PRIMARY CARE PROGRAM IMPROVES REIMBURSEMENT

The Federally Qualified Health Center Program Helps Hospitals Improve Services to the Medically Indigent

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Created by Congress in 1989, the Federally Qualified Health Center (FQHC) program increases Medicaid and Medicare reimbursement to qualified primary care centers serving the medically and economically indigent. For many Catholic hospitals and independent outpatient facilities (particularly those serving a high proportion of Medicaid patients), the program can enhance the level and quality of services to this at-risk population. Providers should be aware that implementing the program can be a complex process and entails relinquishing direct control over the delivery of services; if the FQHC is properly structured, however, hospitals can still retain managerial, operational, and financial control.

Summary Under a program created by Congress in 1989, certain primary care treatment centers serving the medically and economically indigent can become Federally Qualified Health Centers (FQHCs). Recently enacted rules and regulations allow participants in the FQHC program to receive 100 percent reasonable cost reimbursement for Medicaid services and 80 percent for Medicare services.

An all-inclusive annual cost report is the basis for determining reimbursement rates. The report factors in such expenses as physician and other healthcare and professional salaries and benefits, medical supplies, certain equipment depreciation, and overhead for facility and administrative costs. Both Medicaid and Medicare reimbursement is based on an encounter rate, and states employ various methodologies to determine the reimbursement level. In Illinois, for example, typical reimbursement for a qualified encounter ranges from $70 to $88.

To obtain FQHC status, an organization must demonstrate community need, deliver the appropriate range of healthcare services, satisfy management and finance requirements, and function under a community-based governing board. In addition, an FQHC must provide primary healthcare by physicians and (where appropriate) midlevel practitioners; it must also offer its community diagnostic laboratory and x-ray services, preventive healthcare and dental care, case management, pharmacy services, and arrangements for emergency services.

Because FQHCs must be freestanding facilities, establishing them can trigger a number of ancillary legal issues, such as those involved in forming a new corporation, complying with not-for-profit corporation regulations, applying for tax-exempt status, and applying for various property and sales tax exemptions. Hospitals that establish FQHCs must also be prepared to relinquish direct control over the delivery of primary care services.

ENHANCED REIMBURSEMENT

Under recently enacted FQHC rules and regulations, qualified entities are entitled to receive 100 percent reasonable cost reimbursement for Medicaid services and 80 percent reasonable cost reimbursement for Medicare services, each subject to a ceiling.

This 100 percent reasonable cost reimbursement for Medicaid services represents a dramatic shift from the fee-for-service reimbursement traditionally applied in the outpatient setting. Institution-specific rates are determined through use of an all-inclusive annual cost report. The report factors in such expenses as physician and other healthcare professional salaries and benefits, medical supplies, certain equipment depreciation, and overhead for facility and administrative costs.

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Mercy Hospital and Medical Center, Chicago, was the first Catholic hospital to restructure its primary care clinic operations to meet FQHC program requirements. Sr. Marie Moore, RSM, president of Mercy Hospital, reports that obtaining FQHC status has increased the clinic's Medicaid reimbursement from approximately $19 per visit, plus ancillary charges, to approximately $81 per encounter.

In addition to enhancing Medicaid and Medicare reimbursement, FQHC status often improves access to other funding sources. For example, as FQHC organizations, certain primary care service organizations can participate in various publicly and privately sponsored demonstration projects. They also become eligible for additional public and private grants.

FQHCs receive 100 percent reasonable cost reimbursement for Medicaid.

FQHC Criteria

To obtain FQHC status, an organization must satisfy four requirements:

- Demonstrate adequate community need
- Deliver the appropriate range of healthcare services
- Satisfy management and finance requirements
- Function under a community-based governing board

Community Need A proposed FQHC must serve one or more areas that have been designated by the secretary of the Department of Health and Human Services as Medically Underserved Areas (MUAs) or Medically Underserved Populations (MUPs). The application must demonstrate to the reviewers' satisfaction that a sufficient volume of clinic patients reside in MUAs or MUPs.

Delivery of Healthcare Services The FQHC application requires the facility to demonstrate an ability to deliver to its service area directly, or through arrangements with other providers, a number of specified primary, preventive, and ancillary healthcare services, including primary healthcare services by physicians and (where appropriate) by midlevel practitioners, diagnostic laboratory services, diagnostic x-ray services, preventive healthcare services, patient case management, pharmacy services needed to complete treatment, preventive dental services (for Medicaid patients), and arrangements for emergency services. Other requirements that pertain to medical staffing, quality assurance, hours of operation, and medical records must also be satisfied. An FQHC application must describe the method by which the clinic will provide or arrange for these services to its community.

