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# Federal Health Centers: An Overview

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April 21, 2015

**Congressional Research Service**

7-5700

[www.crs.gov](http://www.crs.gov)

R43937

## Summary

The federal Health Center Program is authorized in Section 330 of the Public Health Service Act (42 U.S.C. §§201 et seq.) and administered by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services. The program awards grants to support outpatient primary care facilities that provide care to primarily low-income individuals or individuals located in areas with few health care providers.

Federal health centers are required to provide health care to all individuals, regardless of their ability to pay, and to be located in geographic areas with few health care providers. These requirements make health centers part of the health safety net—providers that serve the uninsured, the underserved, or those enrolled in Medicaid. Data compiled by HRSA demonstrate that health centers serve the intended safety net population, as the majority of patients are uninsured or enrolled in Medicaid. Some research also suggests that health centers are cost-effective; researchers have found that patients seen at health centers have lower health care costs than those served in other settings. In general, research has found that health centers, among other outcomes, improve health, reduce costs, and provide access to health care for populations that may otherwise not obtain health care.

Section 330 grants—funded by the Health Center Program’s appropriation—are only one funding source for federal health centers. The grants are estimated to cover only one-fifth of an individual health center’s operating costs; however, individual health centers are eligible for grants or payments from a number of federal programs to supplement their budgets. These federal programs provide (1) incentives to recruit and retain providers; (2) access to the federally qualified health center (FQHC) designation, which entitles facilities to higher reimbursement rates from Medicare and Medicaid; (3) access to additional funding through federal programs that target populations generally served by health centers; and (4) in-kind support, such as access to drug discounts or federal coverage for medical malpractice claims.

This report provides an overview of the federal Health Center Program, including its statutory authority, program requirements, and appropriation levels. It then describes health centers in general, where they are located, their patient population, and outcomes associated with health center use. The report also describes federal programs available to assist health center operations, including the FQHC designation for Medicare and Medicaid payments. The report concludes with two appendixes that describe (1) FQHC payments for Medicare and Medicaid beneficiaries served at health centers and (2) programs that are similar to health centers but not authorized in Section 330 of the PHSA.

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## Introduction

The federal Health Center Program awards grants to support health centers: outpatient primary care facilities that provide care to primarily low-income individuals. The program is administered by the Health Resources and Services Administration (HRSA)—specifically by its Bureau of Primary Care—within the Department of Health and Human Services (HHS).<sup>1</sup> The federal Health Center Program is authorized in Section 330 of the Public Health Service Act (PHSA)<sup>2</sup> and supports four types of health centers: (1) community health centers, (2) health centers for the homeless, (3) health centers for residents of public housing, and (4) migrant health centers.

According to HRSA data, over 9,200 unique health center sites (i.e., individual health center facility locations) exist;<sup>3</sup> the majority are community health centers (CHCs). CHCs serve the general low-income or otherwise disadvantaged population, whereas the remaining three types of health centers provide care to more targeted low-income or otherwise disadvantaged populations (e.g., migrant farmworkers). Regardless of type, health centers are required by statute to provide health care to all individuals, regardless of their ability to pay, and to be located in geographic areas that have few health care providers.<sup>4</sup> These requirements make health centers part of the health safety net—providers that serve the uninsured, the underserved, or those enrolled in Medicaid.<sup>5</sup> Data compiled by HRSA demonstrate that health centers primarily serve the intended safety net population, as the majority of patients are uninsured or enrolled in Medicaid.<sup>6</sup>

This report provides an overview of the federal Health Center Program, including its statutory authority, program requirements, and appropriation levels. The report then describes health centers in general, where they are located, their patient population, and outcomes associated with health center use. It also describes the federal programs available to assist health center operations, including the federally qualified health center (FQHC) designation for Medicare and Medicaid payments. Finally, the report has two appendices that describe (1) FQHC payments for Medicare and Medicaid beneficiaries served at health centers and (2) programs that are similar to health centers but not authorized in Section 330 of the PHSA.

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<sup>1</sup> For more information about the Health Resources and Services Administration (HRSA), see CRS Report R43304, *Public Health Service Agencies: Overview and Funding*.

<sup>2</sup> 42 U.S.C. §§201 et seq.

<sup>3</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, “The Affordable Care Act and Health Centers,” <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>.

<sup>4</sup> 42 U.S.C. §254b.

<sup>5</sup> Lewin, Marion Ein and Altman, Stuart, *America’s Health Care Safety Net: Intact but Endangered*, Institute of Medicine, Washington, DC, 2000, p. 21; for more information on the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*. For information that discusses health centers’ service to this population, see Peter Shin et al., *Community Health Centers: A 2012 Profile and Spotlight on Implications of State Medicaid Decisions*, The Kaiser Commission on Medicaid and the Uninsured, Issue Brief, Washington, DC, September 2014.

<sup>6</sup> Health Resources and Services Administration, Bureau of Primary Care, *Uniform Data System*, 2010 National Summary Report, Rockville, MD, July 27, 2011, [http://bphc.hrsa.gov/uds/doc/2010/National\\_Universal.pdf](http://bphc.hrsa.gov/uds/doc/2010/National_Universal.pdf) (hereinafter, *2011 UDS Report*); Health Resources and Services Administration, Bureau of Primary Care, *Uniform Data System*, 2012 National Summary Report, Rockville, MD, <http://bphc.hrsa.gov/uds/datacenter.aspx?year=2012&state=AL&compare=Nat> (hereinafter, *2012 UDS Report*); and Health Resources and Services Administration, Bureau of Primary Care, *Uniform Data System*, 2013 National Summary Report, Rockville, MD, <http://bphc.hrsa.gov/uds/datacenter.aspx?q=all&year=2013&state=> (hereinafter, *2013 UDS Report*).

## What Is the Federal Health Center Program?

The federal Health Center Program awards grants to support outpatient primary care facilities that provide care to primarily low-income individuals. This section of the report describes the statutory authority for the federal Health Center Program, program requirements, types of grants awarded in support of the Health Center Program, the Health Center Program's appropriation, and other funding/revenue that health centers receive.

### Statutory Authority and General Requirements<sup>7</sup>

Section 330 of the PHSA authorizes grants for health centers and includes the requirements that entities must meet to receive a health center grant. Section 330 requires health centers to provide services to the entire population of their service area, regardless of individuals' ability to pay. Health centers are also required to document the health needs of the residents in their service area and to update their service area if upon evaluation they determine that changes are needed. Health center grantees must (1) be located in specific geographic areas, (2) have an established fee schedule that meets certain requirements, (3) collect reimbursements for individuals enrolled in public or private insurance programs, (4) have appropriate governance, (5) offer specific health services, (6) meet certain reporting and quality assurance requirements, and (7) license providers and seek accreditation. HRSA is required to determine whether health center grantees meet these requirements; however, the Government Accountability Office (GAO) has raised concerns that the agency may not be providing sufficient oversight of the program and that some health centers may not be meeting these requirements.<sup>8</sup> This report does not evaluate whether health centers meet program requirements; rather, it describes the program's requirements.

### Location Requirements

PHSA Section 330 requires that a health center be located in an area designated as medically underserved or as serving a population designated as "Medically Underserved" (see **text box**).<sup>9</sup>

<sup>7</sup> HRSA details the program's requirements on its website at <http://bphc.hrsa.gov/about/requirements/index.html>. The subsections that follow refer to this website in addition to the citations noted below.

<sup>8</sup> U.S. Government Accountability Office, *Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements*, 12-546, May 2012.

<sup>9</sup> §5602 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required the Secretary of HHS to revise the criteria and methodology used to designate health professional shortage areas (HPSAs) and MUPs. The ACA also required that HHS appoint a committee to undertake this revision and publish a final rule with the new criteria. The committee released a report on October 1, 2011, but the committee's report was not unanimous; therefore, the Secretary is not required to use the report when drafting the new rule. For the committee's report, see <http://www.hrsa.gov/advisorycommittees/shortage/nrmcfinalreport.pdf>. HRSA is currently drafting an interim final rule, but has not, as of the date of this CRS report's publication, released a final rule.

### Medically Underserved Areas/Populations

**Medically Underserved Areas (MUA):** Areas of varying size—whole counties, groups of contiguous counties, civil divisions, or a group of urban census tracts—where residents have a shortage of health care services.

**Medically Underserved Populations (MUPs):** Groups that face economic, cultural, or linguistic barriers to accessing health care.

**Source:** HRSA, Bureau of Primary Care, Shortage Designations, at <http://www.hrsa.gov/shortage/index.html>.

## Fee Schedule Requirements

Health centers must establish their own fee schedules that take into account local rates for health services and the costs that the health center incurs providing services. The health center is then required to establish a separate discounted fee schedule (i.e., sliding-scale fees), which is then further discounted or waived based on a patient's ability to pay. Ability to pay is determined by a patient's income relative to the federal poverty level<sup>10</sup> and the patient's family size—no other criteria may be considered.<sup>11</sup> The statute requires that individuals whose income is above 200% of the federal poverty level pay full charges, while individuals whose incomes are at, or below, 100% of the federal poverty level pay only nominal fees.<sup>12</sup> Individuals with insurance coverage may also be eligible for discounted services if the copayment charged by the individual's health insurance plan would be greater than the amount that the individual would pay for the service under the discounted fee schedule. In this case, the individual would pay only the discounted fee schedule amount and not the full copayment amount.<sup>13</sup>

## Medicaid Coordination and Reimbursement Requirements

Health centers are required to coordinate with state Medicaid and State Children's Health Insurance Program (CHIP) plans to provide services to beneficiaries enrolled in these programs. They are also required to seek reimbursement from third-party payers such as private insurance plans, Medicare, Medicaid, and CHIP. Health centers are further required to have systems to obtain reimbursements, including those used for billing, credit, and collections. These collections provide two-thirds of the Health Center Program's revenue (see **Table 4**).

Although health centers collect reimbursements, GAO found that Medicare payments did not cover the full cost of health center services in nearly two-thirds of the visits it examined.<sup>14</sup>

<sup>10</sup> The 2015 federal poverty level was \$11,770 for an individual living alone, \$15,930 for a two-person family, and \$24,250 for a family of four. For more information, see U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "2015 Poverty Guidelines," <http://www.aspe.hhs.gov/poverty/15poverty.cfm>.

<sup>11</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, *Policy Information Notice: Sliding Fee Discount and Related Billings and Collections Program Requirements*, Document PIN 2014-2, Rockville, MD, September 22, 2014.

<sup>12</sup> 42 C.F.R. 51c.303(f) and §330(k)(3)(G)(i) of the Public Health Service Act (PHSA).

<sup>13</sup> Ibid.

<sup>14</sup> U.S. Government Accountability Office, *Medicare Payments to Federally Qualified Health Centers*, GAO-10-576R, July 30, 2010. The Centers for Medicare & Medicaid Services, the agency that administers the Medicare program, disagreed with GAO's findings; see Enclosure III of U.S. Government Accountability Office, *Medicare Payments to Federally Qualified Health Centers*, GAO-10-576R, July 30, 2010. **Appendix B** describes ACA changes to Medicare FQHC payments that may more closely align Medicare payments to the costs of providing services. CMS released the final rule to implement these changes; see Center for Medicare & Medicaid Services, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for (continued...)"

Similarly, the National Association of Community Health Centers (NACHC)—the main advocacy group for health centers at the national level—reports that the amount received in reimbursements is not sufficient to cover the cost of the health services provided.<sup>15</sup> It found that Medicaid reimbursements covered 81% of the cost of providing services, while Medicare and private insurance reimbursements covered approximately two-thirds.<sup>16</sup> The NACHC also found that the PHSA Section 330 grant amount received per uninsured patient—\$344—was less than half the average health center cost per patient of \$687.<sup>17</sup>

## Governance Requirements

Health centers are required to have a governing board that is made up primarily of health center patients. The governing board provides input on center operational issues, including the center’s budget, operating hours, management, and oversight. The governing board is required to meet monthly, and it must approve the center’s director and must approve grant applications submitted by the center.<sup>18</sup>

## Health Service Requirements

Health centers are required to provide primary health services and preventive and emergency health services.<sup>19</sup> In addition to these three types of services (primary, preventive, and emergency), health centers must provide diabetes self-management training for patients with diabetes or renal disease.<sup>20</sup> Primary health services are those provided by physicians<sup>21</sup> or physician extenders (physicians’ assistants, nurse clinicians, and nurse practitioners) to diagnose, treat, or refer patients. Primary health services include relevant diagnostic laboratory and radiology services. Preventive health services include well-child care, prenatal and postpartum care, immunization, family planning, health education, and preventive dental care. Emergency health services refer to the requirement that health centers have defined arrangements with outside providers for emergent cases that the center is not equipped to treat and for after-hours care.

