, solid waste disposal, rodent and parasite infestation, field sanitation, and housing conditions and the treatment of medical conditions arising therefrom;
- accident prevention programs, including prevention of excessive exposure to pesticides through, but not limited to, notification of appropriate federal, state or local authorities of hazardous conditions due to pesticide use; and
- information on the availability and proper use of health services.²³

These centers may be exempt from providing all required services upon a showing of good cause, and they may be approved to provide certain required health services only during certain periods of the year. The migrant health centers served 758,894 migrant and seasonal farm workers and their families in CY2006.²⁴

Health Centers for the Homeless. Section 330 grants for these centers provide for a particular medically underserved population composed of homeless individuals, defined by the act as (1) one who lacks permanent housing, whether or not the individual is a member of a family, and (2) one who lives in temporary facilities or transitional housing.²⁵ In CY2005 39% of homeless center patients were African American; 36% were white; 21.9 % were Hispanic.²⁶ This is the only federal program responsible for addressing the primary health care needs of homeless people, furnishing a range of services that include emergency shelter, transitional housing, job training, primary health care, education, and some permanent housing. Grants are also available for innovative programs that provide outreach and comprehensive primary health services to homeless children and children at risk of homelessness. Centers that receive grants to care for the homeless are required to provide substance abuse treatment as a condition of the grant. In CY2006, 701,623 homeless individuals were served by this program through 184 grantees.²⁷

²² (...continued)

Administration, *Justification of Estimates for Appropriations Committees*. FY2008, p. 78.

²³ 42 CFR 56.102(g).

²⁴ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, *Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS)*, Calendar Year 2006 Data, National Rollup Report, July 2, 2007.

²⁵ P.L. 104-299, Section. 330(h)(4)(A).

²⁶ Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees*. FY2008. On-line at [<http://www.hrsa.gov/about/budgetjustification08/primarycare.htm>] visited 5/29/2008

²⁷ U.S. Department of Health and Human Services, Health Resources and Services (continued...)

Health Centers for Residents of Public Housing. Section 330 grants fund these centers for the delivery of health services to the medically underserved population composed of residents of public housing. The majority of Public Housing Health Center patients were minorities; 43 % were African American and 42% were Hispanic.²⁸ These centers seek to improve the health status of such residents by providing primary care services on the premises of the public housing projects or at other locations. Barriers to health care such as clinic location, transportation, operating hours, language, and other factors are addressed by providing health services directly at housing projects. Public housing residents must be consulted on the planning and administration of the center. In CY2006, 37 grantees provided services to 129,280 public housing residents.²⁹

Native Hawaiian Health Care. This program makes primary care, health promotion, and disease prevention services available to Native Hawaiians who face cultural, financial, and geographic barriers to health care services. Under the Native Hawaiian Health Care Act of 1988 (P.L. 100-579), the Native Hawaiian Health Care System, composed of five grantees and the Papa Ola Lokahi, a consortium of health care organizations, receive direct funding to provide health care services. In the conference report (H.Rept 104-863) that accompanied the omnibus appropriations bill for FY1997 (P.L. 104-208), the conferees increased funding for the Consolidated Health Centers program, in part, so that the Native Hawaiian healthcare program could be supported under the broader Consolidated Health Centers' budget line instead of its own line item, resulting in increased funding for Native Hawaiian Health Care if HRSA determines such funding would be appropriate. The System provided medical encounters and supportive/enabling services to more than 6,163 Native Hawaiians in CY2005.³⁰

Federally Qualified Health Centers

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), P.L. 101-239, established the Federally Qualified Health Center (FQHC) Program under the Social Security Act. OBRA 1989 authorized payment for FQHC services by Medicare and Medicaid.

All Section 330 health center grantees are automatically designated as FQHCs, making them certified Medicare/Medicaid providers and, therefore, eligible for

²⁷ (...continued)

Administration, Bureau of Primary Health Care, *Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS)*, Calendar Year 2006 Data, National Rollup Report, July 2, 2007.

²⁸ Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees*. FY2008. On-line at [<http://www.hrsa.gov/about/budgetjustification08/primarycare.htm>].

