How to Work with a Federally Qualified Health Center

The term Federally Qualified Health Center or FQHC refers to three types of clinics:

1. Health Centers funded under Section 330 of the Public Health Service (PHS) Act including:
   - Community Health Centers (CHSs)
   - Migrant Health Centers (MHCs)
   - Homeless Health Centers (HCHs),
   - Public Housing Primary Care Centers (PHPCs)

2. FQHC “Look-Alikes” – sites that have been identified by the Health Resources Services Administration (HRSA) and certified by CMS as meeting the definition of a health center under Section 330, but they do not receive funding under Section 330. It is important to note that Look-Alike facilities do participate in the special reimbursement programs set up for grant-funded FQHCs.

3. Outpatient health programs and facilities operated by tribal organizations under the Indian Self-Determination Act.

FQHCs serve as safety net providers, primarily serving underserved populations. They must be located in a designated Medically Underserved Area (MUA) or provide services to a Medically Underserved Population (MUP).

FQHCs must be a nonprofit, tax-exempt corporation or public agency. The organization must have an independent governing board of directors. There are specific criteria for board participation including the fact that at least 51% (simple majority) of the board members must be consumers that the health center serves and represent the population being served by the health center.

Section 330 FQHC grantees receive funding annually from HRSA. As grantees, they have requirements to serve the target population regardless of their ability to pay. In addition, grantees must show an increase in the number of patients that they serve each year or potentially receive a reduction in their grant award.

Contracted Services

An FQHC can contract with another entity to provide services to FQHC patients. However, the contract must have board approval and be part of the site’s scope of allowable services.

In approaching FQHCs about potential partnerships it is important to stress the advantages to FQHCs, such as new source of patient referrals, recurring patients, referrals for other services, etc. FQHCs receive their funding from HRSA. Each facility receives an annual grant to support its operations. A requirement of this grant program is annual reporting to HRSA on multiple aspects of service delivery, including increases in the number of consumers receiving healthcare services, diversity in the types of consumers served and varying payor mixes. An increase in the number of Medicare beneficiaries served meets both of these objectives for the FQHC. An Area Agency on Aging could highlight these facts when discussing providing Diabetes Self-Management Training (DSMT) in partnership with the FQHC.

Reimbursement

Medicare reimbursement to a FQHC is based on an All-Inclusive Reimbursement Rate (AIRR). The AIRR is determined by the average cost that the
FQHC incurs for providing services. Based on the average cost of providing services to beneficiaries, the FQHC will receive the all-inclusive rate for each Medicare beneficiary that receives services from a qualified FQHC. It is important to note that this fixed amount is paid to the center for each Medicare beneficiary that is seen. The level of service provided is not factored into the amount that is paid to the FQHC. In contrast, the non-FQHC Medicare provider receives a graded payment based on the level of services provided to the beneficiary. The AIRR method of reimbursement ensures that the FQHC receives funding that will support the program, as long as it serves the correct number of patients per year.

It is also important to note that FQHC providers have productivity expectations that they must meet. If they do not see an acceptable number of patients each year, they could be cited by HRSA and continual infractions could result in a mandatory change in scope or reduction in grant award. Therefore, it is to the benefit of any FQHC to work with organizations that can help them meet their patient productivity goals each year.

The actual rate that the FQHC receives is based on its all-inclusive reimbursement rate as compared to the national capped amount. The center receives the lower of the two. The national capped amount is the maximum level of reimbursement that a FQHC can receive for services rendered to beneficiaries. The national capped amount is calculated based on the average cost of delivering medical services, based on the Medical Economic Index applicable to primary healthcare practitioner services. The 2012 national capped amount is as follows:

- Urban Payment: $128.49
- Rural Payment: $111.21

Many health centers receive an all-inclusive rate that is close to the national capped amount for each face-to-face encounter between the patient and the center health provider. This same amount is paid to the center if the patient has a 5 minute visit and receives only one service or if the patient is there for an hour and receives multiple services. FQHCs are reimbursed 80% of the all-inclusive rate and the patient is responsible for a coinsurance amount equal to 20% of the billed charges.

**FQHCs and DSMT**

FQHCs have limits on the services they are allowed to provide. Beginning January 1, 2006, FQHCs could begin providing Diabetes Self-Management Training (DSMT) and Medical Nutritional Therapy (MNT) services after the Deficit Reduction Act of 2005 amended the Social Security Act to add these services to the list of core FQHC services. In order to provide DSMT, the FQHC must be accredited and accepted by CMS. Once they obtain certification, they can receive per-visit payments for DSMT. FQHCs are paid at the All-Inclusive Rate for DSMT services. The all-inclusive rate is paid for services rendered to each eligible beneficiary.

Generally FQHCs can only be reimbursed for one service per person/day. However, they are allowed to bill for a basic service and DSMT on the same day. The exception is for MNT. MNT and DSMT cannot be billed on the same day. Medicare makes payments to FQHCs at the all-inclusive encounter rate that they receive for any medical service.

Current regulations only allow FQHC reimbursement for individual, face-to-face DSMT and MNT services. FQHCs cannot be reimbursed for group DSMT or MNT. However, FQHCs can bill the AIRR for all individual visits with a licensed professional who works with individual class
participants. During a standard class it is expected that each participant will visit with a licensed professional to conduct an initial assessment, individual instruction, as needed (e.g., insulin training), and an evaluation post training.

FQHC reimbursement is limited to the individual services because CMS expects that the cost of the group services is included in the standard all-inclusive rate that is provided for the individual, face-to-face services for FQHCs. This is a significant difference in billing procedures at a FQHC versus a standard Medicare provider. A regular Medicare provider can bill for both individual and group DSMT and MNT services, although at a substantially lower billing rate.

**For more information about DSMT accreditation and reimbursement**, please go to the [Diabetes Self-Management Toolkit](http://www.aoa.gov).

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