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the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015,” 79 *Federal Register* 67547 -68010, November 13, 2014; see Section O “Establishment of the Federally Qualified Health Center Prospective Payment System (FQHC PPS).”

<sup>15</sup> See National Association of Community Health Centers, *A Sketch of Community Health Centers*, Chartbook, Washington, DC, 2014, [http://www.nachc.com/client/Chartbook\\_2014.pdf](http://www.nachc.com/client/Chartbook_2014.pdf) (hereinafter, *2014 Health Center Chartbook*).

<sup>16</sup> Ibid.

<sup>17</sup> Ibid. These amounts were for 2012.

<sup>18</sup> 42 U.S.C. §254b; some governance requirements may be waived for migrant health centers, health centers for the homeless, and health centers for residents of public housing (e.g., some migrant health centers are only open for portions of the year so the requirement to meet monthly would not apply in these instances).

<sup>19</sup> 42 C.F.R. 51c.102(h).

<sup>20</sup> This requirement was added by P.L. 109-171, effective January 1, 2006.

<sup>21</sup> The regulation further specifies that these services should be provided by primary care physicians, who are defined as physicians in family practice, internal medicine, pediatrics, or obstetrics and gynecology or, where appropriate, that these services may be provided by physician assistants, nurse practitioners, or nurse midwives.



Health center providers must also have admitting privileges at one or more hospitals located near the health center. This requirement is intended to ensure care continuity for hospitalized health center patients. In instances where a health center physician does not have admitting privileges at a nearby hospital, the health center is required to establish other arrangements to ensure care continuity.

Health centers are also required to provide enabling services such as translation services, health education, and transportation for individuals residing in a center's service area who have difficulty accessing the center. Health centers may also provide supplemental services such as additional dental care, mental health services, and substance abuse treatment.<sup>22</sup> **Table 1** identifies some specific services tracked in the Uniform Data System (UDS) 2013, the HRSA-required health center grantee reporting system.

**Table 1. Examples of Services Provided and the Number of Patients Served by Health Centers (2013)**

Service Provided	Number of Patients Served <sup>a</sup>
Medical Services	18,592,375
Dental Services	4,442,177
Enabling Services <sup>b</sup>	2,077,351
Mental Health Services	1,119,706
Substance Abuse Services	105,605

**Source:** HRSA, Uniform Data System (UDS) Report, UDS, *National Rollup Report, 2013*, at <http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2013&state=>; hereinafter, 2013 UDS Report.

- a. An individual patient may receive more than one type of service in a given year.
- b. For example, translation or transportation to the health center.

## Reporting and Quality Assurance Requirements

Health centers are required to report to HRSA certain information and to have quality improvement and assurance plans in place. First, health centers are required to report patient demographics, services provided, staffing information, utilization rates, costs, and revenue to HRSA's UDS. Second, within the UDS, health centers must report on certain clinical outcomes to assess quality.<sup>23</sup> These outcomes are similar to those examined in other health care settings. They include, for example, the percentage of children who received recommended immunizations by the age of two, the percentage of women who were screened for cervical cancer, and the percentage of patients whose body mass index was assessed and who were referred to appropriate services if found to be obese.<sup>24</sup> Finally, health centers are required to have quality improvement

<sup>22</sup> For specific types of health centers (see "What Types of Health Centers Exist?"), some supplemental services may be required.

<sup>23</sup> The performance measures and clinical outcomes that health centers are required to report are those commonly used by the Medicare and Medicaid programs, and health insurance and managed care organizations. For more information, see <http://bphc.hrsa.gov/policiesregulations/performanceasures/index.html>.

<sup>24</sup> Ibid. HRSA also submitted a report to Congress about ongoing health center quality improvement efforts; see U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Care, *Report to Congress: Efforts to Expand and Accelerate Health Center Program Quality Improvement*, Rockville, MD, (continued...)

systems in place that include clinical services, management, and patient confidentiality assurances. To meet this requirement, health centers must have a clinical director who reports on quality improvement and assurance activities. The clinical director conducts periodic assessments of the health center's services to evaluate the quality and appropriateness of services provided. The HHS Inspector General found that more than two-thirds of the health centers conducted quality assessments.<sup>25</sup> HHS has also awarded grants to health centers to implement quality initiatives such as care coordination through mechanisms like medical homes.<sup>26</sup>

## Licensing and Accreditation Requirements

Health center providers must be properly licensed in the state in which they practice. In addition, they must have admitting privileges at hospitals where health center patients are likely to be referred (see "Health Service Requirements"). Furthermore, providers must maintain proper credentials during their health center employment.

Although health centers are not required to be accredited by a national accreditation agency, HRSA encourages them to seek accreditation. Specifically, HRSA encourages health centers to seek accreditation from either the Accreditation Association for Ambulatory Health Care (AAHC) or The Joint Commission (TJC). HRSA pays some of the costs of seeking and maintaining accreditation from one of these two accrediting entities.<sup>27</sup>

## Grants That Support Federal Health Centers

HRSA awards five types of Section 330 authorized grants to support health centers: (1) grants for new health centers, (2) grants to expand services at existing health centers, (3) grants for construction and renovation, (4) planning grants, and (5) grants to reduce infant mortality.<sup>28</sup> This section describes these types of grants, the entities that are eligible to receive grants, and the factors taken into consideration when awarding grants.

## Grants Available to Support Health Centers

As noted, five types of grant programs support health centers.

- New Access Point (NAP) grants permit existing grantees to establish new sites or new grantees to establish new health centers.

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April 26, 2011, <http://bphc.hrsa.gov/ftca/riskmanagement/healthcenterqualityimprovement.pdf> (hereinafter, *Health Center Quality Improvement Report*).

<sup>25</sup> Stuart Wright, Deputy Inspector General for Evaluation and Inspections, *Memorandum Report: Quality Assurance and Care Provided at HRSA-Funded Health Centers*, Department of Health and Human Services, Office of Inspector General, OE-09-06-00420, Washington, DC, March 2, 2012.

<sup>26</sup> U.S. Department of Health and Human Services, "Affordable Care Act Funds to Enhance Quality of Care at Community Health Centers," press release, September 27, 2012, <http://www.hhs.gov/news/press/2012pres/09/20120927b.html>.

<sup>27</sup> For more information, see <http://bphc.hrsa.gov/policiesregulations/accreditation.html>.

<sup>28</sup> PHSA §330 also authorizes the Secretary to make grants to health centers to plan and develop managed care networks and plans and practice management networks, and to guarantee loans that health centers may incur for these purposes.

- Increased Demand for Services (IDS) or Expanded Service (ES) grants are for health centers to expand the number of patients they serve or to provide additional types of services. A subset of ES grants, Quality Improvement Grants, are used to expand services at existing health centers; these grants award funds to health centers to support activities that support health center quality improvement efforts, including meeting the requirements to become an accredited Patient-Centered Medical Home.<sup>29</sup>
- The Capital Improvement Program (CIP) provides funding for the construction and renovation of health centers.
- Planning Grants are available to entities that are not health centers, to plan and develop health centers. Funds may be used for assessing the health needs of the proposed service population and developing linkages with the community and with health providers in the proposed service area.
- Infant Mortality Grants had been available for activities that aim to reduce infant mortality. These grants have not been awarded in recent years; instead, HRSA supports other infant mortality reduction programs.<sup>30</sup>

### Grant Eligibility and Awarding Criteria

Public and non-profit entities are eligible to apply for Section 330 grants to operate health centers. The majority of health center grantees operate facilities at more than one site, and some operate more than one type of health center.<sup>31</sup> Grants are awarded competitively based on an assessment of the need for services in a given area and the merit of the application submitted. Grants may also be awarded based on certain funding priorities, such as creating a rural-urban balance in health center locations.<sup>32</sup> Under statute, HRSA must allocate certain percentages of the Health Center Program's budget to grants that support health centers serving special populations (e.g., migrant workers, the homeless, residents of public housing). Specifically, the Health Center Program's budget must be allocated as follows:

- at least 8.6% for grants to centers serving migrant or seasonal farmworkers,
- at least 8.7% for grants to centers serving homeless individuals, and
- at least 1.2% for grants to centers serving residents of public housing.<sup>33</sup>

A health center may be of more than one type—for example, a community health center may also operate a migrant health center, but it must devote at least 25% of its HRSA grant funding to migrants to be considered to be serving a “special population.” In addition to these funding requirements, HRSA is required to give special consideration, within the competitive grant

<sup>29</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, *Accreditation and Patient Centered Medical Home Recognition Initiative*, Program Assistance Letter: Document 2015:02, Rockville, MD, February 15, 2015, <http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pal201502.pdf>.

<sup>30</sup> For more information about these programs, see CRS Report R41378, *The U.S. Infant Mortality Rate: International Comparisons, Underlying Factors, and Federal Programs*.

<sup>31</sup> Health Center Quality Improvement Report.

<sup>32</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees, FY2016*, Rockville, MD (hereinafter, *HRSA FY2016 Budget Justification*).

<sup>33</sup> 42 U.S.C. §254(b)(r)(2)(B).

process, to applications for centers that would serve sparsely populated areas, defined as areas with seven or fewer residents per square mile.<sup>34</sup> GAO found that in order to ensure that these percentages are met, HRSA may adjust funding criteria, thereby funding some applications that may not have scored as high in the competitive process.<sup>35</sup>

Grant recipients are not required to provide matching funds, but are required to use grant funds to supplement and not supplant funding that had been available prior to the grant. Grant amounts are based on the cost of proposed grant activity (see **Table 2**). An entity may receive funding for multiyear projects, but amounts awarded in subsequent years are contingent on (1) congressional appropriations and (2) the entity's compliance with applicable statutory, regulatory, and reporting requirements.<sup>36</sup> At the end of the application period, health centers are required to compete for continued funding.<sup>37</sup>

**Table 2. Health Center Grants Awarded (FY2015)**

Grants	FY2015
Total Number of Grants	1,349
Average Awarded Amount	\$2.85 million
Range of Awarded Amounts	\$200,000-\$16.00 million

**Source:** U.S. Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees, FY2016*, Rockville, MD.

## What Is the Health Center Program's Appropriation?

The Health Center Program's appropriation has increased over the past decade, resulting in the establishment of more centers and the ability to serve more patients. From FY2005 through FY2015, the program's funding level increased by 188%, from \$1.7 billion to \$5.0 billion. Over this same time period, the number of health center sites also increased. Beginning in 2002, the George W. Bush Administration began a multiyear effort to expand the Health Center Program by providing funding for new or expanded health centers for 1,200 communities.<sup>38</sup> The program's expansion has continued during the Obama Administration. In FY2009, the Health Center Program received \$2 billion under the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5). Specifically, ARRA provided \$500 million for new sites and expanded services at existing sites. It also provided \$1.5 billion for construction, renovation, equipment, and health information technology. The program's expansion continued under the Patient Protection and Affordable Care Act of 2010 (ACA),<sup>39</sup> which permanently authorized the Health Center Program, appropriated a total of \$1.5 billion for health center construction and repair, and

<sup>34</sup> Ibid. and 42 U.S.C. §254b(p).

<sup>35</sup> U.S. Government Accountability Office, *Health Center Program: 2011 Grant Award Process Highlighted Need and Special Populations Merit Evaluation*, 12-504, May 2012.

<sup>36</sup> As discussed above, GAO has raised concerns with HRSA's oversight of health center grants; see U.S. Government Accountability Office, *Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements*, 12-546, May 2012.