²⁹ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, *Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS)*, Calendar Year 2006 Data, National Rollup Report, July 2, 2007.

³⁰ Personal communication with HRSA personnel August 22, 2007.

reasonable cost reimbursement from Medicare and prospective payment system (PPS) payment from Medicaid.

FQHC Look-Alikes. FQHCs also include non-federally funded “Look-Alike” programs, entities which, based on the recommendation of the HRSA, are determined to meet the statutory, regulatory, and policy requirements of the Section 330 grant program but do not receive the grant. For these centers, HRSA reviews applications for possible “Look-Alike” centers and recommends to CMS which of these non-federally-funded health centers should receive the FQHC “Look-Alike” designation. Designation as a Look-Alike site allows placements of National Health Service Corps personnel because these centers are recognized by HRSA as operating in a medically underserved area or serving a medically underserved population. Other benefits associated with the FQHC Look-Alike designation include enhanced Medicare and Medicaid reimbursement and eligibility to participate in the 340B drug pricing program.³¹ The main reason that organizations apply for FQHC Look-Alike designation is because grants under section 330 are limited and highly competitive. Consequently, FQHC Look-Alike designation serves as a precursor and alternative to section 330 grant funds.

As of July 3, 2007, there were 101 FQHC Look-Alikes operating 255 total sites. As of October 2005, FQHCs were serving about 500,000 unduplicated patients based on self-reporting. In FY2007, approximately 28% of FQHC Look-Alikes that applied for funding under the President’s Health Centers Initiative were successful in obtaining an award.

Tribal FQHCs. Certain outpatient clinics operated by Indian tribes are also included under FQHCs. Those Indian facilities that are operated by a tribe or tribal organization under the Indian Self-Determination Act (P.L. 93-638) or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act (P.L. 94-437) are eligible for FQHC status under OBRA 1989, and all are generally referred to as “Tribal FQHCs.” Though the Indian Health Service determines their eligibility for FQHC status, Medicare and Medicaid authorize payment for these facilities. There are 34 urban Indian health programs in 19 states, of which 20 receive Medicaid reimbursement as FQHCs. One-third of these programs bill Medicare as an FQHC, and the remainder bill Medicare for covered services as other community (or non-Indian Health Service) providers or practitioners. There is no information on the number of Tribal-operated health clinics available.³²

Rural Health Clinics

The Rural Health Clinic Services Act (P.L. 95-210) established the rural health clinic (RHC) program in December 1977. That act amended the Social Security Act to provide payment for rural health clinic services provided to Medicare and

³¹ Information, data and statistics on FQHC Look-Alikes is based on correspondence with HRSA personnel on August 20, 2007.

³² Personal communication with an official at the Indian Health Service, June 19, 2007.

Medicaid beneficiaries in rural communities. There were an estimated 3,721 RHCs in operation as of May 2007.³³

Unlike FQHCs, RHCs are not required to provide services to uninsured or indigent patients; therefore, they are not eligible for Section 330 grants. They receive enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. They must provide outpatient primary care services and basic laboratory services. They can also offer other services, such as mental health services and vision services, but those services may not be reimbursed based on allowable costs.

Some other differences between RHCs and FQHCs are listed in **Table 1** below.

Table 1. Limited Comparison of Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs)

RHCs	FQHCs
Can be nonprofit and for-profit corporations, public agencies, sole proprietorships, and partnerships.	FQHC status is limited to nonprofit, tax exempt corporations and public agencies.
RHCs are permitted, but not required, to provide sliding fee reductions to patients — should an RHC opt to obtain health professional shortage area (HPSA) designation, it would be <i>required</i> to have a sliding fee scale.	FQHCs must utilize a sliding fee scale, with varying discounts available, based on patient family size and income in accordance with federal poverty guidelines.
The RHC program has no requirements related to boards of directors.	FQHC status is restricted to nonprofit corporations and public agencies; therefore, a board of directors that meet specific criteria is required.
Preventive health care not required.	Preventive health care is required on-site or under arrangement.
RHCs are required to provide medical emergency procedures as a first response to common life threatening injuries and acute illnesses (the definition of first response is that the service is commonly provided in a physician office).	FQHCs are required to provide access to emergency care 24/7 — either on site or through clearly defined arrangements for access to health care for medical emergencies during and after the FQHC's regularly scheduled hours.