FQHC services that will be reimbursed by the Medicare program include the following:

- Physician services
- Nurse practitioner or physician assistant services
- Clinical psychologist and clinical social worker services
- Visiting nurse services (under certain conditions)
- Certain preventive healthcare services

Drugs and biologicals ordinarily are covered only when they cannot be self-administered. Because they are explicitly excluded by the Medicare statute, preventive dental services are excluded from the list of Medicare-covered services. FQHC services are not covered when furnished to inpatients of hospitals.

Management and Finance Requirements Each FQHC must have accounting and internal control mechanisms appropriate to the organization's size. These mechanisms must include fee schedules for all billable services, methods for discounting or adjusting fees based on income level and family size, and plans to maximize nonfederal revenues. A related requirement is that the FQHC have an organizational structure appropriate to its size and complexity that defines clear lines of authority flowing from the executive director. The executive director must be responsible for the clinic's overall operation and must be directly accountable to the community-based governing board described next.

Governance Considerations The program requires that FQHC facilities be managed by a community-based governing board with 9 to 25 members, a majority of whom are active users of the facility's healthcare services and represent the popula-

tion served by the facility in terms of age, sex, and ethnicity. The remaining members of the board must generally represent the community served by the facility. No more than half of the nonuser board members may be individuals who derive more than 10 percent of their annual income from the healthcare industry. FQHC guidelines outline a number of other criteria applicable to such a board.

The community-based governance requirement often triggers concerns for Catholic-sponsored organizations about the loss of direct control over the primary care operations. Although a hospital may relinquish direct control, it can establish contractual relationships with the clinic to vest managerial, financial, and operational control in the hospital. For instance, the structure of the Mercy Hospital FQHC—as well as that of the FQHCs being developed by Ancilla Systems for its hospitals in Chicago and East St. Louis, IL—uses management and services agreements, loan and security agreements, and lease agreements. These contractual arrangements can also include a safeguard allowing the hospital to collapse the FQHC structure if the FQHC organization fails to comply with contractual conditions, including compliance with the *Ethical and Religious Directives for Catholic Health Facilities.*

Additionally, although the FQHC must maintain its autonomy for governance purposes, it is not prohibited from maintaining a religious purpose and mission. Through the contractual arrangement and establishment of charitable and religious purposes, Catholic hospitals can ensure, to a significant and meaningful extent, that the clinic operates in a manner consistent with the hospitals' charitable and religious missions.

New Requirements

PHS Regulations In June 1992 the Health Care Financing Administration (HCFA) issued regulations identifying the basic FQHC qualifications and detailed criteria for coverage of FQHC services under the Medicare program. These fall into the four categories identified previously. The federal Medicaid statute permits temporary waiver (up to two years) of certain requirements in granting FQHC status to new FQHC organizations; however, the Medicare statute does not provide for similar waivers.

The new regulations require each FQHC entity to enter into a participation agreement with HCFA. As HCFA acknowledged in the comments accompanying the regulations, the statute does not expressly mandate such an agreement.

Inter-Agency Agreement In December 1992, HCFA and the U.S. Public Health Service (PHS) entered into a new pact, titled the Inter-Agency Agreement for Medicaid Reimbursement for Federally Qualified Health Centers. The agreement outlines PHS responsibilities in reviewing FQHC applications and specifies the forms and procedures to be used in the application process. It also requires that applications received after July 15, 1992, from organizations not already designated as FQHC-qualified provide additional information (e.g., more detailed demographic breakdowns of the service-area population).

Issues to Consider

Although not explicitly included among the criteria for FQHC designation, additional issues arise if the proposed facility will be adjacent to, or part of, a hospital or other existing healthcare facility campus. An FQHC must be a freestanding facility, which has been interpreted by PHS to mean that an FQHC cannot be a hospital outpatient department. PHS has determined that organizations which were previously hospital outpatient departments, but have spun off from the hospital (creating separate governing boards and applying for separate Medicare and Medicaid provider numbers), may be eligible for FQHC status. However, the Inter-Agency Agreement imposes additional requirements on hospital outpatient facilities applying for FQHC status. In particular, it stipulates that a separate accounting system must be established for the FQHC organization.

If a management agreement, lease relationship, or indirect governance relationship will exist between the FQHC and another healthcare facility, PHS will closely scrutinize the arrangement to ensure appropriate authority is vested with the community governing boards. Similarly, full-time equivalency requirements, mandating a certain number of licensed physicians per number of encounters in the FQHC, may affect the structure. Additional issues may need to be considered if the hospital has a residency program that will be serving FQHC patients. All these components must be addressed before implementation of the program and may raise potential hurdles to FQHC clearance.