<sup>37</sup> HRSA FY2016 Budget Justification.

<sup>38</sup> Department of Health and Human Services, *Budget in Brief*, FY2007, pp. 5-6 and 21.

<sup>39</sup> P.L. 111-148, as amended.

created the Community Health Center Fund (CHCF), which included a total of \$9.5 billion for health center operations to be appropriated in FY2011 through FY2015.<sup>40</sup> The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended the CHCF through FY2017, providing a total of \$7.2 billion to support health center operations.

Although the Health Center Program's funding has increased because of the CHCF, this increase was smaller than anticipated when the ACA was enacted in 2010 because the CHCF has been used to offset reductions in discretionary appropriations to the Health Center Program.<sup>41</sup> The ACA also appropriated funding for competitive funds that permitted health centers to receive payments in exchange for training medical residents.<sup>42</sup> Although the program's funding level has nearly doubled since FY2005, the additional appropriated funds have generally been used to expand the number of centers—which increased by 154%<sup>43</sup>—while funding awarded to individual centers increased less rapidly over the same time period.<sup>44</sup>

**Table 3** presents the Health Center Program's appropriations from FY2005 through the FY2016 President's budget request. The table also includes amounts appropriated under ARRA and the ACA and the number of sites in each fiscal year.

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<sup>40</sup> The total amount that will be appropriated was reduced under the FY2013, FY2014, and FY2015 sequester. For more information, see CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, and U.S. Office of Management and Budget, *OMB Report To The Congress On the Joint Committee Reductions for Fiscal Year 2015*, Washington, DC, March 10, 2014, [http://www.whitehouse.gov/sites/default/files/omb/assets/legislative\\_reports/sequestration\\_order\\_report\\_march2014.pdf](http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/sequestration_order_report_march2014.pdf).

<sup>41</sup> Under the ACA, the CHCF was required to be used to increase the health center appropriation level above the FY2008 appropriations level; however, the CHCF was used to augment discretionary funding for the health center program. The same thing occurred in FY2012, FY2013, and FY2014 under the continuing resolution (P.L. 113-46).

<sup>42</sup> CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*, and CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in ACA: Summary and Timeline*. HHS has also awarded grants to health centers to support care coordination initiatives, in particular medical homes; see U.S. Department of Health and Human Services, "Affordable Care Act Funds to Enhance Quality of Care at Community Health Centers," press release, September 27, 2012, <http://www.hhs.gov/news/press/2012pres/09/20120927b.html>. Funding for this program was extended through FY2017 in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10).

<sup>43</sup> See **Table 3**.

<sup>44</sup> CRS analysis of HRSA Budget documents.

**Table 3. Health Center Appropriations and Sites, FY2005-FY2016 (President’s Budget Request)**

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016 (Request)
<b>Dollars in Millions</b>												
Appropriation	\$1,735	\$1,785	\$1,988	\$2,065	\$2,190	\$2,185	\$2,190	\$1,567	\$1,480 <sup>a</sup>	\$1,495	\$1,492	\$1,492
ARRA Funds <sup>b</sup>					\$2,000							
ACA CHCF <sup>c</sup>							\$1,000	\$1,200	\$1,465 <sup>a</sup>	\$2,145 <sup>a</sup>	\$3,509 <sup>a</sup>	\$3,600 <sup>d</sup>
Proposed Mandatory Funds												\$2,700
<b>Total Funding</b>	<b>\$1,735</b>	<b>\$1,785</b>	<b>\$1,988</b>	<b>\$2,065</b>	<b>\$4,190</b>	<b>\$2,185</b>	<b>\$3,190</b>	<b>\$2,767</b>	<b>\$2,945</b>	<b>\$3,640</b>	<b>\$5,001<sup>e</sup></b>	<b>\$4,192<sup>f</sup></b>
<b>Number of Sites</b>												
Approx. number of sites	3,745	___ <sup>g</sup>	3,831	6,208	7,892	8,156	8,501	8,746	9,000	9,200	9,500	___ <sup>g</sup>

**Source:** Compiled by CRS from HRSA budget documents.

**Notes:** Appropriated amounts include federal tort claims funds.

- a. Reflects amount reduced under sequestration as required in the Budget Control Act.
- b. American Recovery and Reinvestment Act (ARRA, P.L. 111-5).
- c. Community Health Center Fund (CHCF) refers to amounts transferred from the CHCF that was created in Section 10503 of the Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended).
- d. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended the CHCF and provided \$3.6 billion for each of FY2016 and FY2017.
- e. The President’s FY2016 budget proposes to reserve a total of \$541 million from the FY2105 CHCF allocation to be used in FY2016, FY2017, and FY2018.
- f. The President’s FY2016 budget proposes to use \$178 million of the amount reserved from the FY2015 CHCF allocation for use in FY2016.
- g. Number not included in HRSA budget documents.

## What Are the Other Sources of Funding for the Health Center Program?

In addition to Section 330 grants, health centers receive funding from reimbursements and from other sources (e.g., state and local grants). The relative contribution of each of these sources to an individual health center's budget varies by center. However, HRSA compiles this information for the Health Center Program. **Table 4** presents data for FY2015, the most recent year of data available. Medicaid is the largest source of health center revenue (41.7%) in FY2015; amounts collected from private insurance increased from 8.6% of revenue in FY2014 to 10.0% in FY2015.<sup>45</sup> In FY2015, Medicare provides 5.8% of the program's revenue; and Section 330 grants provides 19.7% of the program's revenue, an increase from the 17.5% they provided in FY2014. Amounts received from grants and contracts from state, local, and private foundations provide 14.4% of the program's total revenue in FY2015, a decline from FY2014, when these sources were 16.1% of program revenue (see **Table 4**).

**Table 4. Health Center Program Revenue Sources (FY2015)**

(dollars in millions)

	Dollars	Percent of Program Revenue
<b>Section 330 Authorized Grants</b>		
Section 330 Grants	4,210.0	19.7
<b>Subtotal (Section 330 authorized grants)</b>	<b>4,210.0</b>	<b>19.7</b>
<b>Reimbursements</b>		
Medicaid	8,910.0	41.7
CHIP	320.0	1.5
Medicare	1,235.0	5.8
Other third party payers (e.g., private insurance)	2,130.0	10.0
Patient Fees <sup>a</sup>	1,045.0	4.9
<b>Subtotal (Reimbursements)</b>	<b>13,640.0</b>	<b>63.8</b>
<b>Other Federal Grants</b>		
Other Federal Grants	445.0	2.8
<b>Subtotal (Other Federal Grants)</b>	<b>445.0</b>	<b>2.8</b>
<b>State, Local, and Private Grants and Contracts</b>		
State, Local, Other	3,090.0	14.4
<b>Subtotal (State, Local, and Private Grants and Contracts)</b>	<b>3,090.0</b>	<b>14.4</b>
<b>Total (all sources)</b>	<b>21,385.0</b>	<b>100.0</b>

**Source:** U.S. Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees, FY2016*, Rockville, MD.

**Note:** Percentages may not sum to 100% due to rounding.

a. This refers to amounts collected from self-pay patients.

<sup>45</sup> CRS analysis of HRSA FY2016 Budget Justification, p. 62.

## What Are Health Centers?

This section describes health center facilities funded under the Health Center Program appropriation. It includes a discussion of the four types of health centers funded and compares the services offered and populations served by each center type. The section also describes where health centers are located and outcomes associated with health center use.<sup>46</sup>

## What Types of Health Centers Exist?

Four types of health centers exist: (1) community health centers, (2) health centers for the homeless, (3) health centers for residents of public housing, and (4) migrant health centers. The majority of health centers are community health centers (CHCs), which serve a generally underserved population. The other three types of health centers serve more targeted populations. Each type of health center is described below, along with the population targeted by these centers and the specific services that each type of center must provide.<sup>47</sup>

### Community Health Centers

The majority of health centers are CHCs because these facilities serve the general population with limited access to health care. CHCs are required to serve all residents who reside in the CHC service area (also known as the catchment area). CHCs are required to provide “primary health services” (see the “Health Service Requirements” section). CHC-required services are the baseline services that all types of health centers are required to provide. The other three types of health centers may be required to provide certain supplemental services that aim to meet the specific needs of the population they serve. The majority of Health Center Program grant funding is allocated to support CHCs. By statute, 18.5% of the budget must be reserved for grants that support health centers serving special populations; this means that a maximum of 81.5% of the Health Center Program budget may be used to support CHCs.<sup>48</sup>

### Health Centers for the Homeless

Health centers for the homeless (HCHs) provide services to homeless individuals—the only federal health program that targets this generally uninsured population.<sup>49</sup> Section 330 defines homeless individuals as those who lack permanent housing or live in temporary facilities or transitional housing.<sup>50</sup> In addition to the services required of all health centers, HCHs are required

<sup>46</sup> The outcomes discussed are not exhaustive; instead, the discussion focuses on some of the more commonly considered outcomes: improved health, reduced costs, and improved access.

<sup>47</sup> A number of outpatient facilities that are similar to health centers provide care to underserved populations, but these facilities do not receive grants authorized in PHSA §330. These facilities are described in **Appendix A**.

<sup>48</sup> CRS calculations based on requirements in 42 U.S.C. §254(b)(r)(2)(B) and discussion in U.S. Government Accountability Office, *Health Center Program: 2011 Grant Award Process Highlighted Need and Special Populations Merit Evaluation*, 12-504, May 2012.

<sup>49</sup> National Coalition for the Homeless at <http://www.nationalhomeless.org/factsheets/health.html>. Information on other programs available to the homeless population can be found in CRS Report RL30442, *Homelessness: Targeted Federal Programs and Recent Legislation*.

<sup>50</sup> P.L. 104-299 §330(h)(4)(A).



to provide substance abuse services and supportive services that aim to meet the health needs of the homeless population. HCHs may also provide mobile services and aim to connect homeless individuals with supportive services, such as emergency shelter, transitional housing, job training, 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. By statute, HRSA must allocate at least 8.7% of the Health Center Program budget to support these centers.<sup>51</sup>

### Health Centers for Residents of Public Housing

Health centers for residents of public housing<sup>52</sup> are located in public housing facilities and aim to provide primary care to individuals who reside there. These centers provide the services required of CHCs and are not required to provide specific supplemental services. These centers were authorized in 1990 because of congressional concern that public housing residents had worse health than similar (by demographic and economic status) individuals who did not reside in public housing.<sup>53</sup> By statute, HRSA must allocate at least 1.2% of the Health Center Program budget to support these centers.<sup>54</sup>

### Migrant Health Centers

Migrant health centers provide care to migrant farmworkers (persons whose principal employment is in agriculture on a seasonal basis and who establish temporary residences for work purposes) and seasonal farmworkers (persons whose principal employment is in agriculture on a seasonal basis, but do not migrate for this work).<sup>55</sup> HRSA estimates that it provides care to more than one-quarter of all migrant and seasonal farmworkers.<sup>56</sup> In addition to the general health center requirements, migrant health centers are required to provide certain services specific to their service population's health needs, such as supportive services, environmental health services, accident prevention, and prevention and treatment of health conditions related to pesticide exposure.<sup>57</sup> Migrant health centers may be exempt from providing all required services, and may operate only during certain periods of the year. By statute, HRSA must allocate at least 8.6% of the Health Center Program budget to support these centers.<sup>58</sup>

### Comparison of Health Center Types

**Table 5** describes the four types of health centers, their target populations, the additional services they are required to provide, and the number of patients seen in FY2013. Additional services are assessed relative to the CHC service requirements (see "Health Service Requirements").

<sup>51</sup> 42 U.S.C. §254(b)(r)(2)(B).

<sup>52</sup> As defined by 42 U.S.C. §1437 et seq.

<sup>53</sup> P.L. 101-527; see also National Center for Health in Public Housing, "Fact Sheet: Public Housing Primary Care Program (PHPC)," May 2012, <http://www.nchph.org/wp-content/uploads/2013/11/NCHPH-PHPC1.pdf>.

<sup>54</sup> 42 U.S.C. §254(b)(r)(2)(B).

<sup>55</sup> 42 U.S.C. §254b.