Source: Health Resources and Services Administration. *Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs*. Revised June 2006.

RHCs must be certified by the state. Certification requirements for an RHC include

- location in a nonurbanized area;
- location in an area designated as a health professional shortage area or a medically underserved area;

³³ Data for rural health clinics found on HRSA on-line Geospatial Data Warehouse at [<http://datawarehouse.hrsa.gov/>].

- provision of primarily outpatient medical care;
- employment of at least one nurse practitioner, physician assistant, or certified nurse midwife at least 50% of the time that the clinic is open; and
- medical direction from a physician who periodically reviews services of the health professional staff, provides general medical supervision, and is present on site at least once every two weeks.³⁴

Medicare and Medicaid Payments

One significant difference between the Medicaid and Medicare programs in their policies on FQHCs is that under Medicaid, certain requirements for FQHC designation can be waived for a center and that center can still be eligible for reimbursement. The Secretary of Health and Human Services is allowed to waive one or more specific requirements, such as using a limited pool of providers, for up to two years for good cause. These waivers are not allowed under Medicare.³⁵ The second significant difference in the way the FQHCs are treated under Medicare and Medicaid is the way they are reimbursed under the programs.

Medicare Payments. FQHCs and RHCs are paid on the basis of an all-inclusive rate for each beneficiary visit for covered services. The payment rate is calculated by dividing the total allowable cost by the number of total visits for services. An interim payment is made to the FQHC or RHC based on estimates of allowable costs and number of visits and a reconciliation is made at the end of the year based on actual costs and visits. Per-visit payment limits are established for FQHCs and all RHCs (other than those in hospitals with fewer than 50 beds).³⁶ Medicare announces payment rates for FQHCs and RHCs annually. The payments are determined by the rate of the increase in the Medicare Economic Index. **Table 2** below indicates the updated payments for FQHCs and RHCs.

³⁴ University of Southern Maine, Edmund S. Muskie School of Public Service, *The Characteristics and Roles of Rural Health Clinics in the United States: A Chartbook*, January 2003.

³⁵ U.S. Department of Health and Human Services, Bureau of Primary Health Care, "Overview of FQHC Program," at [<http://www.bphc.hrsa.gov>].

³⁶ U.S. Congress, House Committee on Ways and Means, *2004 Green Book, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, committee print, 108th Cong., 2nd sess., WMCP108-6 (Washington: GPO, 2004), Appendix D, p. D-38.

Table 2. Medicare Payment Update for FQHCs and RHCs Effective January 1, 2008, through December 31, 2008

FQHCs (urban)	FQHCs (rural)	RHCs
upper payment limit per visit for urban FQHCs was increased from \$115.33 to \$117.41	the maximum Medicare payment limit per visit for rural FQHCs was increased from \$99.17 to \$100.96	upper payment limit per visit was increased from \$74.29 to \$75.63

Source: Transmittal 1426, Change Request 5896, SUBJECT: Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health enters (FQHCs) Payment Rate Increases, February 1, 2008. *Medicare Claims Processing Manual*, Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers, paragraph 20.6.2 - “Federally Qualified Health Centers.”

Notes: If the FQHC is located within a Metropolitan Statistical Area (MSA) or New England County Metropolitan area (NECMA), then the urban limit applies. If the FQHC is not in an MSA or NECMA and cannot be classified as a large or other urban area, the rural limit applies. Rural FQHCs cannot be reclassified into an urban area (as determined by the Bureau of Census) for FQHC payment limit purposes.

Medicaid Payments. Medicaid also pays for FQHC services on a per visit basis, but in accordance with a prospective payment system (PPS) established under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), P.L. 106-554. The PPS establishes a per visit payment rate for each FQHC in advance.