Implementing an FQHC can trigger a number of ancillary legal issues. For example, forming a new corporation for the purpose of owning and operating an FQHC will involve drafting organizational documents, complying with the applicable not-for-profit corporation act, preparing an application for Section 501(c)(3) tax-exempt status, and applying for state property and sales tax exemption. A hospital can often use an existing primary care corporation, provided that the articles of incorporation, bylaws, and other corporate documents are amended to satisfy the

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FQHC requirements.

Catholic-affiliated organizations typically seek tax-exempt status by applying for membership in the *Official Catholic Directory* (OCD) and qualifying for the exemption under the group ruling given to the Catholic Church. However, because the FQHC corporation cannot be construed as being under the control or auspices of another organization, it must attain an exemption independent of the OCD listing process.

Other issues to consider before implementing the FQHC program include analyzing licensure and other regulatory issues triggered by FQHC status, documenting the relationships between the FQHC and its medical staff and provider hospital, analyzing insurance aspects of the relationship, and addressing potential alienation of property and other canonical issues.

COSTS AND BENEFITS

Participation in the FQHC program can significantly improve Catholic providers' ability to deliver primary healthcare services to populations in need. However, sponsors should be aware that implementing the program *often entails complex licensure and* regulatory issues. In addition, hospital administrators must realize that, in creating an FQHC organization, they are required to give up direct control over the delivery of primary care services.

Before committing to the program, then, providers must ask whether they can meet FQHC requirements and whether the program's benefits justify the effort needed to create an FQHC. For organizations that can answer yes to both questions, the FQHC program presents an opportunity to improve the level and quality of primary healthcare services available in their communities. □

HEALTH POLICY

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5. What are the implementation details; how is it really going to work?

These questions and more will need to be addressed in the coming months as Clinton prepares to submit his plan to Congress. In the interim, Congress has planned a busy schedule of hearings and briefings so that when the plan comes down from the White House, they will be ready. For instance, in late January Rep. Pete Stark, D-CA, who chairs the House Ways and Means Subcommittee on Health, began a series of hearings on healthcare reform. Part of the hearing blitz (30 to 40 are planned) is to educate the large number of new committee members. But another reason is that the sheer complexity of the issues and the difficult policy decisions that lie ahead demand such intensive debate. □

NOTES

1. Alain C. Enthoven, "Consumer Choice Health Plan: A National Health Insurance Proposal," Memorandum to Health, Education, and Welfare Secretary Joseph Califano, September 22, 1977.
2. Alain C. Enthoven, "The History and Principle of Managed Competition," *Health Affairs*, Suppl., March 1993.
3. Enthoven, "The History and Principle of Managed Competition."
4. Paul M. Ellwood, Alain C. Enthoven, and Lynn Etheredge, "The Jackson Hole Initiatives for a Twenty-first Century American Health Care System," *Health Economics*, vol. 1, 1992, pp. 149-168.
5. Enthoven, "The History and Principle of Managed Competition."
6. Paul Starr, *The Social Transformation of American Medicine*, Basic Books, New York City, 1984.
7. Paul Starr, testimony before the Senate Labor and Human Resources Committee, December 17, 1992.
8. Paul Starr and Walter Zellman, "Bridge to Compromise: Managed Competition, Global Budgets, and Universal Coverage," *Health Affairs*, Suppl., March 1993.
9. Starr, testimony; Starr and Zellman.
10. John Garamendi, "California Health Care in the 21st Century: A Vision for Reform," State of California, Sacramento, February 1992.

ANALYSIS

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based on the attributes required for a GCN," Browne explained. Now 80 staff people from LGHS entities, as well as providers and community members, serve on 11 committees.

The committees, which meet every four to six weeks, coordinate activities in many areas, including finance, marketing, education, wellness, information systems, and research. The marketing committee, for example, eliminated separate brochures for each program and produced one brochure for all aging services in the system, Browne said. The education committee is creating training programs aimed at teaching employees to work effectively with older adults and instilling positive attitudes toward aging. The networking committee integrates external service providers into the GCN. And the central access/intake committee eliminates duplication in assessment.

Successful Cooperation "A spirit of collaboration" is integral to establishing a successful GCN, Browne said. "It is difficult for hospitals to treat others as equals," she said, but they must collaborate with consortium members and with outside providers. Also, all persons who work with older adults—no matter what hospital department they are part of—must function as part of a team to serve the chronically ill, she said.

"As we endeavor to reform the way services are financed, administered, and delivered to the chronically impaired elderly, we are asking people to plan and to eventually make some *major changes in the way they operate* on a day-to-day basis," Browne pointed out. She said that Lutheran General continues to incorporate into its daily operations the critical elements of successful internal and external collaboration. These include encouraging employees to work not only within the system but also with community players, ensuring that all stakeholders benefit from the arrangement, identifying effective processes and expected outcomes by allowing all players to speak freely about what they need to do their jobs, and evaluating processes to ensure accountability to the community.

—Judy Cassidy