<sup>56</sup> Health Center Quality Improvement Report.

<sup>57</sup> 42 C.F.R. §56.102(g).

<sup>58</sup> 42 U.S.C. §254(b)(r)(2)(B).

**Table 5. Comparison of Health Center Types**  
(2013)

Health Center Type	Target Population	Additional Requirements <sup>a</sup>	Number of Patients Seen <sup>b</sup>
<b>Community Health Centers</b>	All individuals who live in service area	Not Applicable.	19,857,433 <sup>c</sup>
<b>Health Centers For the Homeless</b>	Homeless individuals	Prevention and treatment services for substance abuse.	851,641
<b>Health Centers for Residents of Public Housing</b>	Individuals who reside in or near public housing	Must consult with public housing residents prior to applying for a grant.	227,665
<b>Migrant Health Centers</b>	Migrant, agricultural workers	Environmental health services including sanitation services; and services related to the prevention and treatment of pesticide exposure.	790,226

**Source:** HRSA's Data Warehouse at <http://datawarehouse.hrsa.gov/sitesdetail.aspx> and HRSA, *UDS*, National Rollup Report 2013.

- a. CHC-required services are considered the baseline; therefore, additional requirements are assessed relative to the requirements for CHCs.
- b. Refers to the 2013 patient population.
- c. HRSA does not report number of patients seen at CHCs; this number was estimated by subtracting the number seen at the three other types of health centers from the total number of patients seen (21,726,965).

## Who Uses Health Centers?

According to HRSA, health centers served 21.7 million patients in 2013. These patients were generally socioeconomically disadvantaged and uninsured or underinsured.<sup>59</sup> The majority of health center patients have incomes at or below the federal poverty level. Nearly a quarter of patients are treated in a language other than English, and the majority of health center patients are racial or ethnic minorities. In 2013, more than one-third of health center patients were identified as Hispanic/Latino and nearly one-quarter identified as African American. Both of these rates are close to double the proportion of these groups in the overall U.S. population. **Table 6** presents some demographic characteristics of the health center patient population in 2013, including age, race, ethnicity, and insurance status.

<sup>59</sup> 2013 UDS Report.

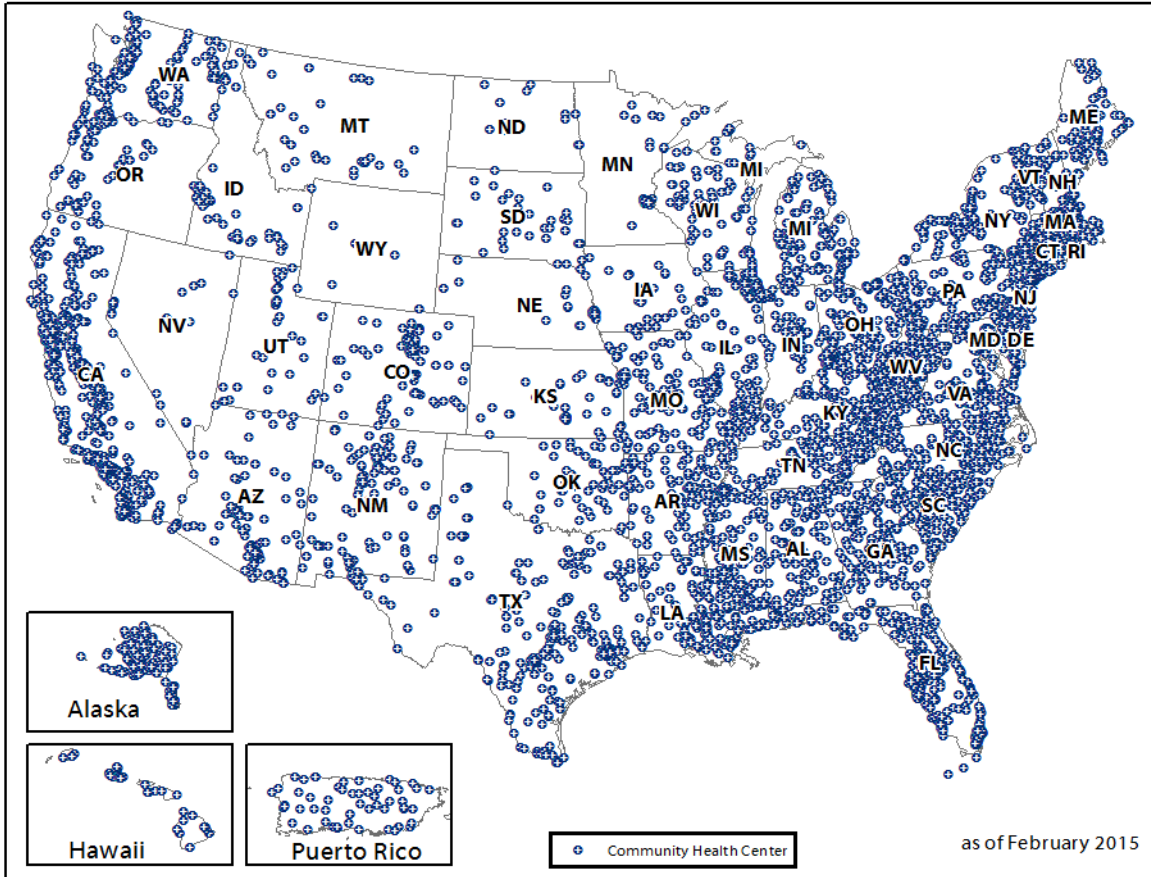
**Table 6. Health Centers' Patient Profiles, 2013**

Demographic Characteristics of Patients	Percentage of Patients Served
Income at or below the federal poverty level	71.9%
Enrolled in Medicaid	41.5%
Uninsured	34.9%
Hispanic/Latino	34.8%
Below age 18	31.7%
African American	23.8%
Enrolled in Medicare	8.4%
Age 65 and older	7.4%

**Source:** Department of Health and Human Services, Health Resources Services and Administration's website: <http://bphc.hrsa.gov/uds/datacenter.aspx>, 2013 Data Snapshot; and HRSA website: "What is a Health Center" at <http://bphc.hrsa.gov/about/>.

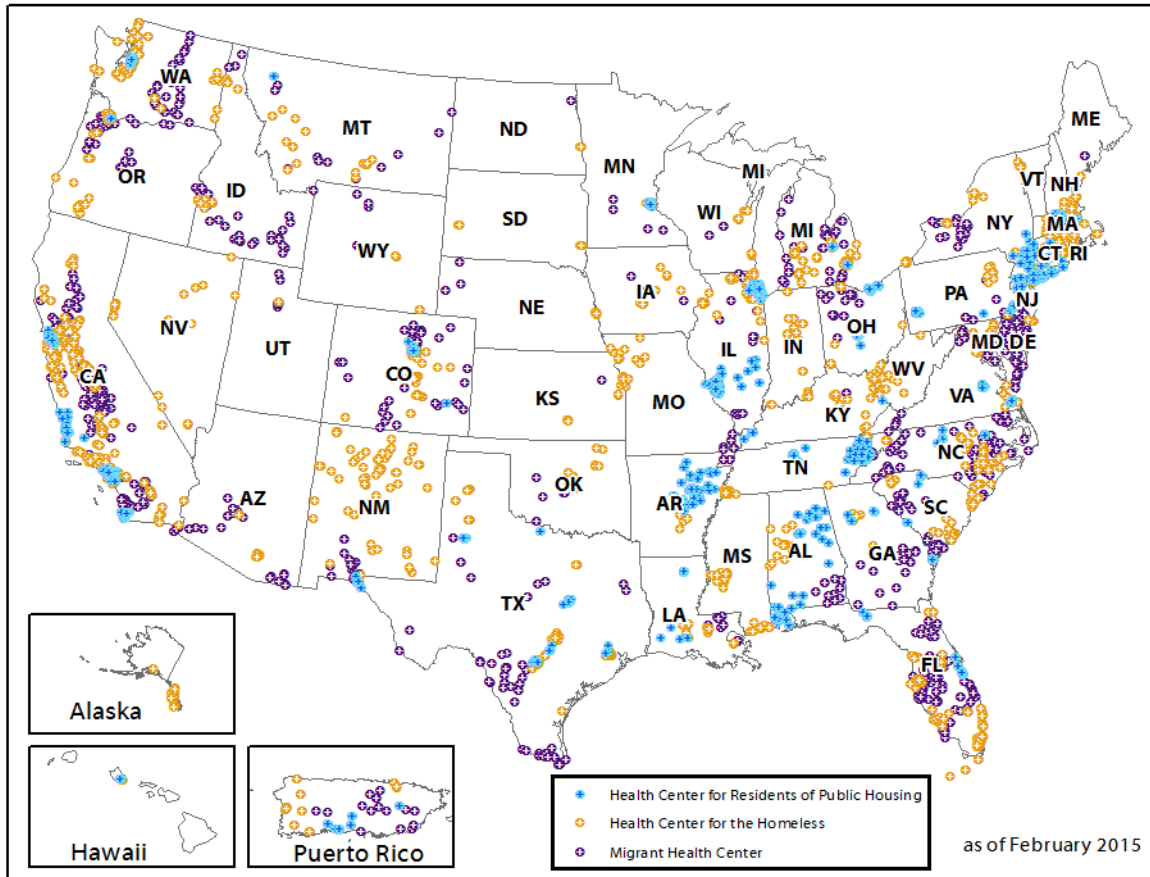
**Figure 1** shows the locations of community health centers funded with PHSA Section 330 grants and **Figure 2** shows the locations of the three other types of health center grantees. **Figure 1** shows that community health centers are distributed throughout the country. **Figure 1**, compared with **Figure 2**, also shows that community health centers are the most numerous type of sites and that a number of health centers receive grants to operate multiple health center types in the same geographic area.

**Figure I. Community Health Center Grantee Sites**  
(Data as of February 2015)



Source: CRS analysis of HRSA grantee data.

**Figure 2. Selected Other Health Center Sites**  
(Data as of February 2015)



Source: CRS analysis of HRSA grantee data.

## What Outcomes Are Associated with Health Center Use?

Researchers have found that access to health centers can improve health outcomes and reduce costs for the populations and areas they serve. Research has also found that health centers may increase access to health care for generally underserved populations, such as those enrolled in Medicaid, and racial and ethnic minorities. This section briefly summarizes the research on the effects of health centers on health, costs, access, and quality.

### Health Outcomes

Health centers focus on preventive care and attempt to manage patients' chronic conditions. This focus may improve health by preventing disease and disease-related complications.<sup>60</sup> Research has found that health center patients are more likely to receive preventive health services—including pap tests and influenza vaccinations—and more likely to receive preventive

<sup>60</sup> U.S. Government Accountability Office, *Hospital Emergency Departments: Health Center Strategies that May Help Reduce Their Use*, GAO-11-414R, April 11, 2011.

screenings—including mammograms and colonoscopies—when compared to non-health center patients of similar socioeconomic status.<sup>61</sup> Health center patients are also more likely to have their chronic conditions (e.g., diabetes) managed.<sup>62</sup>

Finally, health centers aim to increase prenatal care use in low-income pregnant women to reduce outcomes associated with infant mortality such as low birth weight. HRSA has found that health centers have made progress in this effort: an increasing number of health center patients initiate prenatal care in their first trimester, resulting in fewer health center patients—when compared to the national average—having low birth weight babies, which is a major cause of infant death.<sup>63</sup>

## Cost Outcomes

Researchers have found that health centers may lower health care costs by reducing more costly emergency department visits. GAO found that, on average, treatment at health centers is nearly one-seventh the cost of treatment of the same condition in an emergency department.<sup>64</sup> Given these differences in cost, health centers that successfully reduce emergency department use may reduce health care costs. One study found that counties with health centers have lower emergency room use and that individuals who live near health centers use emergency rooms less.<sup>65</sup> In addition, GAO found that health centers attempt to lower emergency department use in the communities in which they operate by educating patients about services offered at health centers and by offering same-day and afterhours appointments.<sup>66</sup>

Health centers may also reduce health care costs by preventing unnecessary hospitalizations. A number of studies have examined “ambulatory care sensitive conditions,” which are conditions

<sup>61</sup> Leiyu Shi et al., “Racial/Ethnic and Socioeconomic Disparities in Access to Care and Quality of Care for US Health Center Patients Compared with Non-Health Center Patients,” *Journal of Ambulatory Care Management*, vol. 32, no. 4 (October-December 2009), pp. 342-350; Leiyu Shi and Gregory D. Stevens, “The Role of Community Health Centers in Delivering Primary Care to the Underserved,” *Ambulatory Care Management*, vol. 30, no. 2 (April-June 2007), pp. 159-170; and L. Elizabeth Goldman et al., “Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures,” *American Journal of Preventive Medicine*, July 2012, pp. 1-8. Neda Laiteerapong et al., “Health Care Utilization and Receipt of Preventive Care for Patients Seen at Federally Funded Health Centers Compared to Other Sites of Primary Care,” *Health Services Research*, vol. 49, no. 5 (October 2014), pp. 1498-1518. Despite higher rates of preventive health services and vaccinations, the HHS Inspector General found that not all health center patients received the recommended preventive services or appropriate vaccinations. See Stuart Wright, Deputy Inspector General for Evaluation and Inspections, *Memorandum Report: Quality Assurance and Care Provided at HRSA-Funded Health Centers*, Department of Health and Human Services, Office of Inspector General, OE-09-06-00420, Washington, DC, March 2, 2012.