Beginning in January 2001, existing FQHCs were paid per visit payments equal to 100% of the average costs incurred during 1999 and 2000, adjusted for any increase or decrease in the cost of services furnished. For new FQHCs, the per visit payments begin in the first year that the center or clinic attains qualification and are based on 100% of the costs incurred during that year, based on the rates established for similar centers or clinics.³⁷

In 2001, the General Accounting Office (GAO) reported to Congress that the PPS under BIPA would be likely to constrain future payments to FQHCs and RHCs.³⁸ The report observed that ultimately a center’s ability to manage under the new PPS would depend on its initial payment rate and its ability to keep its cost growth at or below the inflation adjustment. In many cases, this average payment may be lower than what an FQHC or RHC received in 2000. HHS concurred. HHS also noted that the effects of the new system would vary among FQHCs and RHCs, and agreed that FQHCs and RHCs that were already operating efficiently could be penalized.

³⁷ For further information on the Medicaid prospective payment system for FQHCs, see CRS Report RL30718, *Medicaid, SCHIP, and Other Health Provisions in H.R. 5661: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000*, by Jean Hearne, Elicia Herz, and Evelyne Baumrucker.

³⁸ U.S. General Accounting Office, *Health Centers and Rural Health Clinics, Payments Likely to Be Constrained Under Medicaid’s New System*, GAO-01-577 (Washington: June 2001, p. 12).

GAO conducted a BIPA-mandated study in 2005 to review states' implementation of the new PPS system, the need to rebase or refine BIPA PPS, and CMS oversight. The GAO report concluded that CMS' guidance and oversight regarding the new BIPA payment requirements were inadequate to ensure consistent state compliance with the law. The report also found that CMS had conducted limited oversight of states' implementation and therefore was unaware of compliance issues with some states' payment systems. GAO recommended CMS explore the development of a more appropriate inflation index for the BIPA PPS and improve its guidance for states and its oversight of states' payment methodologies. CMS said it would take steps related to its oversight but disagreed on the need to issue additional guidance. CMS also disagreed on the need to develop an inflation index. GAO maintained its recommendation and also elevated the issue to a matter for congressional consideration.³⁹

Funding for Consolidated Health Centers Program

In addition to federal grant support, fees collected from third-party payors such as Medicaid, Medicare, or private insurers, centers may also collect fees from patients with family incomes above the federal poverty line, according to sliding fee scales. They may also receive funds from state, local, and other sources.

For FY2007, the President requested \$1.963 billion for Health Centers. The final Resolution passed by the Senate February 14, 2007, that became P.L. 110-5, provided a final amount of \$1.988 billion for FY2007 (which included \$44 million for federal tort claims).

For FY2008, H.R. 2764, the Consolidated Appropriations Act for 2008 (P.L. 110-161) signed into law on December 26, 2007 provided \$2.065 billion for health centers (which included \$43 million for federal tort claims).

The President's FY2009 Budget requested \$2.092 billion for health centers, an increase of \$27 million over FY2008 (and includes \$44 million federal tort claims funds).⁴⁰ **Table 3** shows historical appropriations and the number of grantees and sites since FY2001.

³⁹ U.S. General Accounting Office, *Health Centers and Rural Health Clinics, State and Federal Implementation Issues for Medicaid's New Payment System*, GAO-05-452, (Washington: June 2005), summary page.

⁴⁰ U. S. Department of Health and Human Services, *The Budget in Brief*, FY2009, p .18.

Table 3. Consolidated Health Center Funding, Grantees, and Sites, FY2001-FY2008
(in \$millions)

	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
Health center appropriations	\$1,019.0	\$1,168.7	\$1,344.5	\$1,465.3	\$1,572.6	\$1,734.3	\$1,782.3 ^a	\$1,988.0	\$2,065.0
Change in appropriations from previous year	+ \$84	+ \$149.7	+ \$175.8	+ \$110.8	+ \$107.3	+ \$161.7	+ \$48.0	+ \$205.7	+ \$77.0
Grantees	746	748	843	890	914	N/A	N/A	952	1,002
Sites	3,000	3,317	3,488	3,578	3,651 ^b	3,741 ^b	3,745	3,831	6,208

Source: Health Resources and Services Administration budget documents, as compiled by CRS.