<sup>62</sup> Marshall H. Chin et al., “Quality of Diabetes Care in Community Health Centers,” *American Journal of Public Health*, vol. 90, no. 3 (March 2000), pp. 431-434.

<sup>63</sup> FY2016 HRSA Budget Justification and CRS Report R41378, *The U.S. Infant Mortality Rate: International Comparisons, Underlying Factors, and Federal Programs*.

<sup>64</sup> See research summarized in U.S. Government Accountability Office, *Hospital Emergency Departments: Health Center Strategies that May Help Reduce Their Use*, GAO-11-414R, April 11, 2011.

<sup>65</sup> Md. Monir Hossain and James N. Laditka, “Using Hospitalization for Ambulatory Care Sensitive Conditions to Measure Access to Primary Health Care: An Application of Spatial Structural Equation Modeling,” *International Journal of Health Geography*, vol. 8, no. 51 (August 2008) and Janice C. Probst et al., “Association Between Community Health Center and Rural Health Clinic Presence and County-Level Hospitalization Rates for Ambulatory Care Sensitive Conditions: An Analysis Across U.S. States,” *BMC Health Services Research*, vol. 9, no. 134 (July 2009).

<sup>66</sup> U.S. Government Accountability Office, *Hospital Emergency Departments: Health Center Strategies the May Help Reduce Their Use*, GAO-11-414R, April 11, 2011.

that potentially can be treated in an outpatient setting thus avoiding a hospitalization (e.g., asthma or seizures). These studies have found that in communities with health centers, individuals with these conditions were less likely to be hospitalized.<sup>67</sup> Health center patients enrolled in Medicaid were also less likely to be hospitalized and less likely to have an emergency room visit, relative to Medicaid beneficiaries who did not use health centers.<sup>68</sup>

Researchers who looked at the Health Center Program's use of medical homes to coordinate patient care found that patients who received the majority of their care at health centers that have implemented medical homes have lower medical costs (41% lower on average) than those who receive the majority of their care through another source.<sup>69</sup> Another study that examined national survey data found that health centers (whether or not they employed the medical home model) reduced costs by 24%,<sup>70</sup> whereas a North Carolina study found that health center users' annual health care spending was 62% less than similar patients (matched by demographic characteristics and health status) who were served in other outpatient settings.<sup>71</sup> Regardless of the magnitude of the difference, there appears to be consensus that health centers provide less costly health care than other outpatient settings.<sup>72</sup>

The reasons that health centers provide less costly care are debated. The authors of the North Carolina study suggest that health centers provide health care at a lower cost because they can offer discounted services through federal programs (see "Which Federal Programs Are Available to Health Centers?"). They also suggest that health centers may provide less overall costly care because their providers work on a salaried basis, and so do not have financial incentives to order additional tests or procedures. This may not be the case in other outpatient settings because providers generally work under a fee-for-service model, where they may receive additional remuneration for providing more services.<sup>73</sup> Other studies note that differences in the cost of services (i.e., the cost for a particular procedure or visit) do not explain the difference because health centers are paid the FQHC rate, which should likely be comparable to, or higher than, the rates reimbursed in other outpatient settings. Given differing explanations of how health centers

<sup>67</sup> The study measured "ambulatory care sensitive conditions," which are conditions for which hospitalization could have been prevented with timely primary care. These conditions are used as a measure of access to health care, and this measure has been endorsed by the Institute of Medicine, among others. See Md. Monir Hossain and James N. Laditka, "Using Hospitalization for Ambulatory Care Sensitive Conditions to Measure Access to Primary Health Care: An Application of Spatial Structural Equation Modeling," *International Journal of Health Geography*, vol. 8, no. 51 (August 2008).

<sup>68</sup> Health Center Quality Improvement Report.

<sup>69</sup> National Association of Community Health Centers, The Robert Graham Center, and Capital Link, *Access Granted: The Primary Care Payoff*, Bethesda, MD, August 2007, <http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2007/rgcmo-access-granted.Par.0001.File.tmp/rgcmo-access-granted.pdf>.

<sup>70</sup> Patrick Richard et al., "Cost Savings Associated with the Use of Community Health Centers," *Journal of Ambulatory Care Management*, vol. 35, no. 1 (2012), pp. 50-59.

<sup>71</sup> Patrick Richard et al., *Bending the Health Care Cost Curve in North Carolina: The Experience of Community Health Centers*, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief #24, Washington, DC, August 9, 2011.

<sup>72</sup> See, for example, discussion in HRSA FY2016 Budget Justification.

<sup>73</sup> Patrick Richard et al., *Bending the Health Care Cost Curve in North Carolina: The Experience of Community Health Centers*, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief #24, Washington, DC, August 9, 2011.

may reduce health care costs, the researchers state that health center costs may be lower because they avert more costly emergency room visits, specialty care, or hospital stays.<sup>74</sup>

## Access to Health Care

Health centers aim to provide care to underserved populations and, in doing so, may increase health care access. By definition, health centers are located in areas with few providers, including rural and inner city areas. These locations may provide access for populations that are otherwise underserved, for example, because of geography or income. Health centers also serve a more diverse population than do office-based physicians; results from one study indicate health center patients were more likely to be Hispanic or African American.<sup>75</sup> Health centers may also increase access for specific racial and ethnic groups. For example, one study found that health centers increase health care access for Asian Americans, Native Hawaiians, and other Pacific Islanders.<sup>76</sup> Some research has suggested that health centers may reduce health disparities because they provide care to a population that might otherwise have difficulty accessing health care.<sup>77</sup>

Relative to other providers (such as office-based physicians), health centers are more likely to accept new patients and patients who are unable to pay for services (i.e., charity patients).<sup>78</sup> Health center patients are also more likely to be enrolled in Medicaid or CHIP. As noted, health centers are required to coordinate with Medicaid and CHIP plans and are required to accept all patients, regardless of their insurance status or ability to pay. As such, health centers are a common source of care for Medicaid patients. Recent research found that Medicaid patients were more likely to obtain an appointment at a health center than they were at private primary care practice.<sup>79</sup> Researchers have also found that health center presence in a geographic area increases the likelihood that low-income adults have seen a doctor in the past year (whether at a health center or not).<sup>80</sup>

## Quality

Recent evaluations have compared the quality of care provided at health centers to that provided in physician offices. One study examined 18 quality measures and found that health centers performed better on 6 measures (related to treatment for congestive heart failure, coronary artery disease, depression, and screening), no differently on 11 measures, and worse on 2 measures

<sup>74</sup> Patrick Richard et al., “Cost Savings Associated with the Use of Community Health Centers,” *Journal of Ambulatory Care Management*, vol. 35, no. 1 (2012), pp. 50-59.

<sup>75</sup> Esther Hing, Roderick S. Hooker, and Jill J. Ashman, “Primary Health Care in Community Health Centers and Comparisons with Office-Based Practice,” *Journal of Community Health*, vol. 36, no. 3 (2011), pp. 406-413.

<sup>76</sup> Rosy Chang Weir, “Use of Enabling Services by Asian American, Native Hawaiian, and Other Pacific Islander Patients at 4 Community Health Centers,” *American Journal of Public Health*, vol. 100, no. 11 (November 2010), pp. 2199-2205.

<sup>77</sup> Health Center Quality Improvement Report.

<sup>78</sup> Brendan Saloner et al., *The Availability of New Patient Appointments for Primary Care at Federally Qualified Health Centers: Findings from an Audit Study*, The Urban Institute Health Policy Center, Washington, DC, April 7, 2014.

<sup>79</sup> Ibid. and Michael R. Richards et al., “Access Points for the Underserved: Primary Care Appointments Availability at Federally Qualified Health Centers in 10 States,” *Medical Care*, vol. 52, no. 9 (September 2014), pp. 818-825.

<sup>80</sup> Stacey McMorrow and Stephen Zuckerman, “Expanding Federal Funding to Community Health Centers Slows Decline in Access for Low-Income Adults,” *Health Services Research*, vol. 49, no. 3 (June 2014), pp. 992-1010.



(related to diet counseling for at risk adolescents). This was observed despite the study’s finding that health centers treat a population with higher rates of comorbidities, which may make it more difficult to provide care that meets the criteria required by the quality measures examined.<sup>81</sup>

Researchers have also examined the ability of health centers to manage chronic conditions and have found that health centers provide quality care when it comes to managing conditions such as diabetes and hypertension<sup>82</sup> and are successful in managing and reducing hospitalizations and emergency department visits due to asthma.<sup>83</sup>

Another study compared the quality of health center care to that of Medicaid managed care organizations (MCOs) on selected quality measures, including diabetes and blood pressure control.<sup>84</sup> The study found that there were two groups of health centers: those that exceeded Medicaid MCOs in the selected quality measures (called “high performing health centers”) and those that were below the Medicaid MCOs (called “low performing health centers”). The researchers found that more health centers were considered “high performing” (12%) and that relatively few health centers (4%) were considered “low performing.” The authors observed that there were differences in the population served by high- and low-performing health centers and that it is possible that these population differences resulted in the quality differences observed. Specifically, “low performing health centers” were more likely to serve individuals who were uninsured or homeless and had less revenue from Medicaid. There were also geographic differences in the quality of health centers, with “high performing” health centers located mostly in California, New York, and Massachusetts and with “low performing health centers” more often located in southern states.

## Which Federal Programs Are Available to Health Centers?

Section 330 grants, on average, cover approximately one-fifth of the cost of operating a health center;<sup>85</sup> the federal government provides other assistance—for example, provider recruitment and financial assistance—that may support individual health center operations. To assist with operations, health centers may employ members of the National Health Service Corps (NHSC), a program that provides scholarships and loan repayments in exchange for a period of service at a health center.<sup>86</sup> The federal government also provides financial support to health centers. For example, it designates health centers as Federally Qualified Health Centers (FQHCs), thereby making these facilities eligible for higher Medicare and Medicaid reimbursement rates.<sup>87</sup> Medicaid is the largest source of reimbursement, providing 40% of all revenue for the Health Center Program (see **Table 4**). The amount received by an individual health center varies by the

<sup>81</sup> L. Elizabeth Goldman et al., “Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures,” *American Journal of Preventive Medicine*, July 2012, pp. 1-8.

<sup>82</sup> Lydie A. Lebrun, “Racial/Ethnic Disparities in Clinical Quality Performance Among Health Centers,” *Journal of Ambulatory Care Management*, vol. 36, no. 1 (January-March 2013), pp. 24-34.

<sup>83</sup> Sibylle H. Lob et al., “Promoting Best-Care Practices in Childhood Asthma: Quality Improvement in Community Health Centers,” *Pediatrics*, vol. 128, no. 1 (July 2011), pp. 20-28.

<sup>84</sup> The Kaiser Commission on Medicaid and the Uninsured, *Quality of Care in Community Health Centers and Factors Associated with Performance*, Issue Brief, Washington, DC, June 2013.

<sup>85</sup> See **Table 4**.

<sup>86</sup> They may also fulfill their National Health Service Corps (NHSC) commitment at other types of facilities that provide care to populations in health professions shortage areas.

<sup>87</sup> These payments are discussed in more detail in **Appendix B**.

percentage of the patient population enrolled in Medicaid; however, the NACHC estimates that the average health center receives 38.1% of its revenue from Medicaid reimbursements.<sup>88</sup> Health centers are also eligible for discounted prescription drugs and vaccines, and may receive additional support from grants and loans offered through other federal programs.

## National Health Service Corps Providers

Health centers, which are located in medically underserved areas, are also automatically designated as health professional shortage areas (HPSAs)<sup>89</sup> and are therefore eligible for National Health Service Corps (NHSC) providers. The NHSC provides scholarships or loan repayments to health professionals working at specific facilities in HPSAs. About half of Corps members serve in health centers,<sup>90</sup> making the program an important mechanism for health centers to recruit providers. In addition to the NHSC, some states may operate loan repayment programs for health professionals providing care in state-designated shortage areas.<sup>91</sup>

## J-1 Visa Waivers

Health centers may also be able to obtain providers temporarily through special waivers for J-1 visa physicians. In general, foreign medical graduates who entered the country on a J-1 student visa must return to their home country for two years after they have completed their medical training (medical school and residency). J-1 visa waivers permit the two-year foreign residency period to be waived if the J-1 visa holder practices primary care in a HPSA.<sup>92</sup> Because health centers are designated as HPSAs, a number of centers may rely on this program to recruit physicians.<sup>93</sup>

## Federally Qualified Health Center Designation<sup>94</sup>

Health centers are eligible to be designated as Federally Qualified Health Centers (FQHCs),<sup>95</sup> but must enroll as a provider in the Medicare and/or Medicaid programs to receive the higher<sup>96</sup>

<sup>88</sup> 2013 Health Center Chartbook.

<sup>89</sup> Health professional shortage areas (HPSAs) are defined in 42 U.S.C. §254e. See U.S. Department of Health and Human Services, Health Resources and Services Administration, “Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P),” <http://hpsafind.hrsa.gov/>. For a larger discussion of Health Professional Shortage Areas (HPSAs), see CRS Report R42029, *Physician Supply and the Affordable Care Act*.

<sup>90</sup> For more detailed information on the NHSC, see CRS Report R43920, *National Health Service Corps: Changes in Funding and Impact on Recruitment*, by Bernice Reyes-Akinbileje. Funding for this program was extended through FY2017 in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10).

<sup>91</sup> U.S. Department of Health and Human Services, National Health Services Corps, “State Loan Repayment Program,” <http://nhsc.hrsa.gov/loanrepayment/stateloanrepaymentprogram/>.

<sup>92</sup> CRS Report R43735, *Temporary Professional, Managerial, and Skilled Foreign Workers: Policy and Trends*, and [http://www.raconline.org/topics/hc\\_providers/j1visafaq.php](http://www.raconline.org/topics/hc_providers/j1visafaq.php).

<sup>93</sup> This program provides a limited number of visa waivers and requires that the applicant have a three-year employment contract. For more information, see [http://www.raconline.org/topics/hc\\_providers/j1visafaq.php](http://www.raconline.org/topics/hc_providers/j1visafaq.php).

<sup>94</sup> Because all health centers are eligible to be designated as Federally Qualified Health Center (FQHCs), some refer to FQHCs and health centers interchangeably.

<sup>95</sup> Entities that receive PHSA §330 funds directly or through a contract with a §330 grantee may be designated as Federally Qualified Health Centers (FQHCs). When FQHCs were first established in 1989, entities that received PHSA §329 and §340 grants were also eligible to become FQHCs. The latter program is no longer authorized, and the former is not currently funded.

reimbursement rates for services provided to patients enrolled in these programs.<sup>97</sup> This higher reimbursement rate is an important source of health center revenue because more than one-third of the patients seen at health centers are enrolled in Medicaid.<sup>98</sup> Specific FQHC Medicare and Medicaid reimbursement methodology, including recent payment changes, are described in **Appendix B**.

### 340B Drug Pricing Program

Federal health centers are eligible to participate in the 340B Drug Pricing program, which requires drug manufacturers to provide drug discounts or rebates to 340B eligible facilities. The program provides drugs at discount prices—ranging from 13% to 17% below average manufacturer price, depending on the type of drug.<sup>99</sup> HRSA reports that in FY2013, 340B-eligible facilities saved \$3.8 billion because of the program.<sup>100</sup>

### Vaccines for Children Program<sup>101</sup>

Health centers are eligible to participate in the Vaccines for Children Program (VFC), which provides vaccines for low-income children who may not be vaccinated because of costs. The program is administered by the Centers for Disease Control and Prevention (CDC) and partially funded by Medicaid. The CDC buys the vaccines and distributes them to health departments that, in turn, distribute them to VFC providers including health centers. VFC provides free vaccines to Medicaid-enrolled children and VFC-eligible children (those who are uninsured, underinsured,<sup>102</sup> or those who are American Indian or Alaska Native). Health centers are a VFC-eligible provider, and provide vaccinations as part of their mission to provide primary and preventive services. The VFC program enables health centers to provide these vaccines at a lower cost to the patients and to the health center.

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<sup>96</sup> These payments are discussed in more detail in **Appendix B**; payments are considered to be “higher” than the payment rates that physician practices receive because they are cost-based and reflect a broader range of services, than do payments to physician practices. See, for example, Department of Health Policy, School of Public Health and Health Services, The George Washington University, *Quality Incentives for Federally Qualified Health Centers, Rural Health Clinics and Free Clinics: A Report to Congress*, Washington, DC, January 23, 2012.

<sup>97</sup> Health Resources and Services Administration, *Program Assistance Letter: Process of Becoming Eligible for Medicare Reimbursements under the FQHC Benefit*, Rockville, MD, March 8, 2011.

<sup>98</sup> Health Center Quality Improvement Report.

<sup>99</sup> HRSA FY2016 Budget Justification.

<sup>100</sup> *Ibid.*

<sup>101</sup> This paragraph is drawn from Centers for Disease Control and Prevention, “Questions Answered on Vaccines Purchased with 317 Funds” Atlanta, GA, <http://www.cdc.gov/vaccines/imz-managers/guides-pubs/qa-317-funds.html> and Centers for Disease Control and Prevention, “About VFC: The VFC Program at a Glance,” Atlanta, GA, <http://www.cdc.gov/vaccines/programs/vfc/about/index.html>.

<sup>102</sup> Underinsured refers to children who have private insurance coverage that does not cover vaccination or where vaccination coverage is capped at a certain amount. VFC coverage for underinsured children is available only at health centers and rural health clinics.

## Federal Torts Claims Act Coverage

Health center employees and board members do not need to carry medical malpractice coverage because they are covered under the Federal Tort Claims Act (FTCA).<sup>103</sup> Under the FTCA, health center employees and contractors cannot be sued for medical malpractice for care they provided that was within the scope of their health center employment. According to HRSA, in FY2014, 103 claims were paid through the FTCA program totaling \$72.2 million.<sup>104</sup> This program provides financial support to health centers because otherwise they would have to pay for malpractice coverage and would be responsible for payment and rate increases that may accompany claims made against health center providers.<sup>105</sup>

## Ryan White HIV/AIDS Treatment Grants<sup>106</sup>

Health centers are eligible to receive grants authorized under parts A and C of the Ryan White AIDS program. Part A authorizes grants for primary care, access to antiretroviral therapies, and other health and supportive services. These grants are awarded to certain metropolitan areas and are used to provide care for low-income, underserved, uninsured, or underinsured individuals living with HIV/AIDS. Part C grant funds are awarded to entities to provide medical services such as testing, referrals, and clinical and diagnostic services to underserved and uninsured people living with HIV/AIDS in rural and frontier communities.

## Other Federal Grant Programs<sup>107</sup>

Health centers are eligible to apply for a number of federally funded grant programs, including programs that seek to improve rural health and health care,<sup>108</sup> increase mental health and substance abuse services availability,<sup>109</sup> provide services to high-risk pregnant women and their infants,<sup>110</sup> increase health professional training at health centers,<sup>111</sup> and increase access to family planning services for low-income families.<sup>112</sup> The majority of these programs are funded by discretionary appropriations and are competitive grant programs authorized in the PHSA. Programs specific to rural areas may also be administered by the U.S. Department of Agriculture (USDA) and are authorized in other acts. For example, health centers in rural areas may be

<sup>103</sup> CRS Report 95-717, *Federal Tort Claims Act (FTCA)*.

<sup>104</sup> HRSA FY2016 Budget Justification.

<sup>105</sup> This responsibility could include both the cost of the claims and the legal costs resulting from defending providers against these claims.

<sup>106</sup> For more information about this program, see CRS Report RL33279, *The Ryan White HIV/AIDS Program*.

<sup>107</sup> In addition to federal support and amounts collected from reimbursements, health centers may also receive support from private foundations and state or local government grants and contracts; see 2013 UDS Report.

<sup>108</sup> HRSA FY2016 Budget Justification; for programs through the U.S. Department of Agriculture, see [http://www.rurdev.usda.gov/RD\\_Grants.html](http://www.rurdev.usda.gov/RD_Grants.html).

<sup>109</sup> For more information about the Substance Abuse and Mental Health Services Administration, see <http://www.samhsa.gov/>.

<sup>110</sup> Health Resources and Services Administration, Maternal and Child Health Bureau, "Healthy Start," <http://mchb.hrsa.gov/programs/healthystart/index.html> and CRS Report R42428, *The Maternal and Child Health Services Block Grant: Background and Funding*.

<sup>111</sup> CRS Report R41390, *Discretionary Spending Under the Affordable Care Act (ACA)*, and CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*.

<sup>112</sup> CRS Report RL33644, *Title X (Public Health Service Act) Family Planning Program*.

eligible for USDA programs that may assist facilities with acquiring equipment or space through loan guarantees and with acquiring broadband access.<sup>113</sup> Health centers may also use General Services Administration resources to acquire real estate and dispose of property<sup>114</sup> and may use the Department of Housing and Urban Development's insurance program to finance facility repair and improvement.<sup>115</sup>

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<sup>113</sup> For description of these programs, see United States Department of Agriculture Rural Development, November 20, 2014, [http://www.rurdev.usda.gov/HCF\\_CF.html](http://www.rurdev.usda.gov/HCF_CF.html).

<sup>114</sup> See General Services Administration, Federal Real Property Utilization and Disposal at <https://propertydisposal.gsa.gov> and Personal Property for Reuse and Sale at <http://www.gsa.gov/portal/category/21045>.

<sup>115</sup> See U.S. Department of Housing and Urban Development, Property Improvement Loan Insurance (Title I) at [http://portal.hud.gov/hudportal/HUD?src=/program\\_offices/housing/sfh/title/title-i](http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/sfh/title/title-i).

## Appendix A. Other Federal Programs That May Provide Primary Care to the Underserved

The federal government supports a number of facilities that provide primary care to low-income or otherwise medically underserved populations that are similar to health centers, but are not authorized in PHSA Section 330. For example, the ACA authorized funding for school-based health centers and nurse-managed health clinics. Both of these facilities serve underserved populations but have different requirements than facilities authorized in PHSA Section 330. The federal government also provides support for facilities that provide care to targeted populations such as American Indians, Alaska Natives, and Native Hawaiians; facilities located in rural areas; facilities that provide mental health services; and facilities that provide free care. This appendix describes these types of facilities, their authorization, and program requirements.