Note: All appropriation amounts include federal tort claims funds.

a. This amount was derived from P.L. 109-149 and reflects a 1% rescission.

b. Estimate.

Other Federal Support. In addition to the Health Resources and Services Administration (HRSA) start-up grant funds, FQHCs may apply for other HRSA grants.

- The National Health Service Corps provides assistance for qualifying practice sites in recruiting and retaining community-responsive, culturally competent primary care clinicians to deliver health care in underserved communities.
- HRSA’s 340B Drug Pricing Program allows facilities to purchase prescription and non-prescription medications at reduced cost.
- The Ryan White AIDS program provides funding. Seventy-five percent of these funds must be spent on core medical services and 50% on early intervention services. There will be overlap; some approved early intervention services also qualify as core medical services.
- The Rural Health Outreach Grant supports projects that demonstrate creative or effective models of outreach and service delivery in rural communities.
- The Health Information Technology Innovation Initiative provides funding to support health centers in the new implementation of Health Information Technology (HIT) other than electronic health records (EHR) that will substantially enhance the quality and efficiency of primary and preventive care in the health center delivery system.
- Distance Learning and Telemedicine Program Loans and Grants are specifically designed to provide access to education, training and health care resources for people in rural areas to encourage and improve telemedicine services and distance learning services through the use of telecommunications, computer networks, and related advanced technologies.

Other potential grants include the following:

- The Substance Abuse & Mental Health Services Administration (SAMSHA) Special Program: “screening, brief intervention, referral, and brief treatment (SBIRT)” program.
- Grants issued through the Centers for Disease Control and Prevention (CDC) such as
 - Diabetes Control Programs (DCPs), a grant for diabetes education;
 - Vaccines for Children Program (VFC), supporting program operations and providing vaccines to participating providers that administer vaccines for preventable diseases to uninsured or underinsured children; and
 - Health Disparities Collaboratives, a national, federally funded quality-improvement initiative.

Non-Federal Assistance. FQHCs may also receive non-federal grants from state Medicaid programs. A majority of states now provide funding for health centers. According to the National Association of Community Health Centers

(NACHC), “In state FY2007 (which for most states began in July 2007), health centers in 23 states saw an increase in state funding totaling about \$81 million.”⁴¹

A NACHC survey of Primary Care Associations revealed that 36 states, including the District of Columbia, reported they were receiving direct funding from Medicaid for health centers for a total of almost \$590 million, almost \$70 million more than FY2007.⁴²

FQHCs may also receive grants from private foundations or contracts.

Websites on Community Health Centers

Hawaiian Health Centers, Hawaii Primary Care Association
[<http://www.hawaiipca.net/chcs>]

National Association of Community Health Centers
[<http://www.nachc.com/>]

National Coalition for the Homeless
[<http://www.nationalhomeless.org/health/hchprogram.html>]

National Care for the Homeless Council
[<http://www.nhchc.org/>]

The National Center for Farmworker Health
[<http://www.ncfh.org/>]

National Association of Rural Health Clinics
[<http://www.narhc.org>]

Rural Assistance Center
[<http://www.raonline.org>]

Tribal FQHCs (urban Indian health programs), Urban Indian Institute
[<http://www.uihi.org/publications.asp>]

National Council of Urban Indian Health
[<http://www.ncuih.org>]

⁴¹ National Association of Community Health Centers, *Gaining Ground? State Funding, Medicaid Cuts, and Health Centers*, State Policy Report #12, October 2006, p. 3, at [<http://www.nachc.com/client/documents/issues-advocacy/state-issues/state-report-12-direct-funding-final.pdf>].

⁴² National Association of Community Health Centers, *Gaining Ground II: State Funding, Medicaid Changes and Health Centers*, State Policy Report #18, August 2007, p. 4, at [<http://www.nachc.com/client/documents/issues-advocacy/state-issues/SPR-18-direct-funding-survey.pdf>].