### School-Based Health Centers

School-based health centers (SBHCs) are facilities located on or near school grounds that provide age-appropriate comprehensive primary health care services to students regardless of their ability to pay.<sup>116</sup> SBHCs may be located at public, private, charter, or parochial schools and must be open, at a minimum, during school hours.<sup>117</sup> Prior to the ACA, HRSA funded SBHCs through its Section 330 appropriation.<sup>118</sup> The ACA authorized separate SBHC grants in Section 339Z-1 of the PHSA and appropriated \$200 million (\$50 million annually) from FY2010 to FY2013 to support grants for SBHC construction and renovation.<sup>119</sup> Although the ACA authorized grants for SBHC operation, funding has not been appropriated for these grants.<sup>120</sup> Despite the lack of an explicit SBHC operating grant program, some Section 330 grantees may operate SBHCs. HRSA estimates that SBHCs saw 479,670 patients in FY2013.<sup>121</sup>

<sup>116</sup> U.S. Government Accountability Office, *School-Based Health Centers: Available Information on Federal Funding*, 11-18R, October 8, 2010, <http://www.gao.gov/new.items/d1118r.pdf>.

<sup>117</sup> §2110(c)(9) of the Social Security Act defines a sponsoring facility as (a) a hospital; (b) a public health department; (c) a community health center; (d) a non-profit health care agency; (e) a local educational agency; or (f) a program administered by the Indian Health Service or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization.

<sup>118</sup> HRSA recognizes children as an underserved population and permitted SBHCs to apply for health center funding. See 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 (footnote 1) and page 4, at <ftp://ftp.hrsa.gov/bphc/docs/2005pins/2005-20.pdf>

<sup>119</sup> U.S. Department of Health and Human Services, “HHS Announces New Investment in School-Based Health Centers: December 19, 2012, <http://www.hhs.gov/news/press/2012pres/12/20121219a.html>; U.S. Department of Health and Human Services, “Affordable Care Act Support for School-Based Health Centers Will Create Jobs, Increase Access to Care for Thousands of Children,” December 8, 2011, <http://wayback.archive-it.org/3926/20140108161942/http://www.hhs.gov/news/press/2011pres/12/20111208a.html#>; U.S. Department of Health and Human Services, “HHS Announces New Investment in School-Based Health Centers,” July 14, 2011, <http://www.hhs.gov/news/press/2011pres/07/20110714a.html>; and U.S. Department of Health and Human Services, Health Resources and Services Administration, “School-Based Health Centers,” <http://wayback.archive-it.org/3926/20140108162123/http://www.hhs.gov/news/press/2011pres/07/20110714a.html#>.

<sup>120</sup> CRS Report R41390, *Discretionary Spending Under the Affordable Care Act (ACA)*.

<sup>121</sup> Health Resources and Services Administration, Bureau of Primary Care, *Uniform Data System*, 2013 National (continued...)

## Nurse-Managed Health Clinics

Nurse-managed health clinics (NMHCs) provide comprehensive primary care and wellness services to underserved populations at centers where nurses provide the majority of health services. NMHCs are required to serve the entire population in the area in which they are located and must have an advisory committee similar to those required for Section 330 health centers. NMHCs provide wellness services, prenatal care, disease prevention, management of chronic conditions (e.g., asthma, hypertension, and diabetes), and health education. Some also provide dental and mental health services.<sup>122</sup> ACA authorized grants to support NMHCs in PHSA Section 330A-1. In FY2010, HHS awarded \$15 million to provide three years of support for 10 NMHCs.<sup>123</sup> Grantees were required to submit a sustainability plan for operation after the federal grant period was completed in 2013.<sup>124</sup> No funding has been awarded since FY2010.

## Community Mental Health Centers

Community mental health centers (CMHC)<sup>125</sup> are licensed facilities that provide mental health services. These facilities are required to provide mental health services tailored to the needs of children and adults (including the elderly) who have a serious mental illness. These facilities are also required to provide services to individuals who have been discharged from inpatient treatment at a mental health facility. Among the required services, CMHCs must provide emergency services, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and screening for admission into state mental health facilities. The ACA required—effective April 1, 2011—that CMHCs provide less than 40% of their services to Medicare beneficiaries.<sup>126</sup>

CMHCs receive funding from Substance Abuse and Mental Health Services Administration (SAMHSA) block grants. These include SAMHSA substance abuse prevention and treatment block grants and community mental health services block grants.<sup>127</sup> In addition, CMHCs are eligible for HHS grants awarded through the Social Service Block Grant.<sup>128</sup> CMHCs also receive reimbursements from Medicare and Medicaid for covered services provided to beneficiaries enrolled in these programs.

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Summary Report, Rockville, MD, <http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2013&state=> (hereinafter, *2013 UDS Report*).

<sup>122</sup> Tina Hansen-Turton, *NNCC 2010 Annual Report*, National Nursing Centers Consortium, Philadelphia, PA, <http://www.nncc.us/site/pdf/publications/2010AnnualReport.pdf>.

<sup>123</sup> Department of Health and Human Services, “Sebelius Announces New \$250 Million Investment to Strengthen Primary Health Care Workforce,” press release, June 16, 2010, <http://www.hhs.gov/news/press/2010pres/06/20100616a.html>.

<sup>124</sup> *Ibid.*

<sup>125</sup> As defined in 42 U.S.C. §1395x.

<sup>126</sup> The Center for Medicare & Medicaid Services (CMS) has also established conditions of participation—requirements for Medicare providers—for CMHCs. See 78 C.F.R. §64,603.

<sup>127</sup> For more information about the Substance Abuse and Mental Health Services Administration block grants, see <http://www.samhsa.gov/>.

<sup>128</sup> CRS Report 94-953, *Social Services Block Grant: Background and Funding*.

## Native Hawaiian Health Care

The federal government supports the Native Hawaiian Health Care System (NHHCS), which is composed of five grantees and the Papa Ola Lokahi, a consortium of health care organizations that provide primary care, health promotion, and disease prevention services to Native Hawaiians. This population often faces cultural, financial, and geographic barriers to accessing health care services. The NHHCS was originally authorized under the Native Hawaiian Health Care Act of 1988 (P.L. 100-579), which was reauthorized through FY2019 in the ACA.<sup>129</sup> The NHHCS is not a grant program under Section 330 of the Public Health Service Act, but the system receives funding through the health center appropriation.<sup>130</sup> In 2013, NHHCS provided medical and enabling services, such as transportation and translation services, to more than 12,000 people.<sup>131</sup>

## Tribal Health Centers

Indian Tribes (ITs), Tribal Organization (TOs), and Urban Indian Organizations (UIOs)<sup>132</sup> may receive funds from the Indian Health Service (IHS) to operate health centers for American Indians or Alaska Natives. Although tribal health centers may be similar to health centers funded under Section 330 grants, they are not subject to Section 330 requirements. For example, they are not required to provide services to all individuals in their service area. They are also not required to seek payments or reimbursements on behalf of the clients they see because IHS provides services to all eligible American Indians and Alaska Natives free of charge. Tribal health centers—those operated by an IT, a TO, or a UIO—may be designated as Federally Qualified Health Centers (FQHCs)<sup>133</sup> and receive the Medicare and Medicaid FQHC payment rate (see **Appendix B**).

ITs, TOs, and UIOs may also apply for and receive funds under Section 330 of the PHSA; however, should an entity receive Section 330 funds, it would be subject to all Section 330 requirements (i.e., would be required to provide services to non-American Indians and Alaska Natives). Tribal health centers that receive Section 330 grants are also required to ensure that funds received from IHS are used to provide services only to IHS-eligible individuals.

## Rural Health Clinics

Rural health clinics (RHCs) are outpatient primary care facilities located in rural and medically underserved areas. These facilities receive higher Medicare and Medicaid payments—similar to the FQHC payment rate<sup>134</sup>—for services provided to beneficiaries enrolled in the Medicare and Medicaid programs. RHCs are similar to health centers, except that they (1) do not receive federal

<sup>129</sup> See CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*.

<sup>130</sup> The NHHCS program has been funded from the Consolidated Health Centers budget line annually since 1997.

<sup>131</sup> HRSA FY2016 Budget Justification.

<sup>132</sup> Indian Tribes and Tribal Organizations must be operating facilities under the authority of the Indian Self-Determination and Education Assistance Act (P.L. 93-638); Urban Indian Organizations must receive grants authorized under Title V of the Indian Health Care Improvement Act. For more information, see CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

<sup>133</sup> These facilities received the ability to be designated as FQHCs in P.L. 103-66.

<sup>134</sup> Beginning in FY2015, because of requirements included in the ACA, Medicare payments for Rural Health Clinics will differ from those made to FQHCs. See **Appendix B**.



grants, (2) may be operated by for-profit entities, (3) are not required to provide services to individuals regardless of ability to pay, and (4) are not required to offer a sliding-scale fee schedule.<sup>135</sup>

## Free Clinics

Free clinics are outpatient facilities that provide medical, dental, and behavioral health services to underserved populations that are primarily uninsured. Free clinics are tax-exempt organizations that provide health care to individuals regardless of their ability to pay and are not permitted to charge for services.<sup>136</sup> In general, free clinic funding comes from donations (both monetary and in-kind), religious groups, foundations, and corporations.<sup>137</sup> More than 1,200 free clinics<sup>138</sup> provide services to a population that is similar to that served by health centers.<sup>139</sup> Free clinics do not receive HRSA funding, but they may participate in the Free Clinics Medical Malpractice Program administered by HRSA, which provides liability coverage to health care providers at free clinics.<sup>140</sup>

## Federally Qualified Health Center (FQHC) Look-Alikes

FQHC look-alikes are facilities that meet the criteria to receive a health center grant but do not receive a grant because Section 330 funding is not available.<sup>141</sup> The FQHC look-alike program was authorized in 1990 to support the demand for new health centers.<sup>142</sup> HRSA and CMS can designate certain facilities as “FQHC look-alikes,” making these facilities eligible for certain federal programs (e.g., the NHSC and the 340B drug discount program)<sup>143</sup> available to health centers and for the FQHC payment rate. To be designated as an FQHC look-alike, a facility submits an application to HRSA, the agency reviews the application, and then recommends to CMS which facilities should be designated as FQHC look-alikes. In 2013, look-alikes reported serving 1,027,960 patients.<sup>144</sup> Generally, look-alikes offer similar services to health centers but

<sup>135</sup> Health Resources and Services Administration, Department of Health and Human Services, *Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs*, Revised, Rockville, MD, June 2006, <http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf>.

<sup>136</sup> 42 U.S.C. §233.

<sup>137</sup> *Ibid.*

<sup>138</sup> See <http://www.freeclinics.us/>.

<sup>139</sup> Julie S. Darnell, “Free Clinics in the United States: A Nationwide Survey,” *Archives of Internal Medicine*, vol. 170 (June 2010), pp. 946-953.

<sup>140</sup> See <http://bphc.hrsa.gov/ftca/freeclinics/>; this coverage is similar to the Federal Torts Claims Act coverage discussed above; see “Federal Torts Claims Act Coverage.”

<sup>141</sup> A number of look-alikes subsequently obtain health center grants, as HRSA found that between 2002 and 2007, approximately 36% of look-alikes that applied for health center grants were successful. See U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Centers: America’s Primary Care Safety Net, Reflection on Success, 2002-2007*, Rockville, MD, 2008, [ftp://ftp.hrsa.gov/bphc/HRSA\\_HealthCenterProgramReport.pdf](ftp://ftp.hrsa.gov/bphc/HRSA_HealthCenterProgramReport.pdf).

<sup>142</sup> §1905 of the Social Security Act for Medicaid, and §1861(aa)(4) of the Social Security Act for Medicare.

<sup>143</sup> See descriptions of these programs in the report sections “National Health Service Corps Providers” and “340B Drug Pricing Program.” FQHC look-alikes are not eligible for “Federal Torts Claims Act Coverage.”

<sup>144</sup> 2013 UDS Report, Look-Alikes Data.

may have more limited capacity than health centers; for example, they may offer fewer dental services.<sup>145</sup>

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<sup>145</sup> Peter Shin et al., *Community Health Centers: A 2012 Profile and Spotlight on Implications of State Medicaid Decisions*, The Kaiser Commission on Medicaid and the Uninsured, Issue Brief, Washington, DC, September 2014.

## Appendix B. Medicare and Medicaid Payments and Beneficiary Cost Sharing for Health Center Services

All federal Health Center Program grantees may be designated as federally qualified health centers (FQHCs)<sup>146</sup> upon enrolling as an FQHC in the Medicare and Medicaid programs.<sup>147</sup> The FQHC designation makes Section 330 grantees (among others; see text box) eligible for Medicare and Medicaid reimbursements rates that are generally higher than the reimbursement rates for comparable services provided in a physician's office.<sup>148</sup> In FY2015, these reimbursements represented 47.5% of the Health Center Program's revenue (see **Table 4**). The FQHC designation was created to ensure that Medicare and Medicaid reimbursements cover the costs of providing services so that Section 330 grant funds are not used to subsidize these costs.<sup>149</sup> This appendix describes Medicare and Medicaid payments to FQHCs. The Affordable Care Act (P.L. 111-148, as amended) required that a new Medicare payment methodology be developed. As a consequence, Medicare payments to FQHCs increased by approximately 32%. This report describes current Medicare payment methodology. For information about the prior Medicare payment methodology, see CRS Report R42433, *Federal Health Centers*.<sup>150</sup>

### Social Security Act FQHC Definition

FQHC means (1) an entity that is receiving a PHS Section 330 grant or is receiving funding through a contract with a PHS Section 330 grant recipient; (2) an entity that meets the requirements to receive a PHS Section 330 grant as determined by HRSA; (3) an entity that was treated by the Secretary of HHS as a comprehensive federally funded health center for the purposes of Medicare Part B as of January 1, 1990; or (4) an outpatient program or facility operated by an Indian Tribe, Tribal Organization, or Urban Indian Organization receiving funds authorized in the Indian Health Care Improvement Act.

**Source:** §1861I(aa)(4) of the Social Security Act, 42 U.S.C. §1395x and §1905(l)(2)(B), 42 U.S.C. §1396d.

<sup>146</sup> The Medicaid payment designation began in 1990 in the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239). The FQHC payment rate for Medicare was implemented in 1992 in Department of Health and Human Services, "Medicare Program: Payment for Federally Qualified Health Center Services," 57 *Federal Register* 24,961, June 12, 1992, and 61 *Federal Register* 14,640, April 3, 1996.

<sup>147</sup> A §330 grantee can operate facilities at multiple sites; each of these sites must enroll as an FQHC. See Health Resources and Services Administration, *Program Assistance Letter: Process of Becoming Eligible for Medicare Reimbursements under the FQHC Benefit*, Rockville, MD, March 8, 2011.

<sup>148</sup> These payments are considered to be "higher" than the payment rates that physician practices receive because they are cost-based and reflect a broader range of services than payments to physician practices. See, for example, Department of Health Policy, School of Public Health and Health Services, The George Washington University, *Quality Incentives for Federally Qualified Health Centers, Rural Health Clinics and Free Clinics: A Report to Congress*, Washington, DC, January 23, 2012.

<sup>149</sup> See discussion in National Association of Community Health Centers, *Emerging Issues in the FQHC Prospective Payment System*, Washington, DC, September 2011, and U.S. Government Accountability Office, *Medicare Payments to Federally Qualified Health Centers*, GAO-10-576R, July 30, 2010.

<sup>150</sup> Prior to this policy change, Rural Health Clinics and FQHCs were paid using the same payment methodology; Rural Health Clinics are still paid using the payment methodology described in Appendix B of CRS Report R42433, *Federal Health Centers*.

## Medicare Payments to Health Centers<sup>151</sup>

Beginning October 1, 2014, Medicare FQHC payments increased by approximately 32% as the Centers for Medicare & Medicaid Services (CMS)—the agency that administers the Medicare and Medicaid programs—implemented a prospective payment (PPS) system.<sup>152</sup> This change was required in the ACA because of concerns that Medicare payments did not reflect the FQHC’s costs of providing services to Medicare beneficiaries.<sup>153</sup> To develop the PPS, CMS used the Medicare cost report and claims data to ensure that the rate reflects the cost of providing services.<sup>154</sup>

Under the new PPS, FQHCs are paid the lesser of their actual charges or an encounter rate for professional services furnished to a beneficiary in a single day. Medicare pays 80% of this amount which is based on an average reasonable cost for FQHC professional services furnished to a Medicare beneficiary per day. The beneficiary pays the remainder as part of their required cost sharing for FQHC services. The encounter rate is intended to reflect 100% of the reasonable costs of providing a service. It was calculated by estimating the reasonable costs that would have occurred for the year if the PPS was not implemented (excluding vaccines because they are paid at 100% of reasonable costs); this estimate was calculated without the application of copayments, per payment limits or productivity adjustments that limit Medicare payment to other provider types. The new encounter rate is intended to reflect the type, intensity, and duration of services that FQHCs provide and is adjusted to account for the geographic location of the FQHC providing the service. Rates are also adjusted for the initial Medicare visit (i.e., the Welcome to Medicare exam) and for the initial annual wellness visit (i.e., the first visit that Medicare beneficiary has at that FQHC), which are determined to be more intensive than a standard visit.<sup>155</sup> With some exceptions (e.g., mental health visit and when an injury occurs subsequent to the medical visit), the encounter rate is only paid to a facility once per day, because CMS determined that multiple visits per day were rare for Medicare beneficiaries. The new encounter rate applies to all services, except for the costs associated with the influenza and pneumococcal vaccines and their administration, which are paid at 100% of reasonable costs. FY2015 is a period of transition

<sup>151</sup> Unless otherwise specified, this section is drawn from Centers for Medicare & Medicaid Services, “Medicare Program; Prospective Payment System for Federally Qualified Health Centers; Changes to Contracting Policies for Rural Health Clinics; and Changes to Clinical Laboratory Improvement Amendments of 1988 Enforcement Actions for Proficiency Testing Referral,” 79 *Federal Register* 25435-25438, May 2, 2014, and Center for Medicare & Medicaid Services, “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015,” 79 *Federal Register* 67547 -68010, November 13, 2014; see Section O “Establishment of the Federally Qualified Health Center Prospective Payment System (FQHC PPS).”

<sup>152</sup> For information about the earlier payment system, see Appendix B of CRS Report R42433, *Federal Health Centers*.

<sup>153</sup> Sec. 10501(i)(3)(A) required that CMS establish a PPS for FQHCs. For a discussion of Medicare payment rates to FQHCs and their adequacy, see U.S. Government Accountability Office, *Medicare Payments to Federally Qualified Health Centers*, GAO-10-576R, July 30, 2010. Note that CMS disagreed with GAO’s data and findings; see discussion on p. 153 of Medicare Payment Advisory Commission, *Chapter 6: Federally Qualified Health Centers*, Report to Congress: Medicare and the Health Care Delivery System, Washington, DC, June 2011.

<sup>154</sup> In order to develop the new Prospective Payment System (PPS), the ACA required that, as of January 1, 2011, FQHCs report every service provided during a Medicare-covered patient visit using the appropriate Healthcare Common Procedure Coding System (HCPCS) code. HCPCS is used to standardize the identification of medical services, supplies, and equipment. It is used when billing the Medicare and Medicaid programs. For more information, see [https://www.cms.gov/MedHCPCSGenInfo/20\\_HCPCS\\_Coding\\_Questions.asp](https://www.cms.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp).

<sup>155</sup> See “Prevention Under Medicare” section in CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in ACA: Summary and Timeline*.

to the PPS, which will be updated (in accordance with other Medicare payment updates) annually beginning January 1, 2016.

Medicare beneficiaries are subject to different deductible and cost sharing requirements for services provided at FQHCs. Specifically, the Medicare Part B deductible does not apply for FQHC services.<sup>156</sup> Beneficiaries—with some exceptions<sup>157</sup>—must pay the 20% copayment for Medicare services. There are no copayments for preventive services, as required in the ACA.<sup>158</sup> FQHC visits generally include a mix of preventive services (not subject to coinsurance) and services that are subject to coinsurance. To determine which charges will be subject to the coinsurance, CMS subtracts the dollar value of the FQHC’s reported line-item charge for the preventive services provided from the full payment amount, Medicare then pays the FQHC 100% of the dollar value of the FQHC’s reported line-item charge for the preventive services, up to the total payment amount. Medicare will also pay 80% of the remainder of the full payment amount. The beneficiary would then pay the remainder (the 20% coinsurance). Should the reported line-item charge for the preventive services equal or exceed the full payment amount, Medicare pays 100% of the full payment amount and the beneficiary would not be responsible for any coinsurance.

The rule that implemented the Medicare PPS also removed the requirement that certain midlevel providers—certified nurse midwives, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers—be employees of the facility in order to bill Medicare for services that are provided “incident to”<sup>159</sup> the services of physicians.<sup>160</sup>

## Medicare Payment for Mental Health Services

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) changed Medicare reimbursement for mental health services at FQHCs. Previously, Medicare reimbursements were limited at 62.5% of the reasonable costs for outpatient mental health services; however, this was phased out, and as of January 1, 2014, Medicare payments are 100% of the reasonable cost for mental health services.<sup>161</sup>

<sup>156</sup> For discussion of FQHC services, see discussion in report section “Health Service Requirements.”

<sup>157</sup> FQHCs can waive collection of all or part of the coinsurance, depending on the beneficiary’s ability to pay.

<sup>158</sup> CRS Report R40978, *Medicare Coverage of Clinical Preventive Services*, and CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

<sup>159</sup> This refers to services that are provided as part of a patient’s normal course of treatment, where physicians initiate the service, but a non-physician provider continues treatment under the physician’s supervision. See Center for Medicare & Medicaid Services, Medicare Learning Network, “*Incident to*” Services, MLN Matters Number: SE0441, Baltimore, MD, <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf>.

<sup>160</sup> Center for Medicare and Medicaid Service, “D. Removal of Employment Requirement for Services Furnished “Incident to”: Rural Health Clinics (RHSC) and Federally Qualified Health Center (FQHC) Visits,” 79, No. 219 *Federal Register* 67751, November 13, 2014.

<sup>161</sup> U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, *Medicare Claims Process Manual*, Chapter 9- Rural Health Clinics/Federally Qualified Health Centers, Baltimore, MD, November 12, 2010, p. 18, <https://www.cms.gov/manuals/downloads/clm104c09.pdf>, and CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*.

## Medicaid Payments

Medicaid uses a PPS to reimburse FQHCs for services provided to Medicaid beneficiaries.<sup>162</sup> The PPS establishes a predetermined per-visit payment rate for each FQHC based on costs of services. The PPS was established based on cost report data in FY1999 and FY2000 and is updated annually for medical inflation.<sup>163</sup> The state, in turn, receives the appropriate federal matching amount. States are also required to adjust PPS payment rates based on any changes in the scope of services provided at the FQHC. States are not required to use the PPS to reimburse FQHCs, but they may not reimburse an FQHC less than it would have received under the PPS.<sup>164</sup> In 2014, approximately 23 states and the District of Columbia used the PPS, 14 states used an alternative payment methodology (APM) to reimburse FQHCs under Medicaid, and 9 states used a combination of both methods.<sup>165</sup> States are also required to supplement FQHCs that subcontract (directly or indirectly) with Medicaid Managed Care Entities (MCEs). These supplemental payments are supposed to make up the difference, if any, between the payment received by the FQHC from the MCE and the Medicaid payment that the FQHC would be entitled to under the PPS or the APM.<sup>166</sup> The ACA did not include changes in Medicaid FQHC reimbursement policy.

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<sup>162</sup> This was established under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554); 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*. Prior to the PPS, Medicaid used an all-inclusive rate.

<sup>163</sup> U.S. Government Accountability Office, *Medicare Payments to Federally Qualified Health Centers*, GAO-10-576R, July 30, 2010.

<sup>164</sup> *Ibid.*

<sup>165</sup> The remaining states did not respond to the National Association of Community Health Center's survey. See National Association of Community Health Centers, *2014 Update on the Implementation of the FQHC Prospective Payment System (PPS) in the States*, Washington, DC, December 2014.

<sup>166</sup> See a CMS-issued letter providing initial guidance on the new Medicaid prospective payment system, Jan. 19, 2001 at <http://www.cms.hhs.gov/smdl/downloads/smdl011901d.pdf>.